

# P P O O P E N E N R O L L M E N T P O L I C Y

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Policy  
Preferred Provider Open Enrollment Plan

October 6, 2009

Policy  
“SummaCare PPO- Open Enrollment Plan”  
Underwritten by the Summa Insurance Company  
Administered by SummaCare

This booklet is your Policy. It explains details of the SummaCare PPO Open Enrollment Plan benefits designed for Open Enrollment Policyholders and their eligible insured dependents. This Policy and the corresponding Schedule of Benefits will help the Policyholder (also referred to as you) and your insured dependents understand your selected benefit plan by explaining your benefit coverage and the level of payment of these benefits. Please refer to this Policy whenever you require medical services. It describes how to access medical care and what health services are provided under the SummaCare PPO Open Enrollment Plan.

**NOTICE: IF YOU OR YOUR INSURED FAMILY MEMBERS ARE COVERED BY MORE THAN ONE POLICY, YOU MAY NOT BE ABLE TO COLLECT PAYMENT FOR BENEFITS FROM BOTH POLICIES. EACH POLICY MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC HEALTH CARE PROVIDERS. IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH POLICIES AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION. COMPARE THEM WITH THE RULES OF ANY OTHER POLICY THAT COVER YOU OR YOUR FAMILY.**

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## I. Your Good Health

While many health plans limit your choice of providers to only those participating in their provider network, SummaCare realizes that you might prefer to visit other providers for your healthcare needs. This SummaCare PPO Open Enrollment Policy is designed to allow you maximum flexibility in choosing your providers. If you choose to access a Preferred Provider, your individual calendar out-of-pocket expenses for medical services will be kept to a minimum. You still have the option to seek medical treatment from other out-of-network healthcare providers.

### A. Understanding Your Policy

This Policy is easy to use. You need to know how this Policy relates to your Schedule of Benefits. This will allow you to maximize the benefits from your Preferred Provider plan.

This Policy, along with your Schedule of Benefits, gives you complete information about the coverage under your PPO Open Enrollment Plan. To determine your benefits for a specific service you should refer to this booklet and your Schedule of Benefits. You also should check this Policy and your Schedule of Benefits when you have a question about coverage exclusions or other healthcare needs. This Policy presents detailed information about your benefits. Your Schedule of Benefits is a summary of the benefits and costs that you are responsible for under this policy. If you refer to one without looking at the other, you might misunderstand your benefits.

In the back of this Booklet you will find a list of Policyholder's Rights and Responsibilities. Please read these Rights and Responsibilities. You should understand what you must do and what SummaCare must do to make sure you get the most benefits and coverage under your policy. You can always call Customer Service at 330-996-8700 or 800-996-8701 if you need more information.

Definitions are found in section XII of this booklet. It lists the definitions of terms that are used in this Policy and your Schedule of Benefits.

### B. When Care is Received From a Preferred Provider

When you receive care from a Preferred Provider, benefits will be paid at the Preferred Provider maximum allowable charge for the service. Benefits will not be provided for care that is not a covered service even if performed by a Preferred Provider. All services must be directed by a provider and be medically necessary. Under this Policy you must pay for services you receive that are not covered.

If you select to receive care from a Preferred Provider:

- You will receive the highest level of benefit coverage.
- You will not be required to file any claim forms.
- You are not responsible for getting prior authorization of procedures when care is received.

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- ❑ Your Preferred Provider in our service area is responsible for the submission of claims and prior authorization procedures.
- ❑ Our Preferred Providers have agreed to accept the Preferred Provider maximum allowable charge as full payment for their services. There will be no balance billing to the Policyholder or insured dependent other than the appropriate deductible, copayment and coinsurance charged as stated in your Schedule of Benefits.
- ❑ You will need to meet the deductible, before receiving payment of benefits under your Policy. Once the deductible is met your care is covered at the level stated in your Schedule of Benefits. You are also responsible for any copayment and/or coinsurance. This information can be accessed by referring to your Schedule of Benefits. On your Open Enrollment PPO plan there is only an individual deductible per insured, (no family deductible). Your deductible is not included in your out-of-pocket maximum.
- ❑ All Health Care Management will be the responsibility of the Preferred Provider. You should verify that your preferred provider has authorized your inpatient and outpatient services. Your Preferred Providers will communicate with the SummaCare Health Services Management Department on these needed prior authorizations.

It is your responsibility to make sure all services that require a prior authorization outside our Service Area or are performed by a Non-Preferred Provider are completed.

### **C. Relationship Between Parties**

Providers who contract with SummaCare form our network and are called Preferred Providers. Our providers are not agents or employees of SummaCare, nor is SummaCare the agent or employee of any provider.

Your provider is responsible for all medical services you may need.

Summa Insurance Company (SummaCare) and its employees, officers, trustees or agents shall not be held responsible or otherwise liable for any negligence or omission or other liability caused by another. This applies to any participating or non-participating physician, practitioner or other provider. This includes, but is not limited to, doctors, hospitals, and pharmacies. You agree not to bring a claim against SummaCare or any of its employees, officers, trustees, or agents, for such negligence, omission or other liability.

If you would like information about a Provider's qualifications, please call Customer Service at 330-996-8700 or 1-800-996-8701 or access our Web site at [www.summacare.com](http://www.summacare.com).

### **D. When Care is Received from a Non-Preferred Provider**

SummaCare does not contract with Non-Preferred physicians, practitioners and other providers. If you choose to receive care from a Non-Preferred Provider, the services are considered out-of-network and the level of benefit payment will be at the Non-Preferred Provider rate. The only exception is care received for Emergency Services.

If you select to use a Non-Preferred Provider:

- ❑ You may be responsible for filing claims.

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- ❑ You will be responsible for guaranteeing all prior authorizations and pre-approvals are completed by your Non-Preferred Provider. If the proper prior authorization is not completed, the payment for the service will be paid at a lower level. Please refer to the Health Services Management section of this Policy for proper prior authorization procedures and the Prior Authorization List in the back of this booklet. You will incur a 10% penalty for lack of prior authorization when a Non-Preferred Provider is used for healthcare service. The penalty will be taken on the facility charge and will not exceed \$500 per occurrence.
- ❑ You will be responsible for meeting the Non-Preferred Provider deductible. Please note this deductible is separate from the Preferred Provider deductible. Also, you will be responsible for all copayments and coinsurance. The level of coinsurance is stated on your Schedule of Benefits and is a lower reimbursement level than if you would use a Preferred Provider. Please look closely at the chart below as it explains the difference in payment levels.

This is an example of the difference you would pay if you use a Preferred Provider vs. a Non-Preferred Provider.

This example uses a \$25 copayment for the Preferred Provider and 40 % coinsurance for Non-Preferred Provider (Copayments/coinsurance differ by Preferred Provider).

Assumes Deductible Has Been Met	Care Received from a Preferred Provider	Care Received from a Non-Preferred Provider
You are billed	\$150	\$150
SummaCare maximum allowable charge*	\$100	\$100
You will pay Copayment/Coinsurance of:	\$25 copayment	\$40 (40% coinsurance of maximum allowable charge)
SummaCare will pay the maximum allowable charge minus your Copayment/Coinsurance	\$75	\$60 (60% of maximum allowable charge)
Total You Will Pay	\$25	\$40

\*Maximum allowable charges are different for Preferred Providers and Non-Preferred Providers.

**E. Balance Billing under Your Open Enrollment PPO Plan**

On your Open Enrollment Plan, when services are received in the State of Ohio, and when you have used either a Preferred Provider or a Non Preferred Provider, the provider shall not balance bill the member for any charges. This is stated in Ohio Law as quoted below:

As stated in Sections 1751.16 and 3923.122 of the Ohio Revised Code, Section (J): “No hospital, health care facility, or health care practitioner, and no person who employs any health care practitioner, shall balance bill any individual or dependent of an individual for any health care supplies or services provided to the individual or dependent who is insured under a policy issued under this section (Open Enrollment Plan). The hospital, health care facility, or health care practitioner, or any person that employees the health care practitioner, shall accept payment made to it by the carrier under the terms of the policy or contract insuring or covering such individual as payment in full for such health care supplies or services.

As used in this division, “hospital” has the same meaning as in section 3727.01 of the Revised Code; “health care practitioner” has the same meaning as in section 4769.01 of the Revised Code; and “balance bill” means charging or collecting an amount in excess of the amount reimbursable or payable under the policy or health care service contract issued to an individual under this section for such health care supply or services. “Balance bill” does not include charging for or collecting copayments or deductibles required by the policy or contract.

#### **F. Health Services Management - Utilization Management**

SummaCare’s Open Enrollment PPO supports a Utilization Management Program that includes prior authorization, concurrent review, retrospective review, and pharmaceutical review.

Prior authorization review is the process of determining the medical necessity of a proposed procedure, surgery or treatment (including prescribed drug intervention) relative to approved criteria. Prior authorization is required for certain procedures and prescriptions to ensure that the service is medically necessary and that you will get all of the benefits to which you are entitled. We use nationally accepted and internally developed criteria when reviewing a service for prior authorization.

Concurrent review is the process of continual reassessment of the medical necessity and appropriateness of care in a hospital, medical rehabilitation unit or skilled nursing facility.

Retrospective review is the process of determining approval of payment after services have been rendered.

Board certified physician consultants from appropriate specialties are available, as needed, to SummaCare’s Medical Directors in making determinations of medical necessity.

The Health Services Management Program follows nationally accepted criteria. Medically necessary care is defined as services or supplies provided by a provider to identify or treat an illness or injury. This applies when those services or supplies are:

1. Consistent with the symptoms or diagnosis and treatment of the condition, disease, ailment or injury;
2. Appropriate to the standards of good medical practice;
3. Not primarily for the convenience of the patient, the physician , practitioner or other provider; and
4. The most appropriate supplies or services that can be given safely to the patient. If your symptoms or condition require services or supplies that cannot be given safely on an outpatient basis, you will receive the services or supplies on an inpatient basis.

#### **G. Prior Authorization**

**HEALTH SERVICES MANAGEMENT PRIOR AUTHORIZATION PHONE NUMBER:  
1-888-996-8710**

Prior authorization must be obtained for certain healthcare services to establish benefit coverage and medical necessity. You or your provider must notify SummaCare’s Health Services Management Department 48 hours in advance of obtaining the specific healthcare service.

**H. Prior Authorization Required for the Listed Procedures, Admissions and Devices**

Please see the attached Prior Authorization List in the back of this booklet for the list of procedures, admissions and devices that require Prior Authorization. This list is also posted on our website at [www.summacare.com](http://www.summacare.com).

**I. Evaluation of New Technology**

On a regular basis, we review and consider new medical technologies and new applications of existing technologies to include as covered benefits. This includes medical procedures, drugs and devices. Our Chief Medical Officer and our Clinical Quality Committee review and investigate new technology by:

- Finding out if FDA approval has been obtained.
- Reviewing research data.
- Requesting information directly from the manufacturer.

At least two (2) sources of information must be used including such references as scientific literature, abstracts or other data. Regulatory reviews may also be used in review.

Participating providers are informed of the implementation of the new technology and how it relates to each benefit package.

We also continually evaluate new and existing pharmacological technologies, including procedures, services, treatments and pharmaceuticals. The SummaCare Pharmacy and Therapeutic Program is responsible for assuring optimal therapeutic use of pharmaceuticals and for developing policies and procedures to guide pharmacy management.

**J. Calendar Year Out-of-Pocket Maximum**

Your share of the cost of covered services is limited to the annual individual calendar year out-of-pocket maximum shown in your Schedule of Benefits. Copayments do not apply to the annual out-of-pocket maximum. Calendar year individual amounts paid for your deductible do not apply to your out-of-pocket maximum. If there is a penalty to you for not prior authorizing services, the amount of the penalty charged will not apply to the maximum out-of-pocket.

## II. Who Is Eligible for SummaCare

### A. Your PPO Open Enrollment Plan

The SummaCare Open Enrollment Plans shall be available to applicants applying for our Open Enrollment Plan which meet the eligibility requirements as stated below. Our Open Enrollment Period is held yearly and is renewed on a calendar year basis beginning January 1 of each year. Availability will be on a first come first serve basis and will be held open through out the year until our Open Enrollment quota is met. SummaCare shall offer a Preferred Provider Open Enrollment Plan (Standard) and a Basic Indemnity Open Enrollment Plan to applicants.

Written notice of the Open Enrollment Plan shall be posted by the Ohio Department of Insurance and also available on the SummaCare website. Applications will be received, processed and premium rates quoted based on age, sex, and demographics of the enrollee and based on the capped premium rates as established by the Ohio Department of Insurance. The Open Enrollment Plan is considered an individual plan, applicants may also apply for eligible dependents but each family member is rated separately.

The contractual periodic prepayments for premiums charged to subscribers for such Open Enrollment Plans may not exceed:

For calendar years 2010 and 2011, an amount that is two times the base rate charged any other individual to which SummaCare is currently accepting new business and for which similar copayments and deductibles are applied.

For calendar year 2012 and every calendar year thereafter, an amount that is one and one-half times the base rate charged any other individual to which SummaCare is currently accepting new business and for which similar copayments and deductibles are applied.

### B. Applying for An Open Enrollment Plan If You Are Federally Eligible or Non-Federally Eligible

Ohio law requires SummaCare to accept a certain number of individuals for Open Enrollment coverage without regard to health status. If you qualify as a **Federally Eligible Individual (FEI)**, your coverage will be effective immediately without any pre-existing condition exclusion period. If you do not qualify as a Federally Eligible Individual, you may apply for Non-Federally Eligible open enrollment coverage as stated below.

You are a **Federally Eligible Individual** if you meet all of the following conditions;

1. You had health coverage for at least 18 months without a break in coverage greater than 63 days.
2. Your most recent health coverage was under a group health plan, governmental plan or church plans.
3. You are not eligible for coverage under any of the following plans;
  - a. A group health plan
  - b. Medicare
  - c. Medicaid
4. You do not have any other health coverage.
5. Your most recent health coverage was not terminated because of nonpayment of premiums or fraud.

6. If you had been offered the option to continue coverage under COBRA or a state continuation plan, you both elected and exhausted the continuation coverage.

If we have not yet met our enrollment quota, we will offer you this Open Enrollment Plan. You will need to submit proof of previous creditable coverage.

You are a **Non-Federally Eligible Individual** if you meet the following conditions:

1. You are not applying for coverage as an employee of an employer, member of an association or member of any other group.
2. You do not have any other health coverage and are not eligible to be covered under any private or public health benefit plans including the following:
  - a. Medicare or Medicare supplement policy
  - b. Medicaid
  - c. Any COBRA or state continuation coverage plan
  - d. Other health benefits arrangements

If we have not yet met our enrollment quota, we will offer you this Open Enrollment Plan. We are not required to accept applicants who at the time of enrollment, are confined to a health care facility due to chronic illness or permanent injury. As a Non-Federally Eligible Individual coverage may be limited for pre-existing conditions for the first 12 months, however, we will credit time you were covered under a recent previous health plan (refer to the Pre-Existing Condition Section of this Policy).

### **C. Dependent Eligibility- Considered an Individual Plan- Dependents Rated Individually**

Eligible dependents include:

1. Your legal spouse.
2. You or your spouse's unmarried dependent child under the attainment age of 19. After your dependent child reaches the age of 19, he or she will be eligible for his or her own Open Enrollment Plan or Individual Plan.

- **Dependent Child**

The term "dependent child" includes: a) biological children; b) stepchildren (defined as a stepchild who is primarily dependent upon you or your spouse for maintenance); c) legally adopted children; d) children for whom you or your spouse is the legal guardian (the Policy Holder must submit an application within 31 days of the date the legal guardianship is approved by the court); and e) children for whom you are responsible by court decree or Qualified Medical Support Order for principal support.

- **Adopted Child**

Your adopted child becomes an eligible dependent on the same basis as other dependent children. In the case of an agency adoption, the dependent becomes eligible on the date of adoptive placement as specified in the adoptive placement agreement. In the case of an independent adoption, the dependent is eligible on the later of the date the child is placed in your physical custody or the date the petition for adoption is filed with the probate court.

- **Handicapped Child**

Coverage will be continued past the age of 19 only if a dependent continues to be:

- a. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- b. Primarily dependent upon the Policy Holder for support and maintenance.

You must provide proof of such incapacity and dependence within 31 days of the child reaching age 19. SummaCare may request proof of the continuance of such incapacity and dependency once a year.

- **Newborn Child/Children**

Newborn children will be covered for illness or injury for a period of 31 days from the date of the child's birth. A change form is required to add the newborn child to the policy. We will notify you of any premium change as a result of adding your newborn child.

- **Guardian**

We require you to provide a copy of any legal documents awarding guardianship of a child. Temporary custody is not sufficient to establish eligibility under this policy. You must submit this documentation within 31 days of the date the court awards guardianship. Coverage will begin on the date the court approved legal guardianship if we received a change notice within 31 days of this event.

**EFFECTIVE JULY 1, 2010 THE BELOW PROVISION WILL BE ADDED:**

3. Your unmarried adult child after the attainment age of 19 and under the age of 28, if the following requirements are all met: (Unmarried children covered under this Open Enrollment Plan will considered part of the family unit for administration purposes but will be rated Individually).

- a. Your unmarried adult child must be under the age of 28;
- b. Your unmarried adult child must be your natural child, your stepchild, or your adopted child;
- c. Your unmarried adult child is a resident of the state of Ohio or is a full-time student at an accredited college or university;
- d. Your unmarried adult child must not be employed by an employer that offers any health benefit plan that your unmarried adult child is eligible to enroll; and
- e. Your unmarried adult child must not be eligible for coverage under the Medicaid program or the Medicare Program.

**D. Qualified Medical Child Support Orders:**

We will enroll for immediate coverage under this Plan any eligible dependent who is the subject of a Medical Child Support Order that is not already covered by the Plan as an eligible dependent once we have determined that such order meets the standards for qualification under Section 609 the Employee Retirement Income Security Act.

**III. Enrolling In SummaCare**

**A. Enrolling in the SummaCare Open Enrollment PPO Plan**

SummaCare will run an Open Enrollment period for the Open Enrollment PPO Plan beginning January 1 of each year and we will keep this period open though out the year until we reach of capped quota as provided by the Ohio Department of Insurance. The quota will be for calendar years 2010 and 2011; four percent of SummaCare's number of individual or non-employer group insured in the State of Ohio. For calendar year 2012 and every year thereafter eight per cent of SummaCare's number of individuals or non-employer group insured in the State of Ohio unless the Superintendent of Insurance amends this requirement. SummaCare shall not be required to accept under their Open Enrollment Plan applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to SummaCare.

The effective date of this plan will be ninety days after the date of acceptance by SummaCare of the subscriber's application. If an individual had prior coverage with a health benefit plan who exited the market place, and if the subscriber applied for the SummaCare Open Enrollment Plan within sixty-three days of the termination of coverage from that prior plan, the effective date of benefits shall be the date of application acceptance by SummaCare.

**B. Pre-Existing Condition Limitation- Applies to Non-Federally Eligible Individuals (Non-Federally Eligible Individual defined in Section II, B**

A Pre-existing condition is any medical condition that has been diagnosed or treated within six months before your effective date of coverage under the Policy. Insurers may not consider pregnancy or the use of genetic testing for imposing a pre-existing condition exclusionary period.

Pre-existing condition exclusions shall not exclude or limit coverage beyond 12 months from your effective date of coverage. We will shorten the time period for pre-existing conditions by the amount of time you or your dependent was covered under a previous policy or plan if your coverage starts by midnight of the 63<sup>rd</sup> day after another policy or plan ends.

**C. Privacy Requirements**

SummaCare must internally use your protected health information in order to conduct our business and provide you with the care and services to which you are entitled as a member. We may use or disclose information about you in order to facilitate your treatment and/or payment by or to a health care provider, third party administrator, insurance company, or other appropriate entities, including government and law enforcement agencies, without your signed authorization. Additional disclosures may be disclosed to include the following:

- Individuals involved in arranging for your care or payment of your care.
- Business Associates, who are persons or organizations we contract with to assist us with our health care operation.
- As required by law or law enforcement agencies.
- Public Health Activities
- The Food and Drug Administration
- Health Oversight Activities
- Lawsuits and Disputes
- Coroner, Medical Examiners and Funeral Directors

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- Organ and Tissue Donations
- Research
- Military and Veterans
- National Security and Intelligence
- Workers' Compensation

We will use and disclose your protected health information as necessary, and as permitted by law, for our health care operations. Such operations include processing claims, payment, treatment, coordination of care, business management, accreditation and licensing, quality improvement, enrollment, underwriting, compliance, auditing and other functions related to your health benefits plan.

Data used for research will not include personal identification information and must be approved by the Privacy Officer. The release of this information does not require your authorization.

In the event that you are deemed incompetent or cannot provide authorization, SummaCare requires documented proof of power of attorney or guardianship prior to release of any information. Legal counsel will review the documentation prior to release of information.

We must also provide you with a Notice of Privacy Practices when you enroll. The Notice of Privacy Practices gives you more details about your rights and responsibilities concerning the disclosure of your protected health information.

We maintain physical, electronic, and procedural safeguards that comply with applicable regulatory standards to guard your personal health information. In addition, we require all affiliated parties who maintain your health records to enforce confidentiality policies and procedures within their facilities.

In addition, you may review your personal health information within our control by contacting Customer Service at 330-996-8700 or 800-996-8701 to schedule an appointment with the appropriate department representative. You may schedule appointments with health care providers, from whom you are receiving health care, to review personal health information within their control. To maintain confidentiality in accordance with Federal Regulations, access to your spouse's health information will be denied unless your spouse provides a written signed document authorizing the release of the information to you.

We warrant that any other person and/or entity receiving information from us signs a confidentiality agreement which requires them to abide by and release information in accordance with SummaCare's confidentiality policies and procedures.

You may receive a copy of the confidentiality policies by calling the Customer Service Department at 330-996-8700 or 800-996-8701.

**IV. When Coverage Begins**

**A. Initial Enrollment**

The effective date of this plan will be ninety days after the date of acceptance by SummaCare of the subscriber's application. If an individual had prior coverage with a health benefit plan who exited the market place, and if the subscriber applied for the SummaCare Open Enrollment Plan within sixty-three days of the termination of coverage from that prior plan, the effective date of benefits shall be the date of application acceptance by SummaCare. The annual Open Enrollment Period for this Plan is January 1 of each year and benefits will be renewed on a calendar year basis and rates adjusted on January 1 of each year based on member demographics.

**B. Newly Eligible Dependents**

To enroll a new eligible dependent you must add that dependent within 31 days of the date they become eligible for coverage. Also, all dependents will be rated as individual member as the Open Enrollment Plan is an individual plan.

**V. When Coverage Ends**

**A. Your SummaCare Coverage Ends on the Earliest of:**

1. The date the contract between you and SummaCare ends;
2. The date you or your eligible dependent no longer meet eligibility requirements as stated in this Policy;
3. The date on which you request your coverage to end effective at 11:59 PM;
4. The date on which your SummaCare coverage began if it is later determined that you made an intentional misrepresentation of material fact under the terms of the coverage;
5. The date on which you commit fraud or forgery with respect to the plan;
6. The date on which you allowed a person not eligible for benefits to use a SummaCare identification card;
7. Nonpayment of the required premium after written notice has been sent to you of the grace period.

In the event your coverage under this plan terminates while you or your covered dependent is an inpatient in a hospital, the continuation of your SummaCare coverage shall terminate at the earliest occurrence of any of the following:

1. Your or your dependent's discharge from that facility; or
2. The determination by you or your dependent's attending physician that inpatient care is no longer medically needed; or
3. You or your covered dependent has reached the limit for contracted benefits; or
4. The effective date of any new coverage.

**B. Coverage for Your Dependent Will End on the Earliest of:**

1. The date your own coverage ends;
2. The date a dependent is no longer eligible for coverage.
3. Nonpayment of the required premium after written notice has been sent to you of the grace period;
4. The date your dependent reached his attainment age of 19, or after July 1, 2010, the age of 28.
5. You may continue your Open Enrollment Plan coverage and may change from the type of Open Enrollment plan you have once a year during the Open Enrollment Period, which will be held in January. Premiums will be adjusted accordingly.

**VI. Standard Provision**

- ❑ Entire Contract Changes: No change in this policy shall be valid until approved by an executive officer of Summa Insurance Company (SIC) and unless such approval is signed and attached. No agent has authority to change this policy or to waive any of its provisions.
- ❑ Time limit on certain defenses: After two years from the date of issue of the Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for this policy shall be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.
- ❑ Grace Period: The Policy will be terminated for non-payment. The Policyholder will be given a 10-day grace period and be notified in writing of any late payment. If premium payment is not received within the above grace period, termination will be effective on the last day for which the premium payment was received. We will not be responsible for payment of any claims incurred after the premium due date if payment of premium has not been received.
- ❑ No insurer shall cancel or fail to renew the coverage of a subscriber or enrollee because of any health status-related factors in relations to the subscriber or enrollee, the subscriber's or enrollee's requirements for health care services, or for any other reason designated under rules adopted by the superintendent of insurance.
- ❑ Unless otherwise required by state or federal law, no insurer or health care facility or provider through which the health insurer has made arrangements to provide health care services, shall discriminate against any individual with regard to enrollment, disenrollment, or the quality of health care services rendered, on the basis of the individual's race, color, sex, age, religion, military status as defined in Section 4112.01 of the Revised Code, or any health status-related factor in relation to the individual.
- ❑ The insurer may cancel or decide not to renew the coverage of an enrollee if the enrollee has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relations to the enrollee.

## **VII. Covered Services**

The following services are covered under your Policy. Coverage is provided subject to the deductibles, copayments, coinsurance, limitations and exclusions that are specified in this booklet or your Schedule of Benefits. **All services must be medically necessary and some services are subject to prior authorization rules. Refer to the Prior Authorization List provided or at [www.summacare.com](http://www.summacare.com) member section.**

### **A. Outpatient Services Covered**

1. Office visits to your provider, including physical exams, well child care, immunizations and other preventive health care services that are based on the recommendations of the United States Preventive Services Task Force. Copies of these recommendations are available from Customer Service. Refer to preventive limits as stated in your Schedule of Benefits.
2. Office visits to an OB/GYN specialist for obstetrical/gynecological services. Refer to the Maternity limits as stated in your Schedule of Benefits.
3. X-ray, lab and other diagnostic services.
4. Medically necessary surgical procedures and anesthesia that are covered benefits.
5. Office visits to medical or surgical specialists.
6. Urgent and Emergency care services.
7. Services for mental health and substance abuse detoxification/rehabilitation.
8. Allergy testing and treatment.
9. Physical, occupational and speech therapy. (Refer to your Schedule of Benefits for Plan limits).
10. Cardiac and pulmonary rehabilitation therapy/pulmonary therapies.

### **B. Inpatient Hospital Services Covered**

1. Semi-private room and board; private room and special care units if medically necessary and prior authorized by the SummaCare Health Services Management Program. Intensive Care Unit paid at three times the average semi-private rate.
2. Provider services related to medical treatment or surgery.
3. General nursing services.
4. X-ray, lab and other diagnostic services.

5. Operating room, anesthesia and supplies as part of the inpatient surgery. If two or more procedures are performed through the same incision, payment shall be limited to the amount payable for the procedure having the greater payment. If two or more procedures are performed through separate incisions, payments shall be limited to the amount payable for the procedure having the greater payment plus one-half of the amount that would have otherwise been payable for the procedure having the lesser benefit. In the event an assisting surgeon is medically necessary to assist in the performance of an operation, the maximum benefit shall not exceed 20% of all eligible charges made by the surgeon performing the operation.
6. Medically necessary supplies and services, such as oxygen, including equipment required for its administration, blood and blood plasma (if not replaced) and other fluids to be injected into the circulatory system; braces, crutches, casts, splints, trusses, surgical dressings and ostomy supplies used while in the hospital.
7. Prescribed drugs administered while in the hospital.
8. Physical, occupational and speech therapy.
9. Cardiac/pulmonary therapies.
10. Transplants. (Refer to Other Services Covered under Transplants for details.)
11. Mental health and substance detoxification/rehabilitation. Refer to your Schedule of Benefits for any benefit limitations. (Refer to Other Services covered under Mental Health Services).

### **C. Coverage for Emergency Services/Urgent Care Situations**

Emergency services are available 24 hours a day, seven days a week. In an emergency, go to the nearest hospital. An emergency is defined as a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual or the health of a pregnant woman or her baby in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any body organ or part. Some examples of emergencies are:

1. Unusual and severe chest pain;
2. Unusual or excessive bleeding;
3. Poisoning;
4. Inability to breathe; or
5. Obvious limb fractures.

If you experience symptoms that meet the definition of an emergency, call 911 for emergency assistance or go to the nearest hospital.

## **Urgent Care**

An urgent care situation occurs when you require care as soon as possible, but it is not life-or limb-threatening. Some examples of urgent care situations are:

1. Minor cuts and abrasions;
2. Minor burns;
3. Sprains;
4. Earaches or stomachaches; and
5. Other minor injuries.

## **D. Other Services Covered**

### **1. Ambulance Transportation**

Charges for emergency transportation to the nearest hospital. In situations that are not an emergency, ambulance transportation must be prior authorized by SummaCare's Health Services Management Program. Ambulance transportation must be provided by a professional ambulance service.

### **2. Cancer Clinical Trials**

The costs of any routine patient care administered to you or your dependent participating in any stage of an eligible cancer clinical trial, if that care would be covered under the plan if you or your dependent were not participating in a clinical trial.

### **3. Chiropractic Services**

Service performed by a licensed chiropractor or a licensed physician. Refer to your Schedule of Benefits for benefit limitations. Services include skeletal adjustment, adjunctive therapy, vertebral manipulation, and dislocation-subluxation services.

### **4. Dental Services**

Initial treatment for damage to sound, natural teeth resulting from accidental injury. Initial treatment includes treatment that is necessary to stabilize the injury after trauma. Those injuries resulting from biting, chewing or eating are not covered to the extent that dental services would be required. Refer to the Exclusion Section for further clarification.

### **5. Durable Medical Equipment and Prosthetic Devices**

Purchase or rental (whichever costs less) of durable medical equipment for temporary use, not to exceed a six-month period.

### **6. Home Health Care Services**

The following home health care services are covered if the need for services meets medical necessity guidelines. (Refer to you Schedule of Benefits for combined Calendar Year Maximums).

- a. Skilled Nursing services provided by a registered or licensed practical nurse;
- b. Physical, occupational, speech therapies when your condition limits your ability to go to a facility to receive these services; and
- c. Medical social services

## 8. Hospice Care

The following hospice services are covered if the need for services meets medical necessity guidelines (Refer to your Schedule of Benefits for combined Calendar Year Maximums).

- a. All covered home health care services listed above, such as:
  1. Nursing services, which may be authorized for up to eight hours in any 24 hour period
  2. In-home medical social services, under the direction of a provider;
  3. In-home consultation or case management services by a provider;
  4. In-home physical therapy, occupational therapy and speech-language pathology services;
  5. Home health aid (part-time or intermittent, up to eight hours in any one day, which consist mainly of caring for the family member);
  6. In-home dietary counseling;
  7. Medical supplies, drugs and medicines, prescribed by a provider;
  8. Durable medical equipment.
- b. Room and board while in a hospice facility;
- c. Services and supplies furnished by the hospice facility during the admission, including part-time nursing care by or under the supervision of a registered nurse;
- d. Bereavement counseling for family members who are enrolled members, up to two visits.

Homemaker, volunteer and spiritual counseling services, food or home-delivered meals, and custodial care, rest care or care for someone's convenience are not covered. Chemotherapy or radiation therapy if other than palliative treatment is not covered.

## 9. Lab and Other Diagnostic Services including X-ray

SummaCare's Open Enrollment PPO will cover the cost of medically necessary lab work and other diagnostic services.

## 10. Maternity Services

Maternity services are covered. Refer to your Schedule of Benefit for Coverage Limitation of \$3,000 per occurrence for a normal delivery and nursery care. Coverage includes:

- a. Hospital charges related to your pregnancy;
- b. Pre-and post-natal care;
- c. Treatment for complications of pregnancy, childbirth and any obstetrical disorder; and
- d. Injury or condition arising from childbirth

We cover up to a 48-hour hospital admission for routine vaginal delivery and up to a 96-hour admission for cesarean section delivery, unless authorization for an extended hospital stay has been obtained from the SummaCare Health Services Management Program. Complication of pregnancy is a condition that is distinct from the pregnancy, but is adversely affected by pregnancy. Examples of such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and conditions of comparable severity. It also includes conditions such as emergency non-elective cesarean section, ectopic pregnancy, hyperemesis gravidarum, and spontaneous abortion occurring when a viable birth is not possible. It does not include: false labor, occasional spotting, physician-prescribed rest during pregnancy, morning sickness, pre-eclampsia, or other conditions related to a difficult pregnancy.

If mother or newborn are discharged prior to 48 hours (vaginal) or 96 hours (cesarean), home follow-up care that is provided within 72 hours of the time of discharge will be covered.

SummaCare's Open Enrollment PPO also covers physician directed follow up care, which includes:

- a. Physical assessment of the mother and newborn;
- b. Parent education;
- c. Assistance and training in breast or bottle-feeding;
- d. Assessment of the home support system;
- e. Performance of any medically necessary and appropriate clinical tests; and
- f. Any other services that are consistent with the follow up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

This coverage applies to services provided in a medical facility and/or through home health care visits. These providers must be knowledgeable and experienced in newborn care. All emergency deliveries are covered.

## 11. Mental Health Services

SummaCare PPO will cover mental health services both biologically based and non-biologically based as stated in your Schedule of Benefits. Biologically based mental health services must be clinically diagnosed per the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) criteria by a licensed physician or psychologist, a clinical nurse specialist whose nursing specialty is mental health or by a professional clinical counselor, professional counselor, or independent social worker. Non-biologically based mental health services must be legally performed by or under the clinical supervision of a licensed physician or psychologist, a clinical nurse specialist whose nursing specialty is mental health or by a professional clinical counselor, professional counselor, or independent social worker.

The following Mental Health services are covered: (Refer to your Schedule of Benefits for benefit limitations).

### Biologically Based Mental Health Benefit

Mental Health services are covered for the diagnosis and treatment of **biologically based mental illness**, which include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder and panic disorder, as these terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. These Biologically based services are covered as other Basic Health Care Services and are covered at the level stated on your Schedule of Benefits.

### Non-Biologically Based Mental Health Benefit

Non-Biologically Based Mental Health Services are covered as a combined benefit with Substance Abuse and Alcohol Abuse. Any covered mental health service that does not meet the definition of Biologically Based Mental Health illness will be covered under this benefit.

### Mental Health Inpatient Hospitalization – (Inpatient Hospital Services require prior authorization)

Inpatient services are provided while you are confined in a Hospital on a 24 hour-a-day basis to treat mental health disorders, including room and board, physician services, nursing care, pharmacy services, diagnostic tests and the following:

- Diagnostic Evaluation;
- Individual and group psychotherapy;

- Psychological testing.

### **Mental Health Outpatient Treatment**

The Outpatient Mental Health Benefit listed on your Schedule of Benefits provides coverage for the following outpatient services:

- Diagnostic Evaluation;
- Individual and group psychotherapy;
- Psychological testing.

Mental deficiency, retardation or autism services necessary to evaluate and diagnose mental deficiency or retardation or autism. (Refer also to the Exclusion Section.)

### **12. Podiatry Services**

SummaCare PPO covers medically necessary treatment by a podiatrist. Routine foot care and orthotics are not covered.

### **13. Preventive Health Services**

SummaCare Open Enrollment PPO covers a variety of periodic health examinations that conform to national guidelines. Examples of preventive health services include, but are not limited to:

- a. Well child care, including immunizations and Child Health supervision services from birth to the age of nine, which shall include periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of a hearing screening, by an audiologist. (Refer to the Calendar Year Maximums for Child Wellness in your Schedule of Benefits).
- b. Cholesterol screening;
- c. Blood pressure checks;
- d. Annual screening mammograms beginning at age 35 to 39; Age 40 to 49, one every two years unless a risk factor is diagnosed by your provider; Age 50 to 64, one per year; high risk mammograms as needed;
- e. PAP smears and cytological screening to detect cervical cancer.

\*Mammogram benefit includes examinations that are performed in a health care facility or a mobile mammography-screening unit that is accredited under the American College of Radiology Mammography Accreditation Program and included in the SummaCare provider network.

If you have any questions about which preventive health services are covered, please call Customer Service at 330-996-8700 or 800-996-8701

### **14. Rehabilitation Services**

Rehabilitative services, including physical, occupational, speech and cardiac/pulmonary therapies, will be covered. Refer to your Schedule of Benefits for limitations.

Speech therapy is designed to provide treatment following acute conditions, congenital hearing loss and congenital conditions for which corrective surgery has been performed (e.g. cleft palates). Conditions such as behavioral speech disorders, learning disorders, stuttering, slow speech development, chronic muscle imbalance and language therapy are excluded. Refer to your Exclusion Section of this Booklet.

### 15. Re-constructive Breast Surgery

Re-construction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of the mastectomy, including lymphedemas are covered.

### 16. Skilled Nursing

Skilled nursing services are covered if the need for services meets medical necessity criteria. Services must be prior authorized by your physician, practitioner or other provider through SummaCare's Health Services Management Program. (Refer to the combined Calendar Year Maximum in your Schedule of Benefits).

### 17. Substance Abuse/ Alcohol Abuse

Detoxification and rehabilitation services are provided for the treatment of Substance and Alcohol Abuse. The benefit is a combined benefit with Non-Biologically Based Mental Health Service (any mental health service that does not meet the definition of Biologically Based Mental Health as defined under the Mental Health Benefit) and is administered at the levels and with the limitations stated in the Summary of Benefits.

#### Covered Services:

**Inpatient Detoxification** is usually as a result of an emergency admission for alcohol use. Term of the stay is based on medical necessity for an inpatient status. This benefit would apply to the inpatient substance abuse limit. **Inpatient detoxification requires prior authorization.**

**Inpatient Rehabilitation** is an elective admission for chemical dependency and alcohol. This Rehabilitation admission usually occurs after a member is detoxified. **Inpatient Rehabilitation requires prior authorization.**

**Partial Hospitalization Program.** This is an elective outpatient program. Program hours are usually over four hours daily, sometimes five to seven days per week. The day limit comes out of the inpatient benefit at a two-to-one ratio, two partial hospital program sessions equal one inpatient day.

**Intensive Outpatient Program** is an elective outpatient program. Program hours are under four hours daily, usually three to four times per week. This program counts towards the member's outpatient visit limit.

#### Non-Covered Services:

**Residential Treatment** for substance abuse is not a covered benefit. A residential treatment facility is a facility providing room, board and care on a 24 hour a day, seven day a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders in which residents do not require care in an acute or more intensive medical setting. Residential care is defined as supported accommodations through a supervised home environment that is not an acute hospital setting.

### 18. Transplants

Non-experimental organ transplants are covered for the insured recipient if the recommended treatment program, including all pre-operative assessments, is pre-authorized and approved by the SummaCare Health Services Management Program and performed at an approved transplant "Centers of Excellence" facility. Covered transplants include: heart, heart-lung, lung, liver, kidney, bone marrow, pancreas and cornea. No other transplants are covered.

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Reasonable travel and lodging expenses are covered for the insured recipient if the transplant is received out of area at an approved "Centers of Excellence" facility and approved in advance by the SummaCare Health Services Management Program. Initial testing and diagnosis; immunosuppressant drug therapy, before and after surgery; complications resulting from surgery, organ rejection/failure; and repeat transplants of same organ are covered under this PPO Open Enrollment Plan. Refer to the Lifetime Maximum in your Schedule of Benefits.

**VIII. General Exclusions**

**A. No Benefits will be Paid for:**

1. Transportation, except local to or from a Hospital by professional ground ambulance services.
2. Normal childbirth, normal pregnancy or routine nursery care (except as provided in the Schedule of Benefits), elective cesarean section or voluntarily induced abortion.
3. Fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of fertility or the inability to conceive or conception by artificial means, including, but not limited to, in-vitro fertilization or embryo transfer.
4. Replacement of artificial limbs and artificial eyes.
5. Blood or blood plasma which has been replaced.
6. Donation of any body organ by an insured person.
7. Services performed by a person who ordinarily resides in the insured person's home or is a close relative of the insured person or by the insured person's partner.
8. Cosmetic surgery, except as stated in the plan or required to restore a part of the body that has been altered as a result of an accidental bodily injury or illness.
9. Custodial care.
10. Services or treatments not prescribed by a doctor or for services or treatments not shown as covered.
11. An illness arising out of, or in the course of, employment for wages or profit.
12. Expenses incurred after the insurance terminates.
13. Experimental or investigational treatments or services.
14. Eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy; or for eye refractions, eye glasses or contact lens including fitting or examinations.
15. Treatment, services or supplies furnished by a department or agency of the United States Government. This exclusion will not apply to a non-service connected illness of a veteran of the United States armed forces who does not have a service-connected illness.
16. Services and supplies eligible for payment by a government or charitable program, except as required by law.
17. Hearing aids, including fitting and examinations.

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18. Non-medically necessary care or treatment of an illness.
19. Which would not be made if no insurance existed.
20. Recreational or educational therapy or vocational rehabilitation.
21. Speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection with or related in any way to the treatment of a learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma, except as allowed under covered charges.
22. For which the insured is not leally obliged to pay.
23. Treatment or services which are not generally accepted medical practices in the United States for a given illness.
24. Treatment of obesity, morbid obesity or for weight reduction purposes.
25. Illnesses that result from participation in any assault, unlawful act, strike, civil disorder or riot.
26. The treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis.
27. Routine physical or premarital examinations except as may be covered under the child wellness benefit, mammograms and pap smears are covered.
28. A private room in excess of the average semi-private room and board rate.
29. A pre-existing condition. This exclusion relates to conditions treated during the six months immediately preceding the effective date of this coverage. Benefits will be paid for such charges incurred after the end of the period of twelve (12) consecutive months while insured under the policy. This exclusion does not apply to federally eligible individuals.
30. Amounts in excess of reasonable and customary charges.
31. Services or supplies prohibited by law.
32. Sex changes.
33. Sterilization and reversal of sterilization.
34. Charges resulting from any suicide, attempted suicide or intentionally self-inflicted injury or sickness while same or insane unless such act is the result of an underlying medical condition.

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35. Examination, treatment or surgery of the teeth, gums or direct supporting structure, except for repair or injury to sound natural teeth, (including their replacement) as a result of an accidental bodily injury. Treatment must be given within ninety (90) days of the date of the accident to be covered.
36. Illness caused by any act of war, whether or not declared.
37. Surrogate pregnancy.
38. Surgery of the jaw or for any treatment of temporomandibular joint (TMJ disorder). Treatment of jaw fractures and removal of tumors of the jaw will not be subject to this exclusion.
39. Treatment of complications arising from or connected in any way with a surgical or medical treatment or procedure that is not a covered expense under the terms of the policy, whether or not the insured person was insured under the policy at the time the non-covered treatment or procedure was performed.
40. Foot care due to:
  - a. Treatment of weak, strained or flat feet or instability or imbalance of the foot.
  - b. Treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses or similar medical seriousness.
41. For contraceptives, infertility drugs and growth hormones.

**IX. Claims**

**A. The Usual Procedure**

You usually do not have to complete and submit claim forms. Your preferred provider will submit a claim for covered services to us. All you have to do is make your required copayment while at your provider's office. (Services that require copayments, and the amount of those copayments, are listed in your Schedule of Benefits). If you receive a bill for services from your Preferred Provider, send the bill to us. You do not have to complete a claim form when a Preferred Provider provides services. You will receive an explanation of benefits (EOB) detailing how much we have paid for the care you received.

If you receive services from a Non-Preferred Provider, you may be responsible to submit a claim form to SummaCare. You will be responsible for any balance not covered by SummaCare.

Send the form to:

SummaCare  
P.O. Box 3620  
Akron, Ohio 44309-3620

You must attach the provider's bills to your claim form. You or your provider have one year from the date of service to submit a claim. Claims submitted after one year will not be covered.

We use the most current CPT and ICD-9 codes in effect as published by the United States Department of Health and Human Services. We also use the most current HCPCS codes in effect, as published by Centers for Medicare and Medicaid Services.

In the event that Summa Insurance Company becomes insolvent, you may be responsible for paying for health care services given by a provider or health care facility that is not under contract with SummaCare. It does not matter if we authorized the use of the provider or health care facility.

**B. Emergency/Urgent Care**

In the event of an emergency or urgent care situation, if you receive services from a non-SummaCare provider you may have to pay for those services at the time of service and submit the claim to us. You can obtain claim forms from SummaCare. You must attach the doctor and hospital bills from the provider to your claim form. Refer to the covered service section of this booklet for more information on Emergency/Urgent Care.

**X. Complaint Procedure**

If you are not happy with a decision about a claim, or have another complaint, you can call Customer Service at (330) 996-8700 or 800-996-8701. A Customer Service representative will ask you questions about your complaint and investigate the facts. You will receive a verbal response to your complaint within five business days.

If you are still not happy, you can pursue your complaint further through one of SummaCare's two formal complaint processes. They are the Grievance and the Appeal Process. The Appeal Process should be used whenever you disagree with SummaCare's decision to deny, reduce, or terminate a service or a claim. The Grievance Process is used for all other complaints, regarding such things as service, quality of care, or timely access to doctors and other providers. Each process is explained in detail below:

**A. Grievances:**

If you are not happy with the care or service you receive from SummaCare or any of our contracted providers, you may address those concerns through our formal grievance process. Some examples of a grievance are:

- A very long time on hold when calling Customer Service;
- Rude treatment by a provider or his office staff;
- You believe that the care you received from a SummaCare provider was not appropriate;
- You believe a SummaCare employee has violated your privacy rights.
- Out-of-Network payment issues.

To file a grievance, send your request to:

SummaCare  
Grievance Department  
P.O. Box 3620  
Akron, Ohio 44309-3620

You may also fax your grievance to (330) 996-8545, or submit it electronically to [info@Summacare.com](mailto:info@Summacare.com). If you wish, you may bring your grievance to the SummaCare offices located at 10 N. Main Street, Akron, Ohio. Please be as clear as possible when describing your grievance. If you need help with your grievance, please call Customer Service for assistance. A Customer Service Representative will help document the details of your grievance over the phone. If your complaint is about the quality or appropriateness of care, you must file your grievance within 180 days from the date you received the service.

We will investigate your grievance and respond to you in writing within 30 calendar days. Our response will inform you of our findings and any action that we have or will take as a result of your grievance.

If you are not happy with our response, you may file a second level grievance at the same address listed above. Your second level grievance will be reviewed by individuals who were not previously involved in investigating your complaint. A written response will be issued within 40 calendar days. The response will inform you of any further action we will take.

If you still are not happy, you may file a complaint with the Ohio Department of Insurance, Consumer Services Division, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215. You may also call the Ohio Department of Insurance at 800-686-1526 or 614-644-2673.

**B. Internal Summa Insurance Appeals:**

As a member of SummaCare PPO, you have the right to appeal decisions that deny or limit your health care benefits. If a service is denied, reduced or terminated, or if payment of a claim is fully or partially denied, you may appeal that denial. To file an appeal, send a written request to:

SummaCare  
Appeals Department  
P.O. Box 3620  
Akron, Ohio 44309-3620

You may also fax your appeal to 330-996-8545 or submit electronically to [appeals@summacare.com](mailto:appeals@summacare.com). If you wish, you may bring your appeal to the SummaCare offices located at 10 North Main Street, Akron, Ohio. Please be as clear as possible when describing your appeal. Any additional documentation that supports your request should be submitted with your appeal. If you need help with your appeal, please call Customer Service for assistance. A Customer Service representative will help document the details of your appeal over the phone. However, you will still need to follow-up with a signed, written appeal. You must file your appeal within 180 days from the date you first received notice of the denial you wish to appeal. We may accept an appeal from you after 180 days for just cause, but we are under no obligation to do so. An authorized individual, who may be a friend, family member, doctor, or anyone you choose, may appeal for you; but we must receive a signed and dated statement from you or other legal authority authorizing that person to act on your behalf.

After we investigate the facts, your appeal will be reviewed by individuals who had no previous involvement with the decision. If your appeal is in any way related to the medical appropriateness of the care or services in question, the appeal would be reviewed by a board certified physician. The exact time frame for resolving your appeal depends upon a number of factors that are explained below. However, in every case we will resolve both levels of internal appeal within 60 days from the date we received your first appeal letter, or as fast as is medically necessary.

**C. First Level Post-Service Appeals:**

If your appeal is about a service that you have already received, it will be handled as a post-service appeal. We will notify you in writing of the outcome to your first level post-service appeal within 30 calendar days from the date we received your appeal.

**D. First Level Pre-Service Appeals:**

If your appeal is asking that we cover a service or medical item that you have not yet received, we will notify you in writing of the outcome within 15 calendar days. Our response will explain the basis of the decision and inform you of any action that SummaCare has or will take as a result of your appeal.

### E. Expedited or Fast Appeals:

We may agree to expedite your appeal if you believe that waiting 15 days for a pre-service decision could result in any of the following:

- Place you or your unborn child in serious jeopardy;
- Cause serious impairment to bodily functions or serious dysfunction of any organ or part;
- Place you in severe pain that cannot be adequately managed without the care or treatment in question.

Expedited appeals are only granted in medically urgent situations. We do not have to expedite your appeal if we believe that it does not meet any of the three reasons listed above. If we determine that your appeal does not qualify for a fast/expedited review, we will still process it as a standard pre-service appeal. If you disagree with our decision not to expedite an appeal, you may file a grievance. If a licensed physician indicates that expedition is necessary for medical reasons, we will automatically expedite your appeal.

Expedite appeals will be completed within 72 hours from the time it is received or as fast as medically necessary. To request that your appeal be expedited, you must call Customer Service at 330-996-8700 or 800-996-8701. If your expedited appeal is denied in whole or in part, you may skip the second level of internal appeal and proceed immediately with an expedited independent review (see N below).

### F. Second Level Appeals:

We will complete the entire appeals process within 60 calendar days from receipt of your first level appeal request. In order to meet this requirement, we will automatically begin reviewing your appeal at the second level of review if your first level appeal is not approved.

For **post-service appeals** you will have ***seven days after*** we issue our first level decision to contact us and let us know that you wish us to complete the second level appeal process. For **pre-service appeals** you will have ***45 days from the date we received your first level appeal letter*** to contact us and let us know that you wish us to complete the second level appeal process described below. You may contact us over the phone, by fax, mail or email. If we do not hear from you within these time frames, we will assume that you agree with the first level decision and do not wish to have your appeal considered at the second level. Your second level appeal may then be dismissed. If you contact us after these time frames and ask to proceed with the second level of appeal, we may not be able to complete both levels of appeal within 60 calendar days. For this reason, we may not be able to consider your request at the second level. However, even if you have missed the time frame for filing a second level appeal, you may still have the right to appeal further via one of the additional external appeal processes described below.

Your second level appeal will be reviewed by individuals who were not involved in either the initial denial or the first level appeal. If your second level appeal is in any way related to the medical appropriateness of the care or services in question, the appeal will be reviewed by a board certified physician or other appropriately licensed healthcare professional in the same or similar specialty that typically treats the medical condition or provides the procedure or treatment in question. If your second level appeal is purely a benefit issue, it will be heard by the SummaCare Appeals Committee.

**G. Second Level Post-Service Appeals:**

SummaCare will send you a written response to your second level post-service appeal within 30 calendar days from the date we receive your second level request and within 60 calendar days from the date we received your first level appeal letter (whichever comes first).

**H. Second Level Pre-Service Appeals:**

SummaCare will send you a written response to your second level pre-service appeal within 15 calendar days from the date we received your second level request and within 60 calendar days from the date we received your first level appeal letter (whichever comes first).

**Please Note:** The time frame for resolving any of the internal appeals described above may be shortened if the seriousness of your condition requires a faster review. In certain situations, we may, with your permission, choose to skip the internal appeal process and proceed directly with one of the additional external appeal processes described below. SummaCare may choose to skip the second level of internal appeal without your permission.

**I. Additional External Appeals:**

If you are still not happy with SummaCare's decision, you may request a review from another source. You may appeal denials for any of the reasons listed below:

- They are not covered services
- They are not medically necessary
- They are experimental and you have a terminal illness

These additional appeals are available only after you complete our internal appeal process. The procedures for appealing denials beyond SummaCare are explained below.

**J. Denial Because Services are Not Covered:**

If SummaCare denies a service because it is not a covered service, you may request a review from the Ohio Department of Insurance after exhausting the internal review process. You can write the Department of Insurance at 50 W. Town Street, Third Floor – Suite 300, Columbus, Ohio 43215 or call the Department at 800-686-1526.

The Department will review your contract and the type of service requested. If the Department is not able to determine if the service is a covered benefit because deciding requires resolution of a medical issue, upon notice from the Department, we will initiate an external review. If the external review by an Independent Review Organization (IRO) determines that the service is a covered benefit, we will pay for the service.

**K. Denial Because Services are Not Medically Necessary:**

If we deny a service because it is not medically necessary and the service and related expenses will cost you more than \$500 if it is not covered by us (the \$500 requirement does not apply to expedited cases), you may request an external review from an (IRO). The IRO is not affiliated with SummaCare.

You must request this review within 180 days of receiving notice that your appeal was denied. Your request must be in writing and include certification from the provider that the service will cost you more than \$500.

The IRO will review your medical records and determine if the recommended service is medically necessary. If the IRO determines that the service is medically necessary, we must pay for the service according to the terms of the contract. If the IRO determines that the service is not medically necessary, we do not have to pay for the service.

**L. Denial Because Services are Experimental:**

If you have a terminal illness you may also request an external review when services are denied because they are experimental or investigative. To qualify for this review you must meet all of the following criteria:

1. You have a terminal condition that, according to the current diagnosis, has a high probability of causing death within two years.
2. You request an external review not later than 180 days after receiving our decision denying the requested service because it is experimental.
3. Your physician certifies that one of the following situations applies to your condition:
  - a. Standard Therapies have not been effective in improving your condition;
  - b. Standard Therapies are not medically appropriate for you;
  - c. There is no standard therapy covered by the policy that will benefit you more than the therapy requested by either you or your physician.
4. Your physician has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to benefit you more than standard therapies; or you have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
5. You have exhausted all internal levels of appeal.
6. The drug, device, procedure, or other therapy would be covered if it were not considered to be experimental or investigative.

**M. Instructions for Requesting an Independent Review:**

You must request an external review in writing within 180 days of receiving notice from us that your request for coverage is denied. You, an authorized person, the provider, or the health care facility representative may request the review. The provider and health care facility must have your signed authorization to request a review. You do not need the authorization of the provider. You are not required to pay for the review. SummaCare pays for the review.

The independent review organization must provide you with a response within 30 days. The decision of the IRO must include:

- a. A description of the patient's condition;
- b. The principal reason for the decision; and
- c. An explanation of the clinical rationale for the decision.

**N. Expedited Review:**

When the independent review must be completed quickly because of your medical condition, you may request an external review by phone, fax or email. However, you must follow up this request with a written request within five days. The independent review organization must provide you with a response to an expedited review within seven days of your initial request.

You may request an expedited independent review if delaying the review will do any of the following:

- a. Place the health of the patient or unborn child in serious jeopardy;
- b. Cause serious impairment to bodily functions; or
- c. Cause serious dysfunction of any body organ or part.

No claim for benefits may be brought unless all the requirements of this section have been followed.

**O. Provider Reconsiderations:**

We offer your provider the right to request in writing, on your behalf, a review of a decision you disagree with. We may require that your provider obtain a signed statement from you authorizing him or her to request reconsideration. We will work with your provider to get the information needed to review the decision. We will reply to your provider's request within three business days.

## XI. Coordination of Benefits (COB)

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. **Plan** is defined below.

The order of benefit determinations rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the **Primary plan**. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expense. The Plan that pays after the Primary plan is the **Secondary plan**. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

SummaCare pays for health care only when you follow our rules and procedures as stated in this Certificate of Insurance. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans.

### A. Definitions for COB

1. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
  - a) **Plan** includes:
    - Group and non-group insurance contracts;
    - Health insuring corporations (“HIC”) contracts;
    - Closed panel plans or other forms of group or group-type coverage (whether insured or uninsured);
    - Medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts, and;
    - Medicare or any other federal governmental plan as permitted by law.
  - b) **Plan** does not include:
    - Hospital indemnity coverage or other fixed indemnity coverage;
    - Accident only coverage;
    - Specified disease or specified accident coverage;
    - Supplemental coverage as described in Revised Code Sections 3923.37 and 1751.56;
    - School accident type coverage;
    - Benefits for non-medical components of long-term care policies;
    - Medicare supplement policies;
    - Medicaid policies; or
    - Coverage under other Federal governmental plans, unless permitted by law.

Each contract for coverage under (a) or (b) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. **This Plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
3. The order of benefits determination rules determine whether this Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When this plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100 % of the total Allowable Expense.

4. **Allowable Expense** is a health care expense, including deductible, coinsurance and copayments that are covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
- b) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- c) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- d) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable Expense for all Plans. If the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary plan to determine its benefits.
- e) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

5. **Closed Panel Plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that has contracted with or is employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
6. **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year without regard to temporary visitation.

### **B. Order of Benefit Determination Rules**

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
2. (a) Except as provided in paragraph (b), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provision of both Plans state that the complying plans is primary.  
  
(b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base plan hospital and surgical benefits, and coverage that is written in connection with a Closed panel plan to provide out-of-network benefits.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. Each Plan determines its order of benefits using the first of the following rules that apply:
  - (a) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, (e.g. as an employee, member, policyholder, subscriber or retiree) is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. If the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
  - (b) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
    - i. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

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- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
  - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
  - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
- ii. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
- a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
  - b. If the parent with responsibility for health coverage does not have health coverage for the expenses of the dependent child, but the spouse of that parent does, then the plan of that parent's spouse is the primary plan. This rule applies to plan years commencing after the plan is given notice of the court decree.
  - c. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, benefits should be coordinated as though the parents were married or living together as stated in provision (i) above.
  - d. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, benefits should be coordinated as though the parents were married or living together as stated in (i) above.
  - e. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The Plan covering the Custodial parent;
    - The Plan covering the spouse of the Custodial parent;
    - The Plan covering the non-custodial parent; and then
    - The Plan covering the spouse of the non-custodial parent.
- iii. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child.

- (c.) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits
- (d.) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (e.) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the plan that covered the person the shorter period of time is the Secondary plan.
- (f.) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary Plan.

### **C. Effects on the Benefits of This Plan**

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans, during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Plan and other Closed Panel Plans.

### **D. Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. SummaCare may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. SummaCare need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give SummaCare any facts it needs to apply those rules and determine benefits payable.

### **E. Facility of Payment**

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, SummaCare may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. SummaCare will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

### **F. Right of Recovery**

If the amount of the payments made by SummaCare is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

### **G. Coordination Disputes**

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at SummaCare, 330-996-8700 or [www.summacare.com](http://www.summacare.com) and initiate your appeal rights as stated in the Certificate of Insurance. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526 or visit the Department’s website at <http://insurance.ohio.gov>.

### **H. Integration with Medicare**

Under Federal law, if you or your covered dependents are covered by both SummaCare and Medicare benefits, usually SummaCare PPO is the primary plan and Medicare is the secondary plan. But when permitted by law, SummaCare PPO is the secondary plan.

### **I. Subrogation**

This provision applies if we pay benefits to, or on behalf of you or your dependent for care for an injury or illness for which the covered person has a legal right to recover from another person, including, when sustained in any situation covered by Workers Compensation, automobile insurance, homeowners insurance, or other liability insurance.

We will have the right to recover the value of benefits paid from the covered person or from any other responsible person or organization, through reimbursement, assignment or subrogation for the same injury, illness or other loss from which the payment is made. SummaCare’s right to recovery shall be binding upon the Certificate Holder, insured dependent, beneficiary or legal representative.

Regardless of whether the covered individual has received a settlement or judgment for all injuries, illnesses or other damages (including, without limitation, pain and suffering, consequential, punitive, exemplary or other damages, whether alleged, proven in a court of law, or otherwise substantiated), SummaCare has the right to be repaid first for any and all amounts expended to, or on behalf of, a covered person.

SummaCare will not bear any costs of suit or attorney’s fees incurred by the covered person or the covered person’s representative or beneficiary.

The covered person, or the covered person's representative or beneficiary, will execute documents and do whatever is necessary for SummaCare to exercise its subrogation and assignment rights and will do nothing to limit, interfere or prejudice SummaCare's rights.

XII. Definitions

When used in this booklet or your Schedule of Benefits, the terms listed below will have these meanings:

**Accident**

A sudden, unforeseen event that causes trauma to the body.

**Base Rate**

Base rate means, as to any health benefit plan that is issued by a carrier in the individual market, the lowest premium rate for new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any individual with similar case characteristics.

**Calendar Year**

A period of one year beginning January 1 and ending December 31.

**Policyholder**

You, the Policyholder, as covered under this Policy.

**Contract Year**

The 12-month period beginning on the effective date or any renewal date of the contract between Summa Insurance Company and you.

**Coordination of Benefits**

The provision that applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate over insurance or duplication of benefits. You may not be insured under certain plans if you have this PPO Open Enrollment Plan, therefore your Coordination of Benefits option will be limited.

**Copayment/Coinsurance**

The dollar amount and/or percentage of costs shown in the Schedule of Benefits that a Policyholder or insured dependent must pay directly to the physician, practitioner or other provider for certain covered services (in addition to Premiums). Note: Copayments are dollar amounts as stated in the Schedule of Benefits that are due at the time the service is delivered. Coinsurance, a percent, as stated in the Schedule of Benefits is due after the Policyholder or insured dependent receives his/her Explanation of Benefits.

**Covered Person**

An eligible person, who enrolls, is eligible for and receives, covered benefits under this policy.

**Covered Services**

The healthcare services and items described in this booklet and updated in the Schedule of Benefits, for which the SummaCare PPO plan provides benefits to covered persons.

**Creditable Coverage**

Coverage of the individual from a wide range of specified sources including group health plans, health insurance coverage, Medicare, Medicaid and COBRA.

**Custodial Care**

Care comprised of services and supplies, including room and board and other institutional services, that is provided to an individual, whether disabled or not, primarily to assist in the activities of daily living.

### **Eligible Cancer Clinical Trial**

A cancer clinical trial that meets all of the following criteria:

- (a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- (b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- (c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- (d) The trial does one of the following:
  - (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
  - (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
  - (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
  - (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.
- (e) The trial is approved by one of the following entities:
  - (i) The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;
  - (ii) The United States food and drug administration;
  - (iii) The United States department of defense;
  - (iv) The United States Department of Veterans' Affairs.

### **Eligible Person**

The Policyholder, spouse or child who meets the eligibility requirements specified in Section II of this booklet.

### **Emergency**

A medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual or the health of a pregnant women or her baby in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

### **Emergency Services**

Healthcare services which are available seven days per week, 24 hours per day in order to prevent jeopardy to a covered person's health status (as defined under "Emergency") which would occur if such services were not received as soon as possible including, where appropriate, ambulance transportation and indemnity payments for out of area coverage.

### **Episode of Illness or Injury**

A period of consecutive days beginning with the first day (not included in a previous Episode of Illness or Injury) on which a covered person is furnished health care services for a single diagnosis and any conditions directly related to the diagnosis, and ending with the last day in which the covered person is furnished healthcare services related to that diagnosis and any condition directly related to that diagnosis.

### **Expense Incurred**

An expense results when the service or the supply for which it is charged is actually provided.

### **Family Coverage**

Coverage for you and one or more of your eligible dependents.

### **Federally Eligible Individual**

An individual who has 18 months of creditable coverage; the most recent coverage under an employer, church or government plan; the individual is not eligible for Medicare/Medicaid; the individual has accepted and exhausted all continuation of benefits options and new coverage was put into place within 63 days from the loss of coverage.

### **Home Health Aid**

A person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

### **Home Health Care Agency**

A public or private agency or organization, or part of one, that mainly provides skilled nursing and other therapeutic services. It must be legally qualified in the state or locality in which it operates. It must keep clinical records on all patients. The services must be supervised by a physician or registered nurse and they must be based on policies set by associated professionals, which include at least one physician and one registered nurse.

### **Home Health Care Plan**

A plan for continued care and treatment of a covered person in his or her home. To qualify, the plan must be established in writing by a participating physician who certifies that the covered person would require confinement in a hospital if he or she did not have the care and treatment stated in the plan. The Home Health Care plan is subject to review and prior approval by the SummaCare Health Services Management Program.

### **Hospice Care Agency**

An agency or organization that is properly licensed in the state, in which it operates, has terminal care available 24 hours a day, seven days a week and provides or arranges for hospice care services or supplies.

### **Hospice Care Plan**

A plan that is supervised by a participating physician and involves a team consisting of:

1. A participating physician who provides hospice care;
2. Licensed nurses;
3. A licensed mental health specialist; and
4. A licensed social worker.

The Hospice Care plan must:

1. Provide the patient's plan of care;
2. Provide regular reviews of the patient's care;
3. Inform the proper persons of any change in the patient's condition; and
4. Comply with governmental regulations.

### **Hospice Facility**

A facility that is properly licensed in the state in which it operates and is engaged mainly in providing palliative care to terminally ill patients.

### **Hospital**

An institution that:

1. Provides medical care and treatment of sick and injured persons on an inpatient basis;
2. Is properly licensed or permitted legally to operate as such;
3. Has a physician on call at all times;
4. Has licensed graduate registered nurses on duty 24 hours a day;
5. Maintains facilities for the diagnosis and treatment of illness and for major surgery; and
6. Meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

In no event will the definition of hospital include an institution or any part of one that is a convalescent/extended care facility, or any institution, which is used primarily as:

1. A rest facility;
2. A nursing facility;
3. A facility for the aged; or
4. A place for custodial care.

### **Health Delivery Organization**

An:

1. Alcoholism or drug addiction treatment facility;
2. Psychiatric hospital;
3. Ambulatory surgical facility;
4. Freestanding birth center; or
5. Hospice facility, provided that the facility is licensed in the state in which the facility operates and is operating within the scope of its license.

### **Illness**

Any physical or mental sickness or disease that manifests treatable symptoms and that requires treatment of a physician. This definition also includes pregnancy.

### **Injury**

Any accidental bodily damage or harm sustained while the person is covered under the plan and that requires treatment by a physician.

### **Insured**

A person protected by an insurance policy or certificate.

### **Maximum Allowable Charge**

The amount billed for covered services for which benefits are available under the contract.

### **Medically Necessary**

A service or supply must be necessary and appropriate for the diagnosis and treatment of an illness or injury as determined by SummaCare Health Services Management Program and based on generally accepted current medical practice.

The fact that any particular physician, practitioner or other provider may prescribe order, recommend or approve a service or supply does not, of itself, make that service medically necessary.

A service or supply will not be considered medically necessary if:

1. It is provided only as a convenience to the covered person;
2. It is not appropriate treatment for the covered person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment.

### **Medicare**

Title VIII (Health Insurance of the Aged) of the United States Social Security Act, as amended.

### **Outpatient**

A covered person will be considered an outpatient if treated on a basis other than as an inpatient in a hospital or other covered facility. Outpatient care includes services, supplies and medicines provided and used at a hospital or other covered facility under the direction of a physician to a person not admitted as an inpatient.

### **Participating Physician, Practitioner or Other Provider**

Any physician, hospital or other health services physician, practitioner or other provider who has a contract with SummaCare to provide covered services to covered persons.

### **Physician**

A legally qualified person acting within the scope of his or her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

### **Policy**

The contract between you and SummaCare regarding your PPO Open Enrollment Plan.

### **Policyholder**

The Subscriber to this PPO Policy.

### **Practitioner**

Doctor of Dental Surgery (D.D.S.); Doctor of Podiatry (D.P.M.); Licensed Clinical Psychologist (Ph.D.); Certified Nurse Midwife (C.N.M.) acting within the scope of his or her license, under the direction and supervision of a licensed physician; Physician Assistant (P.A.); Licensed Social Worker (L.S.W.); or Licensed Physical Therapist (L.P.T.) or Licensed Speech Therapist (L.S.T.) acting within the scope of his or her license, and performing services ordered by a Doctor of Medicine or a Doctor of Osteopathy.

### **Preferred Provider**

Any physician, practitioner or other provider who has a contract with SummaCare to provide covered services to covered persons.

**Premium (Rate)**

The monthly charge for the coverage provided under the SummaCare PPO policy.

**Provider**

A person or organization responsible for furnishing health care services, including a hospital, a skilled nursing facility, rehabilitation facility, ambulatory surgery center, physician or practitioner.

**Reasonable and Customary Charges (R&C)**

Charges made for medical services or supplies will be considered reasonable and customary if they are the amount normally charged by the physician, practitioner or other provider for similar services and supplies, and do not exceed the amount ordinarily charged by most physicians, practitioners or other providers of comparable services and supplies in the locality where the services or supplies are received. Determination of whether or not a charge is reasonable and customary will be made by SummaCare based on nationally obtained and recognized survey data.

**Room and Board**

Charges made by a hospital or other covered institution for the cost of the room, general duty nursing care and other services routinely provided to all inpatients, not including special care units.

**Routine Patient Care**

All health care services consistent with the coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

**Semi-private Charge**

The charge made by a hospital for a room containing two or more beds not including the charge made by the hospital for special care units.

**Service Area**

The geographic area within which Summa Insurance Company is licensed and arranges for the provision of covered services by contracting with providers.

**Schedule of Benefits**

A Schedule of Benefits provides information on the limits and maximums of the plan and copayment amounts that you must pay.

**Skilled Nursing Facility**

Any institution, other than a hospital, which meets all of the following requirements:

1. Maintains permanent and full-time facilities for bed care of ten or more resident patients;
2. The services of a physician;
3. Has a registered nurse (R.N.) or physician on full-time duty in charge of patient care and one or more registered nurses (R.N.s) or licensed vocational nurses (LVNs) or licensed practical nurses (LPNs) on duty at all times;
4. Maintains a daily medical record for each patient;
5. Is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their illness or injury;

6. Is operating lawfully as a convalescent/extended care facility in the jurisdiction where it is located or meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations; and
7. Has a written agreement with at least one other hospital providing for the transfer of patients and medical information between the hospital and convalescent/extended care facility.

In no event, however, will a convalescent/extended care facility include an institution, which is primarily: (a) a place for rest; (b) a place for the aged; (c) a place for drug addicts, alcoholics, the blind or deaf; (d) a place for the mentally ill or retarded; or (e) a hotel or similar place.

**Special Care Units**

A specific hospital unit that provides concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant and continuous attention.

This term will include charges for intensive care, coronary care and acute care units of a hospital but does not include care in a surgical recovery or post-operative room. The unit must meet the required standards of the Joint Commission on Accreditation on Healthcare Organizations (JCAHO) for special care units.

**Subrogation**

The procedure where an insurance company can recover from a third party full or part of benefits paid or to be paid to a covered member.

**You, Your**

A covered person, Policyholder, the Policyholder's covered dependents.

**Important Phone Numbers**

SummaCare Customer Service	330-996-8700 800-996-8701
SummaCare 24 – Hour Nurse Line	330-379-5000 800-379-5001

**FRAUD WARNING**

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements, is guilty of insurance fraud. If you are found guilty of insurance fraud, you will be terminated from the plan.