Certificate of Insurance
"SummaCare Small Group Off Exchange PPO"
Underwritten by The Summa Insurance Company
Administered by SummaCare

This booklet is your Certificate of Insurance (also referred to as the Certificate). It explains details of the SummaCare PPO Plan benefits designed for Group Certificate Holders and their eligible Insured dependents. This Certificate and the corresponding Schedule of Benefits will help the Certificate Holder and your Insured dependents (also referred to as you/your) understand your selected benefit Plan by explaining your benefit coverage and the level of payment of these benefits. Please refer to this Certificate whenever you require medical services. It describes how to access medical care and what health services are provided under the SummaCare PPO Plan. This Certificate of Insurance is issued under the Master Group Major Medical Policy of your Employer.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

NOTICE: THE OHIO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS, AND REQUIRE CONTINUED RESIDENCY IN OHIO. YOU SHOULD NOT RELY ON COVERAGE BY THE OHIO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. COVERAGE IS NOT PROVIDED FOR YOUR POLICY OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS A VARIABLE CONTRACT SOLD BY PROSPECTUS. YOU SHOULD CHECK WITH YOUR INSURANCE COMPANY REPRESENTATIVE TO DETERMINE IF YOU ARE ONLY COVERED IN PART OR NOT COVERED AT ALL. INSURANCE COMPANIES OR THEIR AGENTS ARE REQUIRED BY LAW TO GIVE OR SEND YOU THIS NOTICE. HOWEVER, INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE GUARANTY ASSOCIATION TO INDUCE YOU TO PURCHASE ANY KIND OF INSURANCE POLICY. OHIO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION, 5005 HORIZONS DRIVE, SUITE 200 COLUMBUS, OHIO 43220. OHIO DEPARTMENT OF INSURANCE, 50 W. TOWN STREET, THIRD FLOOR, SUITE 300, COLUMBUS, OHIO 43215.

NOTICE: OHIO HOUSE BILL 388 AND THE FEDERAL NO SURPRISES ACT ESTABLISH PATIENT PROTECTIONS INCLUDING FROM OUT-OF-NETWORK PROVIDERS' SURPRISE BILLS ("BALANCE BILLING") FOR EMERGENCY CARE AND OTHER SPECIFIED ITEMS OR SERVICES. WE WILL COMPLY WITH THESE NEW STATE AND FEDERAL REQUIREMENTS INCLUDING HOW WE PROCESS CLAIMS FROM CERTAIN OUT-OF-NETWORK PROVIDERS.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM SUMMACARE.

SummaCare does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the Plan, including enrollment and benefit determinations.

I. Your Good Health

While many health plans limit your choice of Providers to only those participating in their Provider network, SummaCare realizes you might prefer to visit other Providers for your healthcare needs. This SummaCare PPO Group Health Care Policy is designed to allow you maximum flexibility in choosing your Providers. If you choose to access a Preferred Provider, your 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 Certificate

This Certificate is easy to use. You need to know how this Certificate of Insurance relates to your Schedule of Benefits. This will let you maximize the benefits from your Preferred Provider group Plan.

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

In your Member Handbook, you will find a list of Certificate Holder'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 Member Services at 330.996.8700 or 800.996.8701 (TTY: 711) if you need more information.

Definitions are found in Section XIV of this booklet. It lists the definitions of terms used in this Certificate of Insurance 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. Under this Certificate, you must pay for services you receive that are not covered.

If you elect to receive care from a Preferred Provider:

- ❑ You will receive the highest level of benefit coverage.
- ❑ All services must be directed by a Participating Provider and be Medically Necessary.
- ❑ You will not be required to file any claim forms.
- ❑ You are not responsible for getting Prior Authorization of procedures when care is received from a Preferred Provider.
- ❑ 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 Certificate Holder or Insured dependent other than the appropriate deductible, Copayment and Coinsurance charged as stated in your Schedule of Benefits.
- ❑ If your Plan has a deductible, you will need to meet the deductible before receiving payment of benefits under your Certificate. 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.
- ❑ All in-network health care management Prior Authorizations will be the responsibility of the Preferred Provider. You should verify your Preferred Provider has authorized your inpatient and Outpatient services. Your Preferred Provider will communicate with the SummaCare Health Services Management Department on these needed Prior Authorizations.
- ❑ In cases where a Preferred Provider is terminated without cause, and you are in an active course of treatment, we must permit you to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.
    - Active course of treatment means:
        - o an ongoing course of treatment for a life-threatening condition, a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

- an ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Covered Person is currently receiving, such as chemotherapy, radiation therapy, a scheduled non-elective surgical procedure or post-operative visits, including institutional or facility care;
- the second or third trimester of pregnancy, through the postpartum period;
- an ongoing course of treatment for a health condition for which a treating Physician or health care Provider attests discontinuing care by that Physician or health care Provider would worsen the condition or interfere with anticipated outcomes; or
- being determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and receiving treatment for such illness from such provider or facility.

❑ Our decision for a request for continuity of care is subject to our internal and external grievance and appeal processes.

❑ If you or your dependent are required to pay for health care costs out-of-pocket or with funds from a Health Savings Account, the amount you will pay to the health care Provider or pharmacy shall not exceed the amount SummaCare would pay under our Reimbursement Rates negotiated with the Provider or pharmacy, except a health care Provider or pharmacy shall not waive all or part of a copay or deductible. This provision does not apply when SummaCare has no applicable negotiated Reimbursement Rate with the Provider. SummaCare shall maintain a system where a member may obtain information regarding potential out-of-pocket costs provided by Preferred Providers.

❑ SummaCare shall abide by the following regarding negotiated Discounts with a health care Provider:

- SummaCare shall disclose the existence of such Discount to any Policy Holder or Certificate Holder or enrollee who has purchased health care coverage. Such disclosure shall be contained in the body of the insurance contract with the Employer and the certificate for group coverage. Only disclosure of the existence of such Discount is required; disclosure of the extent of the Discount is not required.
- SummaCare shall calculate any annual maximums only on the basis of actual payments made to non-capitated health care Providers.
- SummaCare shall maintain adequate records of the above requirements.
- Severability - If any section, term or provision of the above rule is judged invalid for any reason, such judgment shall not affect, impair or invalidate any other section, term or provision of this rule, but the remaining sections, terms and provisions shall be and continue in full force and effect.

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 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 Member Services at 330.996.8700 or 800.996.8701 (TTY: 711) or access our website at 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. Exceptions to this provision include care received for Emergency Services and ancillary services associated with the use of a preferred provider (see Section I, Subsection E).

If you elect to use a Non-Preferred Provider:

❑ Non-Preferred Providers are not obligated to accept SummaCare's Maximum Allowable Charge as payment-in-full. The Non-Preferred Provider may bill you for the difference between our Maximum Allowable Charge and the Billed Charges.

❑ You may be responsible for filing claims, which will be processed in accordance with your out-of-network benefit.

- 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 service will be reviewed for medical necessity and to determine if the service is a covered service. If the service is not Medically Necessary or not a covered service, the claim will be denied. You have the right to appeal this decision if you disagree with our decision. Please refer to the Health Services Management section of this Certificate for proper Prior Authorization procedures and the Prior Authorization list in your Member Handbook or on our website at www.summacare.com.
- 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 and any balance billing from the Non-Preferred Provider. 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 $10 Copayment for the Preferred Provider and 20 percent Coinsurance for the 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 or Coinsurance of:	$10 Copayment**	$20 (20% Coinsurance of Maximum Allowable Charge)**
SummaCare will pay the Maximum Allowable Charge minus your Copayment/Coinsurance	$90	$80 (80% of Maximum Allowable Charge)
You pay the difference between the billed charge and the Maximum Allowable Charge when you use a Non-Preferred Provider.	$0 (SummaCare Providers have agreed to accept the Maximum Allowable Charge as full payment)	$50 (this amount does not apply towards your deductible or Out-of-Pocket Maximum)
Total You Will Pay	$10	$70

* Maximum Allowable Charges may be different for Preferred Providers and Non-Preferred Providers.
** If your Policy has a deductible, this deductible is included in SummaCare's Out-of-Pocket Maximum.

Reimbursement will be made for Medically Necessary services provided by licensed Providers of osteopathy, optometry, chiropractic or podiatry, a person so licensed who has received a doctorate of psychology or has a minimum of five years' clinical experience, a person licensed in this state for the practice of dentistry, a certified nurse-midwife performing the service in collaboration with a licensed Physician (the collaborating Physician shall be identified on the insurance claim form and the reimbursement fee will be agreed upon by the certified nurse-midwife and the Physician and in no case shall the total exceed the fee the Physician would have charged had the Physician provided the entire service), and a mechanotherapist who was issued a certificate as a mechanotherapist and has completed educational requirements in mechanotherapy on or before November 3, 1975. Providers operating within their scope of practice cannot be discriminated against.

E. Non-Preferred Providers that Provide Services at Participating or Contracted Facilities

SummaCare makes best efforts to contract with Providers based at participating or contracted facilities. However, there may be non-contracted Providers at contracted facilities including, but not limited to, emergency room Physicians, radiologists, pathologists and anesthesiologists.

If you receive services from a Non-Preferred Provider that provides services at a preferred facility, you will be responsible for the preferred provider cost share. You cannot be balanced billed.

SummaCare will make payment based on either the qualified payment amount (QPA) – the median contracted rate on January 31, 2019, for the same or similar item or service in the same geographic area increased for inflation – or the greater of:

- The median amount negotiated with Preferred Providers for the emergency service furnished;
- The amount for the emergency service calculated using the same method we generally use to determine payments for non-network services but substituting the network cost-sharing provisions for the non-network cost sharing provisions; or
- The amount that would be paid under Medicare for the emergency service.

F. Health Services Management - Utilization Management

SummaCare 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 the service is Medically Necessary and you will get all 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 assist 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:

- Consistent with the symptoms or diagnosis and treatment of the condition, disease, ailment or Injury;
- Appropriate to the standards of good medical practice;
- Not primarily for the convenience of the patient, the Physician, Practitioner or other Provider; and,
- 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. Preferred contracted Providers will be responsible for securing the Prior Authorization for services listed on our Prior Authorization list. The member will be responsible for securing or making sure the Non-Preferred Provider has secured the Prior Authorization for services listed on our Prior Authorization list. The member's claim will be denied if Prior Authorization is not secured for listed services from non-Preferred Providers. Services not covered or benefits not Medically Necessary will be denied.

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

Please go to our website at www.summacare.com for the list of procedures, admissions and devices that require Prior Authorization (Emergency Services do not require Prior Authorization). Prior Authorization does not guarantee coverage for or payment of the service or procedure review. For benefits to be paid:

- You must be eligible for benefits;
- Premium must be paid for the time period the service was rendered;
- The service cannot be an excluded service under this Certificate;
- The service must be a covered benefit under this Certificate; and
- You must not have exceeded any applicable limits under your benefit.

I. Review Process for a Prior Authorization Request

If the Provider submits the request for Prior Authorization electronically through SummaCare Plan Central (our portal), we shall respond to all Prior Authorization requests within 48 hours for urgent care services, or 10 calendar days for any Prior Authorization request that is not for an urgent care service, of the time the request is received by us. "Urgent care services" means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- ❑ Could seriously jeopardize the life, health or safety of the patient or others due to the patient's psychological state;
- ❑ In the opinion of a Practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

Upon receipt of the Prior Authorization, we will provide an electronic receipt to the Provider acknowledging the Prior Authorization request was received.

Our response shall indicate whether the request is approved or denied. If the Prior Authorization is denied, we shall provide the specific reason for the denial.

If the Prior Authorization request is incomplete, we shall indicate the specific additional information required to process the request.

We shall disclose to all Participating Providers any new Prior Authorization requirement at least 30 days prior to the effective date of the new requirement. This notice may be sent via electronic mail or standard mail and shall be noted “Notice of Changes to Prior Authorization Requirements.” The notice is not required to contain a complete listing of all changes made to the Prior Authorization requirements, but shall include specific information on where the Provider may locate the information on our website or our portal.

All Preferred Providers shall promptly notify us of any changes to their electronic mail or standard mail address.

We will make available to all Preferred Providers on our website or Provider portal a listing of the Prior Authorization requirements, including specific information or documentation a Provider must submit in order for the Prior Authorization request to be considered complete.

We will make available on our website information about the policies, contracts or agreements we offer that clearly identifies specific services, drugs or devices to which a Prior Authorization requirement exists.

For an adverse Prior Authorization determination, the appeal process relating to that shall include all the following:

- ❑ For urgent care services, the appeal shall be considered within 48 hours after we receive the appeal.
- ❑ For all other matters, the appeal shall be considered within 10 calendar days after we receive the appeal.
- ❑ The appeal shall be between the Provider requesting the service in question and a clinical peer.
- ❑ If the appeal does not resolve the disagreement, either the Covered Person or an Authorized Representative as defined in Section 3922.01 of the Ohio Revised Code may then directly request an external appeal review without first exhausting the standard internal appeal process to the extent Chapter 3922 of the Ohio Revised Code is applicable.

Except in cases of fraudulent or materially incorrect information, we will not retroactively deny a Prior Authorization for a health care service, drug or device when all the following are met:

- ❑ The Provider submits a Prior Authorization request to us for a health care service, drug or device;
- ❑ We approve the Prior Authorization request after determining all of the following are true:
  - You or your dependent is eligible under the health benefit Plan.
  - The health care service, drug or device is covered under your benefit Plan.
  - The health care service, drug or device meets our standards for medical necessity and Prior Authorization.
- ❑ The Provider renders the health care service, drug or device pursuant to the approved Prior Authorization request and all of the terms and conditions of the Provider’s contract with us;
- ❑ On the date the Provider renders the prior approved health care service, drug or device, all of the following are true:
  - The member is eligible under the health benefit Plan.
  - The member's condition or circumstances related to the member's care has not changed.
  - The Provider submits an accurate claim that matches the information submitted by the Provider in the approved Prior Authorization request.

J. 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 Utilization Medical Policy Committee review and investigate new technology by:

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

At least two 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.

K. Deductible Credit for Initial Enrollment

If you had Expenses applied to a deductible under another healthcare Plan or group Policy you had prior to enrolling in SummaCare, this amount can be applied to your SummaCare deductible only if those services were received during the current Calendar Year. The services must be services that would be covered under your Policy for the credit to apply.

This credit only applies to initial members of the new group enrollment and only applies to the Preferred Provider deductible. If you are a new hire joining SummaCare after your Employer group's initial enrollment, you are not eligible for the credit.

It is your responsibility to provide documentation during the initial open enrollment session or to our Member Services Department of any prior deductible. You will need to provide an Explanation of Benefits (EOB) from your prior carrier to enable SummaCare to carry over any prior deductible. You can obtain a copy of the Deductible Credit Transfer Form on our website at www.summacare.com.

L. Calendar Year Out-of-Pocket Maximum

Your share of the cost of Covered Services is limited to the annual Out-of-Pocket Maximum shown in your Schedule of Benefits. This is the maximum you will pay under this Plan. The individual Maximum Out-of-Pocket on your Plan applies to each family member regardless of coverage type. Once an individual family member has reached his or her Out-of-Pocket Maximum, claims will pay at 100 percent even if the family Out-of-Pocket Maximum has not been met. For a family, each family member's Out-of-Pocket Maximum will not exceed the amount listed for an individual, and once the family Out-of-Pocket Maximum is met, all family members' claims will pay at 100 percent. Charges you pay that exceed the Maximum Allowable Charge for services received from a Non-Preferred Provider do not apply to the annual Out-of-Pocket Maximum. Preferred and non-preferred Out-of-Pocket Maximums are separate.

M. Non Assignment

You may not assign or transfer your right to the reimbursement or payment for the benefits contained in this Plan, and any right to reimbursement or payment for such benefits, in whole or in part, in any manner or to any extent, to any person or entity, other than to a Hospital as required under Ohio Revised Code Section 3901.386. You shall not sell, assign, pledge, transfer or grant any interest in or to these benefits or any right of reimbursement or payment arising out of these benefits to any person or entity. Any such purported sale, assignment, pledge, transfer or grant is not enforceable against SummaCare and imposes no duty or obligation on SummaCare. SummaCare will not honor any such purported sale, assignment, pledge, transfer or grant.

II. Who Is Eligible

A. Employee Eligibility

To apply, you must:

- ❑ Be eligible to participate in your Employer's health benefits program under the Employer's written requirements (for some Employers this may include retirees);
- ❑ Be considered a legitimate, regularly employed Employee. You must work at least 30 hours per week;
- ❑ Have satisfied any Waiting Period of the group (not to exceed 90 days); and
- ❑ Meet the eligibility criteria stated in the group contract.

You may also be eligible if you used to be employed by the Employer currently contracting with SummaCare and you were covered by SummaCare Insurance through this Employer. The Employer must have elected to continue group coverage under state or federal law. Contact your Employer's personnel or Employee benefits office for more information about eligibility.

B. Dependent Eligibility

Eligible dependents may include your legal spouse, unless specifically prohibited by the written rules of your plan sponsor, and must include your natural born, adopted/placed for adoption dependent or stepchild under the age of 26. Dependent children are eligible to be covered up to the age of 26.

Dependent Children Include:

- ❑ **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 Certificate 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.

- ❑ **Adopted Child**
  Your adopted child becomes an eligible dependent on the same basis as other dependent children. An adopted child is covered from the date of placement.

- ❑ **Handicapped Child-Disabled Dependent Children**
  The attainment of the limiting age for dependent children shall not operate to terminate the coverage of a dependent child if the child is and continues to be both of the following:
  - Incapable of self-sustaining employment by reason of mental or physical disability; and,
  - Primarily dependent upon the Certificate Holder for support and maintenance.

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

- ❑ **Newborn Child/Children**
  Newborn children will be covered at no cost for the first 31 days from the date of the child's birth. Depending upon your current Plan or Policy, coverage of your newborn beyond the 31st day may require additional Premiums. If additional Premiums are required to add your newborn, you must provide a change form and the additional required Premiums within 31 days of the birth. (Please contact your Human Resources Department for forms).

  Contact your Human Resources Department to determine if additional Premiums are required after the first 31 days after birth. The coverage for newly born children shall consist of coverage from birth and shall include necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

- ❑ **Child for which Guardianship is Awarded**
  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 receive a change notice within 31 days of this event.

C. Qualified Medical Child Support Orders

We will enroll for immediate coverage under this Certificate any dependent who is the subject of a Medical Child Support Order that is not already covered by this Certificate as an eligible dependent once we determine such order meets the standards for qualification under Section 609 of the Employee Retirement Income Security Act. Either parent must be permitted to enroll court-ordered children without any enrollment period restriction. An Employer must enroll court-ordered children when a parent does not.

D. HIPAA 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 will provide you with a Notice of Privacy Practices when you enroll and at least every three years after that, as well as whenever substantive changes are made. The Notice of Privacy Practices gives you more details about your rights and responsibilities concerning the disclosure of your protected health information. The most current Notice of Privacy Practices is also available on our website at www.summacare.com/legal-and-privacy/notice-of-privacy.

III. Enrolling in Your Group Preferred Provider Plan

A. Initial Enrollment

Group insurance will cover any small group of two or more Employees, members or other persons, with or without one or more of their dependents and members of the immediate families. Under this Certificate, small group is defined as a group with up to 50 Employees, including a business owner with one Employee. This group insurance may be offered to groups without regard to the purpose or type of group or the occupation of the Employees, members or other persons Insured under the Policy. SummaCare shall make available to every small Employer group every health benefit Plan it currently markets. Certain contribution or group participation rules may apply to the group enrollment. SummaCare, at the time of initial group enrollment, shall make coverage available to all the eligible Employees of a small Employer without a service Waiting Period. The decision to impose a service Waiting Period shall be made by the small Employer group and shall be no more than 90 days. At least once every 12-month period, SummaCare shall provide to all late enrollees, who are identified by the small Employer, the option to enroll in the SummaCare Plan during an Open Enrollment session.

SummaCare shall furnish to the Policyholder, for delivery to each Employee of the group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of the Employee and to whom benefits are payable. If dependents or members of the immediate family of the Employee are included in the coverage, only one certificate will be issued to each family unit. The group may add eligible new Employees and dependents of their families in accordance with the Policy terms.

B. Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) during an initial enrollment period or Open Enrollment because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in the Plan, provided you request enrollment within 31 days after the marriage, birth or adoption.

If you have a change in family status, you may enroll the qualified person within 31 days following the date of the qualifying event. Failure to notify us of persons no longer eligible for coverage or services will not obligate us to provide benefits or payment for such benefits. You are responsible for notifying your Employer group, who notifies us of any changes. These changes include:

- ❑ Changes in address
- ❑ Marriage
- ❑ Divorce/Legal Separation
- ❑ Death
- ❑ Change of Dependent disability or dependency status
- ❑ Enrollment or disenrollment in another health Plan, Medicaid or Medicare

If we receive an application to add your dependent after 31 days after the qualifying event, that person is only eligible for coverage as a late enrollee. We will not be able to enroll that person until the next Open Enrollment period.

Eligible Employees and dependents may also enroll under the two additional circumstances as listed in subsections C and D of this section.

C. Late Enrollees

You are considered a late enrollee if you are an Eligible Person or dependent who did not request enrollment for coverage during the initial enrollment period, during a Special Enrollment period or as a newly eligible dependent who failed to qualify during the Special Enrollment period and did not enroll within 31 days of the date you were first entitled to enroll. At least once in every 12-month period, SummaCare shall provide to all late enrollees who are identified by the Employer the option to enroll in the health benefit Plan. The enrollment option shall be provided for a minimum period of 30 consecutive days and is considered an Open Enrollment period.

D. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires that SummaCare permit you or your dependent, if eligible but not enrolled in coverage under your group health Plan, to enroll if either of the following conditions is met:

- You or your dependent covered under Medicaid or the State Children's Health Insurance Program (CHIPRA) has coverage terminated as a result of loss of eligibility and you request coverage for you or your dependent within 60 days after termination; or
- You or your dependent becomes eligible for a subsidy (state assistance program) under Medicaid or CHIPRA, if you request coverage within 60 days after the eligibility determination date.

E. Pre-Existing Condition Limitation/Guaranteed Issue and Availability

There is no pre-existing condition limitation on this Certificate. SummaCare will accept every eligible individual or Employer who applies for coverage. The Employer shall provide to any eligible Employee an opportunity to enroll in this small group Plan.

IV. When Coverage Begins

A. Open Enrollment Period

Summa Insurance Company contracts with the Employer group, considered the master Policyholder. The Group's Master Policy covers all Insured eligible Employees, considered the Certificate Holders. The Employer group negotiates the terms of the group Policy with us. No Eligible Person will be discriminated against and refused enrollment based on health status, race, color, national origin, disability, health needs, genetic information, age, sex, gender identity or sexual orientation. This Plan will not discriminate in favor of a highly compensated individual.

To enroll yourself and any eligible dependents in the Policy covered under this Certificate, you must complete an enrollment application.

When you become eligible, you can enroll in the group Policy during your Employer's Annual Open Enrollment period (see below for Enrollment Date) or 31 days after the date you become eligible due to a qualifying event. At that time, you will choose whether you want coverage for only yourself or for yourself and your eligible dependents.

If you choose not to enroll yourself or your eligible dependents during the Open Enrollment period or within 31 days following the date of any qualifying event, you must wait until the next Annual Open Enrollment period to apply for the SummaCare Group Plan.

The small Employer group will set the specific Open Enrollment period. The enrollment period shall be provided for a minimum of 30 days. Renewals for existing group Employees will be provided in the Open Enrollment period.

- ❑ Coverage will begin at 12:01 AM on the effective date or Enrollment Date (which is the date enrolled in the Plan or the first day of the Waiting Period of such enrollment as specified by your Employer) and the date specified by your Employer's master Policy.

Coverage will be offered to:

- ❑ Any Employer's eligible Employee who lives or works in the Service Area regardless of his or her health status, risk or medical claims and costs incurred for such claims. Coverage will be offered to all full-time eligible Employees.
- ❑ A full-time eligible Employee is an Employee who works at least 30 hours.

B. Newly Eligible Employees or Dependents

If the enrollment form is received during your Employer's Open Enrollment period or after the effective date of the Policy:

- ❑ You are hired during your Employer's Open Enrollment period, coverage will become effective when you have met your Employer's eligibility requirements. The Waiting Period can be no more than 90 days.
- ❑ Coverage is effective on the date of eligibility provided you meet your Employer's eligibility requirements within 31 days of first becoming eligible.
- ❑ Your dependent child is eligible for the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA requires SummaCare permit you or your dependent, if eligible but not enrolled in coverage under your group health Plan, to enroll if either of the following conditions is met:
  - You or your dependent covered under Medicaid or the State Children's Health Insurance Program (CHIPRA) has coverage terminated as a result of loss of eligibility and you request coverage for you or your dependent within 60 days after termination; or
  - You or your dependent becomes eligible for a subsidy (state assistance program) under Medicaid or CHIPRA, if you request coverage within 60 days after the eligibility determination date.
- ❑ **The Family and Medical Leave Act of 1993 -** A Certificate Holder taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Certificate Holder and his or her dependent shall not be considered ineligible due to the Certificate Holder not being actively at work. This Plan may not establish a rule for eligibility or may not refuse to provide benefits because an individual is not actively at work on the day that individual would otherwise become eligible for benefits or set any individual's Premium or contribution rate based on whether an individual is actively at work.

  If the Certificate Holder does not retain coverage during the leave period, the Certificate Holder and any eligible dependent(s) who were covered immediately prior to the leave may be reinstated upon return to work without imposition of an additional Waiting Period.

V. When Coverage Ends

A. Your Coverage Will End on the Earliest of:

- The date the master Policy between your Employer and SummaCare ends;
- The date you stop being an eligible Employee;
- After receipt of your termination request at 11:59 PM on the last date of the billing period in which Premium has been paid and if special qualifying events occur as dictated by the IRS Code;
- The date on which your coverage began if it is later determined you made an intentional material misrepresentation on your application;
- The date on which you commit fraud with respect to the Policy;
- The date which you allowed a person not eligible for benefits to use your identification card; or,
- The date stated for nonpayment of the required Premium after written notice has been sent to the master Policyholder.

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

- Your or your dependent's discharge from that facility;
- The determination by your or your dependent's attending Physician that inpatient care is no longer medically indicated;
- You or your dependent has reached the limit for contracted benefits; or
- The effective date of any new coverage.

If you or your dependents are confined to a Hospital on the effective date of coverage with SummaCare, we will not duplicate any benefits or services related to this stay if paid for by any other insurance coverage.

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

- The date the subscriber's coverage ends;
- The date a dependent is no longer eligible for coverage. This is according to the eligibility requirements of your Employer and SummaCare under Section II;
- The date on which the dependent commits fraud or intentional material misrepresentation regarding the terms of the Policy.
- The end of the billing period for which the Premium has been paid for your covered dependent.

For exceptions regarding the above, see "Continuation of Coverage" or call Member Services at 330.996.8700 or 800.996.8701 (TTY: 711).

C. Certification of Prior Creditable Coverage

If your coverage is terminated and you or your covered dependents need a certification showing when you were covered under the Plan, you may request one be provided to you at any time by contacting Member Services at the phone number listed on the back of your Identification Card.

VI. Re-enrolling in Your Group PPO

If your coverage ends and you want to re-enroll in a SummaCare Plan through a different Employer and a different Plan (group number), your benefits will be effective as though you are enrolling for the first time. If you are re-enrolling in SummaCare PPO through the same Employer and Policy (group number), any benefit limits and Coinsurance that have been made for that Calendar Year will be carried forward. Any Employer eligibility Waiting Period will apply to this reinstatement.

VII. Standard Provisions

Entire Contract Changes: The Employer's (referred to as the Master Policyholder) Policy, including any endorsements and any attached papers including this Certificate, Schedule of Benefits and the individual applications submitted in connection with the Policy by the Employees or members, shall constitute the entire contract of insurance. 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. All statements, in the absence of fraud, made by any applicant shall be deemed representation and not warranties, and no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application.

Time Limit on Certain Defenses: After two years from the date of issue of this 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. No claim for loss incurred or disability (as defined in this Policy) commencing after two years from the date of issue of this Policy shall be reduced or denied on the grounds a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Rescission: A rescission of your coverage means the coverage may be legally voided all the way back to the day the Plan begins to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf) perform an act, practice or omission that constitutes fraud or unless you (or a person seeking coverage on your behalf) make an intentional misrepresentation of material fact as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your Employer. You will be provided with 30 calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeals process is exhausted, you have the additional right to request an independent external review.

Renewability: SummaCare shall renew or continue in force such coverage at the option of the Employer group (guaranteed renewability).

If we make an Adverse Benefit Determination based on one of these standard provisions, you may be entitled to appeal the decision in accordance with this Certificate. See the Complaint Procedure section of this Certificate.

VIII. Covered Services

The following services are covered under your Certificate including Essential Health Benefits as required by federal law (refer to Definitions section for definition of Essential Health Benefits). Covered Services and benefits provided on this Plan will not discriminate against an individual on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation. Coverage is provided subject to the deductibles, Copayments, Coinsurance, limitations and exclusions specified in this booklet or your Schedule of Benefits. All services must be Medically Necessary and not experimental or investigative in nature and some services are subject to Prior Authorization rules. Refer to the Prior Authorization List provided at our website at www.summacare.com.

A. Outpatient/Facility Services Covered

Outpatient services include facility, ancillary, facility use and professional charges when given as an Outpatient at a Hospital, alternative care facility, retail health clinic or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing diagnostic and therapy services, surgery or rehabilitation or other Provider facilities as determined by us.

Outpatient services include, but are not limited to:

1. Office visits to your Provider (primary Physician-includes pediatrician for a child, and specialist) and includes physical exams, well child care, immunizations and other preventive health care services based on the recommendations of the United States Preventive Services Task Force. Services are covered to treat an Illness or Injury and include services provided by a nurse Practitioner or nurse assistant. Services including immunizations and child health supervision services from birth, 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. Periodic review means a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical exam, developmental assessment, anticipatory guidance, appropriate immunizations and the lab tests. Pediatric services are covered up to the end of the month of the 19th birthdate of the child.
2. Office visits to an OB/GYN specialist for obstetrical/gynecological services. No referrals required for visits to an OB/GYN or any other specialist.
3. X-ray, lab and other diagnostic services.
4. Medically Necessary surgical procedures and anesthesia that are Covered Benefits.
5. Surgical Physicians and specialists services and surgery in Outpatient facilities and Ambulatory Surgery Centers.
6. Urgent and emergency care services. (Refer to Emergency/Urgent Care section for more details.)
7. Services for mental health and substance abuse detoxification/rehabilitation. (Refer to the Mental Health and Substance Abuse benefit.)
8. Allergy testing and treatment.
9. Physical, occupational, speech and habilitative therapy.
10. Cardiac and pulmonary rehabilitation therapies.
11. Outpatient facility fee, including services at a hospital or other alternative care facility or ambulatory surgical care center.

For Non-Covered Outpatient Services, please refer to Section IX of this document (General Exclusions).

B. Inpatient Hospital Services Covered

1. Semi-private Room and Board; private room in a Hospital and Special Care Units if Medically Necessary and prior authorized by the SummaCare Health Services Management Program.

2. Provider services related to medical treatment or surgery. Provider services include medical care, intensive medical care and concurrent care when the nature or severity of your condition requires the skills of separate Physicians, newborn exam and Physician services for surgery or administration of general anesthesia.

3. General nursing services.

4. X-ray, lab and other diagnostic services.

5. Operating, delivery rooms and equipment and anesthesia and supplies as part of the inpatient surgery.

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. Includes coverage for Day Rehabilitation Program services subject to combined 60-day limit with inpatient services.

9. Cardiac/pulmonary therapies.

10. Transplants. (Refer to Transplants benefit under "Other Services Covered" section.)

11. Mental health and substance detoxification/rehabilitation. (Refer to Mental Health and Substance Abuse benefit under the "Other Services Covered" section.)

12. For inpatient skilled nursing services. (Refer to the skilled nursing benefit.)

For Non-Covered Inpatient Services, please refer to Section IX of this document (General Exclusions).

C. Coverage for Emergency Care Services/Urgent Care Situations

Emergency Services are available 24 hours a day, seven days a week without regard to where service is provided in or out of our network. 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 that of a pregnant woman or her baby in serious jeopardy;
- Serious dysfunction of any bodily organ or part.

"**Emergency Services**" means the following:

- A medical screening examination, as required by federal law, within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
- Such further medical examination and treatment required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff available at the Hospital, including any trauma and burn center of the Hospital.

"**Emergency Medical Condition**" means the following:

- A medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, 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 that of a pregnant woman or her baby in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

If you experience symptoms that meet the definition of an emergency, call 911 for emergency assistance or go to the nearest Hospital. In-network and out-of-network emergency care will be paid at the same cost share except the Non-Preferred Provider may send you a bill for charges remaining after your Plan has paid, which is called balance billing. The maximum allowed amount for emergency care from a Non-Preferred Provider will be one of the following situations: (1) for a Provider under the federal "No Surprises Act" the payment will

be the Qualified Payment Amount (QPA), as defined in Section I, Subsection E, or (2) for a provider under the Ohio law, the payment will be the greater of the following amounts:

- ❑ The median amount negotiated with Preferred Providers for the emergency service furnished;
- ❑ The amount for the emergency service calculated using the same method we generally use to determine payments for non-network services but substituting the network cost-sharing provisions for the non-network cost sharing provisions; or
- ❑ The amount that would be paid under Medicare for the emergency service.

Emergency Services and stabilization services do not require Prior Authorization. "Stabilize" means to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable probability, no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. Care and treatment provided once you are stabilized is no longer considered emergency care. Continuation of care from a Non-Preferred Provider beyond what is needed to evaluate and stabilize your condition in an emergency will be covered as a non-network service unless we authorize the continuation of care and it is Medically Necessary. Emergency room care which is non-emergent in nature is not covered. Example would be removal of suture in the emergency room.

Refer to your Schedule of Benefits for your specific Plan's Copayments for Emergency Services. If admitted to the Hospital, the emergency copay will be waived. For inpatient admissions following emergency care, we must be notified within 24 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the inpatient setting is appropriate and if so, the number of days considered Medically Necessary. By calling us, you may avoid financial responsibility for any inpatient care determined to be not Medically Necessary under your Plan. Care or treatment once you are stabilized is no longer considered emergency care.

Urgent Care Center Services

An urgent care situation occurs when you require care as soon as possible, but it is not a life-or limb- threatening emergency. An urgent care medical condition is an Illness or an Injury requiring treatment that cannot be postponed in lieu of seeing your regular Physician. This care is not considered an emergency. Urgent care visits will be subject to the urgent care Copayment. Some examples of urgent care situations are:

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

Non-Covered Services include:

Non-emergency care when traveling outside the United States.

D. Other Services Covered

1. Ambulance Emergency Transportation

Charges for Medically Necessary emergency transportation to the nearest Hospital are covered. Ambulance services are transportations by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals.

Emergency Services covered:

- ❑ From your home, scene of Accident or medical emergency to a Hospital;
- ❑ Between Hospitals; or
- ❑ Between a Hospital and Skilled Nursing Facility.
- ❑ From a Hospital or Skilled Nursing facility to your home.

Treatment of a sickness or Injury by medical professionals from an ambulance service when you are not transported will be covered if Medically Necessary.

Other vehicles which do not meet this definition, including but not limited to ambulettes, are not Covered Services. Ambulance services are a Covered Service only when Medically Necessary, except:

- ❑ When ordered by an Employer, school, fire or public safety official and the member is not in a position to refuse; or
- ❑ When SummaCare requires a member to move from a Non-Preferred Provider to a Preferred Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the member's health. Any ambulance usage for the convenience of the member, family or Physician is not a covered service.

Non-Covered Services for ambulance include, but are not limited to, trips to:

- ❑ a Physician's office or clinic;
- ❑ a morgue or funeral home.

2. Cancer Clinical Trials and Expanded Coverage by Federal Law of Approved Clinical Trials

Benefits are available for services for Routine Patient Care rendered as part of a Cancer Clinical Trial if the services are otherwise Covered Services under this Certificate and the trial meets all the following criteria:

- ❑ The purpose of the trial is to test whether the intervention potentially improves the trial participant's health or the treatment is given with the intention of improving the trial participant's health, and is not designed simply to test toxicity or disease pathophysiology;
- ❑ The trial does one of the following:
  - Tests how to administer a health care service, item or drug for the treatment of cancer;
  - Tests responses to a health care service, item or drug for the treatment of cancer;
  - Compares the effectiveness of health care services, items or drugs for the treatment of cancer; or
  - Studies new uses of health care services, items or drugs for the treatment of cancer.
- ❑ The trial is approved by one of the following:
  - The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
  - The United States Food and Drug Administration (FDA);
  - The United States Department of Defense; or
  - The United States Department of Veteran's Affairs.

Benefits do not, however, include the following:

- ❑ A health care service, item or drug that is the subject of the Cancer Clinical Trial or is provided solely to satisfy data collection and analysis needs for the Cancer Clinical Trial that is not used in the direct clinical management of the patient;
- ❑ An investigational or experimental drug or device that has not been approved for market by the FDA;
- ❑ Transportation, lodging, food or other Expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the Cancer Clinical Trial;
- ❑ An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
- ❑ A service, item or drug eligible for reimbursement by a person other than the Insurer, including the sponsor of the Cancer Clinical Trial.

3. Chiropractic Services/Osteopathic Manipulation Therapy

Service performed by a licensed chiropractor or a licensed Physician for osteopathic/chiropractic manipulation therapy. Refer to your Schedule of Benefits for benefit limitations. Chiropractic care not covered in a home health care setting.

4. Dental Services Related to Accidental Injury Defined as an Essential Health Benefit under the Affordable Care Act

Related to Accidental Injury:

Outpatient services, Physician home visits and office services, emergency care and urgent care services for dental work and oral surgery are covered if they are for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an Accident and are not excessive in scope, duration or intensity to provide safe, adequate and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental Injury. "Initial" dental work to repair injuries due to an Accident means performed within 12 months from the Injury, or as reasonably soon thereafter as

possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related Injury, there may be several years between the Accident and final repair.

Covered Services for accidental dental include, but are not limited to:

- ❑ oral examinations
- ❑ x-rays
- ❑ tests and laboratory examinations
- ❑ restorations
- ❑ prosthetic services
- ❑ oral surgery
- ❑ mandibular/maxillary reconstruction
- ❑ anesthesia

Other Dental Services:
The only other dental Expenses that are Covered Services are facility charges for Outpatient services. Benefits are payable for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

5. Diabetic Education and Testing Supplies
Medically Necessary diabetic education and nutritional counseling will be provided for an individual when the following conditions are met: ordered by a Physician and provided by a health professional licensed, registered or certified under state law and has obtained certification in diabetes education by the American Diabetes Association.

Benefits include:

- ❑ Testing strips, glucometers and lancets,
- ❑ Diabetes education classes taught by an ADA-approved Provider,
- ❑ 24/7 Nurse Line.

Medically Necessary orthopedic/therapeutic shoes are also covered.

6. Dialysis
Treatment to provide artificial replacement for reduced or lost kidney function and may include the supportive use of an artificial kidney machine. Kidney dialysis shall be deemed to include such benefits on an equal basis if the dialysis is performed on an Outpatient basis. Outpatient basis includes care rendered at any location whether or not at a Hospital, upon approval by the attending Physician.

7. Durable Medical Equipment, Supplies and Prosthetic Devices and Foot Orthotics
The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Charge for a standard item that is a covered service, serves the same purpose and is Medically Necessary. Any Expense that exceeds the Maximum Allowable Charge for the standard item which is a covered service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by SummaCare. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- ❑ The equipment, supply or appliance is a covered service;
- ❑ The continued use of the item is Medically Necessary;
- ❑ There is reasonable justification for the repair, adjustment or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

- ❑ The equipment, supply or appliance is worn out or no longer functions.
- ❑ Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
- ❑ Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth or deterioration of function, etc.
- ❑ The equipment, supply or appliance is damaged and cannot be repaired. Benefits for repairs and replacement do not include the following:
  - Repair and replacement due to misuse, malicious breakage or gross neglect.
  - Replacement of lost or stolen items.

We may establish limitations for suppliers, and quantity limits, for certain supplies, equipment or appliances allowing for substitution of same or similar application.

Covered Services may include, but are not limited to:
Medical and surgical supplies - Certain supplies and equipment for the management of disease that SummaCare approves are covered under the prescription drug benefit, if any. These supplies are considered a medical supply benefit if the supplies, equipment or appliances are not received from SummaCare's mail service or from a network pharmacy. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Prescription drugs and biologicals that cannot be self-administered are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers and petroleum jelly.

Covered Services may include, but are not limited to:
- ❑ Allergy serum extracts
- ❑ Chem strips, Glucometer, Lancets
- ❑ Clinitest
- ❑ Needles/syringes
- ❑ Ostomy bags and supplies except charges such as those made by a pharmacy for purposes of a fitting are not covered services.

Non-Covered Services include, but are not limited to:
- ❑ Adhesive tape, bandages, cotton tipped applicators
- ❑ Arch supports
- ❑ Doughnut cushions
- ❑ Hot packs, ice bags
- ❑ Vitamins
- ❑ Medijectors

If you have any questions regarding whether a specific medical or surgical supply is covered, call the Member Services number on the back of your Identification Card.

Durable medical equipment - The rental (or, at SummaCare's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of Illness or Injury; and is appropriate for use in a patient's home. Examples include, but are not limited to, wheelchairs, crutches, Hospital beds and oxygen equipment. Some items are rented, such as home ventilators, while other items are purchased, such as wound care supplies. Oxygen is rented for a period of time and then enters a maintenance fee period where the cost for members is decreased. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:
- ❑ Hemodialysis equipment
- ❑ Crutches and replacement of pads and tips
- ❑ Pressure machines
- ❑ Infusion pump for IV fluids and medicine
- ❑ Glucometer
- ❑ Tracheotomy tube
- ❑ Cardiac, neonatal and sleep apnea monitors

Augmentive communication devices are covered when SummaCare approves based on the member's condition.

Non-covered items may include, but are not limited to:
- ❑ Air conditioners
- ❑ Ice bags/coldpack pump
- ❑ Raised toilet seats
- ❑ Rental of equipment if the member is in a facility expected to provide such equipment
- ❑ Translift chairs
- ❑ Treadmill exerciser
- ❑ Tub chair used in shower.

If you have any questions regarding whether specific durable medical equipment is covered, call the Member Services number on the back of your Identification Card.

Prosthetics – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs and replacements of prosthetic devices and supplies that:

- ❑ Replace all or part of a missing body part and its adjoining tissues; or
- ❑ Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

- ❑ Aids and supports for defective parts of the body including, but not limited to, internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates and vitallium heads for joint reconstruction.
- ❑ Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- ❑ Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for prosthetic devices, if any, do not apply.
- ❑ Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
- ❑ Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or Injury; the first pair of contact lenses or eyeglasses is covered. The donor lens inserted at the time of surgery is not considered a contact lens nor the first lens following surgery. If the Injury is to one eye or if cataracts are removed from only one eye and the member selects eyeglasses and frames, reimbursement for both lenses and frames will be covered.
- ❑ Cochlear implant.
- ❑ Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- ❑ Restoration prosthesis (composite facial prosthesis)
- ❑ Wigs (not to exceed one per benefit period).

Non-covered prosthetic appliances include, but are not limited to:

- ❑ Dentures, replacing teeth or structures directly supporting teeth.
- ❑ Dental appliances.
- ❑ Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
- ❑ Artificial heart implants.
- ❑ Wigs (except as described above following cancer treatment).
- ❑ Penile prosthesis in men suffering impotency resulting from disease or Injury.

If you have any questions regarding whether a specific prosthetic is covered, call the Member Services number on the back of your Identification Card.

Orthotic devices - Covered Services are the initial purchase, fitting and repair of a custom-made rigid or semi-rigid supportive device used to support, align, prevent or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Foot orthotics are in certain situations covered as prescribed by your Physician for a member diagnosed with diabetes, peripheral neuropathy, rheumatoid arthritis or peripheral vascular disease and as defined by Health Services Management (HSM) criteria.

Covered orthotic devices may include, but are not limited to, the following:

- ❑ Cervical collars.

- ❑ Ankle foot orthosis.
- ❑ Corsets (back and special surgical).
- ❑ Splints (extremity).
- ❑ Trusses and supports.
- ❑ Slings.
- ❑ Wristlets.
- ❑ Built-up shoe.
- ❑ Custom-made shoe inserts.

Orthotic appliances may be replaced once per year per member when Medically Necessary in the member's situation. However, additional replacements will be allowed for members under age 18 due to rapid growth, or for any member when an appliance is damaged and cannot be repaired.

Non-Covered Services include, but are not limited to:

- ❑ Orthopedic shoes (except therapeutic shoes for diabetics).
- ❑ Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
- ❑ Standard elastic stockings, garter belts and other supplies not specially made and fitted (except as specified under medical supplies).
- ❑ Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered, call the Member Services number on the back of your Identification Card.

8. Home Health Care Services

Medical treatment provided in the home on a part-time or intermittent basis including visits by a licensed health care professional, including a nurse, therapist, Home Health Aide and physical, speech and occupational therapy, are covered. When private duty nursing services and home infusion therapy is done in the home setting, they are not subject to the normal home health visit limit of 100 visits per year.

Home health services include:

- ❑ Intermittent skilled nursing services (by an R.N. or L.P.N.).
- ❑ Medical/social services.
- ❑ Diagnostic services.
- ❑ Nutritional guidance.
- ❑ Home Health Aide services. The member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the home health care Provider. Other organizations may provide services only when approved by SummaCare, and their duties must be assigned and supervised by a professional nurse on the staff of the home health care Provider.
- ❑ Therapy services (except for manipulation therapy, which will not be covered when rendered in the home). Home care visit limits specified in the Schedule of Benefits for home care services apply when therapy services are rendered in the home.
- ❑ Medical/surgical supplies.
- ❑ Durable medical equipment.
- ❑ Prescription drugs (only if provided and billed by a Home Health Care Agency).
- ❑ Private duty nursing.

Non-Covered Services include, but are not limited to:

- ❑ Food, housing, homemaker services and home delivered meals.
- ❑ Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- ❑ Physician charges.
- ❑ Helpful environmental materials (hand rails, ramps, telephones, air conditioners and similar services, appliances and devices.)
- ❑ Services provided by registered nurses and other health workers who are not acting as Employees or under approved arrangements with a contracting home health care Provider.
- ❑ Services provided by a member of the patient's immediate family.
- ❑ Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from SummaCare (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to: injections (intra-muscular, subcutaneous and continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy.

9. Hospice Care

Hospice Care may be provided in the home or at a Hospice Facility where medical, social and psychological services are given to help treat patients with a terminal Illness. Hospice services include routine home care, continuous home care, inpatient Hospice and inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the member lives longer than six months.

When approved by your Physician, Covered Services include the following:

- ❑ Skilled nursing services (by an R.N. or L.P.N.).
- ❑ Diagnostic services.
- ❑ Physical, speech and inhalation therapies if part of a treatment plan.
- ❑ Medical supplies, equipment and appliances (benefits will not be covered for equipment when the member is in a facility that should provide such equipment).
- ❑ Counseling services.
- ❑ Inpatient stay at a Hospice.
- ❑ Prescription drugs given by the Hospice.
- ❑ Home Health Aide.

Non-Covered Services include, but are not limited to:

- ❑ Services provided by volunteers.
- ❑ Housekeeping services.

10. Infertility Diagnosis

SummaCare will cover the costs for Medically Necessary testing and exploratory procedures to determine a diagnosis of infertility, including surgical procedures to correct a medically diagnosed disease or condition of the reproductive organs. This includes, but is not limited to, treatment of the following:

- ❑ Endometriosis;
- ❑ Collapsed/clogged fallopian tubes; or
- ❑ Testicular failure.

Coverage does not include infertility drug therapy or monitoring or procedures used to induce pregnancy. (Please refer to the "Infertility" and "Pregnancy Inducement/ Surrogate Parenting" entries in Section VII "General Exclusions" for more information). Infertility therapy must be prior authorized by the SummaCare Health Services Management Authorization Unit.

11. Infusion Therapy/IV Therapy

Infusion therapy includes a combination of nursing, durable medical equipment and pharmaceutical services delivered and administered intravenously in the home. Home intravenous (IV) therapy includes but is not limited to: injections (intra-muscular, subcutaneous and continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy and drug infusions (antibiotic, pain management, chemotherapy, hormonal support of pregnancy, other select drugs). Select drugs require Prior Authorization; refer to the SummaCare Medical/Drug Prior Authorization List. Infusion therapy is not included in the home health care 100-visit limit per year.

12. Lab and Other Diagnostic Services Including X-Ray

SummaCare will cover the cost of Medically Necessary lab work and other diagnostic services. Diagnostic services are tests or procedures performed when you have specific symptoms to detect or monitor your condition. Diagnostic services include, but are not limited to:

- ❑ X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- ❑ Magnetic Resonance Angiography (MRA).
- ❑ Magnetic Resonance Imaging (MRI).
- ❑ CAT scans.
- ❑ Laboratory and pathology services.
- ❑ Cardiographic, encephalographic and radioisotope tests.
- ❑ Nuclear cardiology imaging studies.

- ❑ Ultrasound services.
- ❑ Allergy tests.
- ❑ Electrocardiograms (EKG).
- ❑ Electromyograms (EMG) except that surface EMG's are not Covered Services.
- ❑ Echocardiograms.
- ❑ Bone density studies.
- ❑ Positron emission tomography (PET scanning).
- ❑ Diagnostic tests as an evaluation to determine the need for a covered transplant procedure.
- ❑ Echographies.
- ❑ Doppler studies.
- ❑ Brainstem evoked potentials (BAER).
- ❑ Somatosensory evoked potentials (SSEP)
- ❑ Visual evoked potentials (VEP)
- ❑ Nerve conduction studies.
- ❑ Muscle testing.
- ❑ Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

13. Maternity Services

Maternity care, maternity related checkups and delivery of the baby in the Hospital are covered for you and your covered dependent and include:

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

All emergency deliveries are covered. We cover up to a 48-hour Hospital admission for a normal 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 Authorization Unit. Maternity coverage will be provided for the member or the covered dependent.

Any decision to shorten the length of inpatient stay to less than that specified above shall be made by the Physician attending the mother or newborn, except if a certified nurse-midwife is attending the mother in collaboration with a Physician, the decision may be made by the nurse-midwife. Decision regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. A person responsible for the mother or newborn may include a parent, guardian or any other person with authority to make medical decisions for the mother or newborn.

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

SummaCare also covers follow-up care directed by a Physician or advanced practice registered nurse, which includes:

- ❑ Physical assessment of the mother and newborn;
- ❑ Parent education;
- ❑ Assistance and training in breast or bottle-feeding;
- ❑ Assessment of the home support system;
- ❑ Performance of any Medically Necessary and appropriate clinical tests; and
- ❑ Any other services 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 maternity and newborn care.

If a newborn child is required to stay as an inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from an ordinary routine nursery admission, and be subject to the inpatient Coinsurance or Copay of the Plan.

Elective abortions, whether surgically or pharmaceutically induced, are not covered except when continuation of pregnancy poses a serious health hazard to the mother or in the case of incest or rape. Infertility drug therapy or monitoring or procedures used to induce pregnancy are not covered. (See also "Pregnancy Inducement/Surrogate Parenting" exclusion.) Diagnostic testing or treatment related to a diagnosis of infertility is excluded.

14. Mental Health Services

SummaCare PPO covers mental health services for the treatment of both biologically based and non-biologically based mental health. Biologically based mental health services must be clinically diagnosed per the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) 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 prescribed treatment cannot be experimental or investigational and have proven its clinical effectiveness in accordance with generally accepted medical standards.

The following mental health services are covered:

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. SummaCare shall provide benefits for the diagnosis and treatment of biologically based mental Illnesses on the same terms and conditions as, and shall provide benefits no less extensive than, those provided under this Certificate for treatment and diagnosis of all other physical diseases and disorders.

Non-Biologically Based Mental Health Benefit

Non-biologically based mental health services are covered under this Certificate in accordance with the Federal Mental Health Parity Act and are for services not defined as biologically based services.

Mental Health Inpatient Hospitalization (Inpatient Hospital Services require Prior Authorization)

Inpatient services are provided while you are staying 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;
- ❑ Residential treatment centers are covered when medical necessity criteria are met.

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 and treatment;
- ❑ Psychological testing;
- ❑ Partial hospitalization;
- ❑ Intensive Outpatient treatment.

Non-Covered Services:

Custodial or domiciliary care, supervised living or halfway houses, programs for outward bound programs are excluded. Services provided in a Custodial Care center for the developmentally disabled are not covered.

15. Physician Home Visits and Office Services

Covered Services include care provided by a Physician in their office or your home. Refer to the sections in this Certificate titled Preventive Health Services, Maternity Services, Home Health Care Services and Mental Health and Substance Abuse Services covered by this Plan. For emergency care, refer to the Emergency Care and Urgent Care section. Covered Services by a Physician include:

- **Office visits** for medical care and consultations to examine, diagnose and treat an Illness or Injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When an allergy injection is the only charge for a Physician's office visit, no Copayment is required.
- **Home visits** for medical care and consultations to examine, diagnose and treat an Illness or Injury performed in your home.
- **Diagnostic services** when required to diagnose or monitor a symptom or condition.
- **Surgery and surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy services** for physical medicine therapies and other therapy service when given in the office of a Physician or other professional Provider.
- **Online clinic visits**. When available in your area, your coverage will include online clinic visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice.

Non-Covered Services include, but are not limited to, communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to doctors outside the online care panel
- Benefit Prior Authorization
- Physician to Physician consultations

16. Podiatry Services

SummaCare PPO covers Medically Necessary treatment by a podiatrist, covered under your specialist benefit. Routine foot care and some orthotics are not covered. (Refer to orthotics under the Durable Medical Equipment benefit and refer to the exclusion section "Foot Care".)

Non-Covered Services:

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and prevention maintenance foot care, including cleaning and soaking the feet; applying skin creams in order to maintain skin tone; other services performed when there is not a localized Illness, Injury or symptom involving the foot; and cosmetic foot care are not covered.

17. Preventive Health Services

SummaCare PPO covers a variety of periodic health examinations conforming to national guidelines that are performed in an Outpatient or office setting. Screenings are covered as preventive care when there is no current symptom or prior history of a medical condition associated with that screening. The following list of covered preventive services meets requirements determined by federal and state laws.

All services with an "A" and "B" rating from the United States Preventive Services Task Force are covered at a 100 percent coverage level (no cost share) when provided by a Preferred Provider as mandated by the Affordable Care Act.

Examples of preventive health services (as mandated by state and federal laws) include, but are not limited to:

- Well child care through age 19.
- Cholesterol screening.
- Blood pressure checks.
- One routine screening mammogram every year, including digital breast tomosynthesis. Screening mammography does not include diagnostic mammography. The total benefit for this screening mammogram under this Plan, regardless of the number of claims submitted by Providers, will not exceed 130 percent of the Medicare reimbursement rate in the state of Ohio for a screening mammography. ("Medicare reimbursement rate" means the reimbursement rate paid in this state under the Medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection). No Provider, Hospital or other health care facility shall seek or receive compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio. Mammogram benefits include examinations performed in a health care facility or a mobile mammography screening unit accredited under the American College of Radiology Mammography Accreditation Program and included in the SummaCare Provider Network. For 3D mammograms, medical necessity coverage can be approved by our Health Services Management Program.

- ❑ Supplemental breast cancer screening (any additional screening method deemed medically necessary by a treating health care provider for proper breast cancer screening in accordance with applicable American College of Radiology guidelines, including magnetic resonance imaging, ultrasound or molecular breast imaging) for an adult woman who meets either of the following conditions:
  - The woman's screening mammography demonstrates based on the breast imaging reporting and data system established by the American College of Radiology, that the woman has dense breast tissue.
  - The woman is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition or other reasons as determined by the woman's health care provider.
- ❑ PAP smears and routine cytological screening to detect cervical cancer that are processed and interpreted in a lab certified by the College of American Pathologist or in a Hospital.
- ❑ Type 2 Diabetes Mellitus screenings.
- ❑ Immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- ❑ Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- ❑ Routine hearing screenings for children.
- ❑ Routine vision screenings for children.
- ❑ All preventive care under the Women's Health Act enacted on or after August 1, 2012, as mandated by federal law includes:
  - Well-women visits;
  - Screening for gestational diabetes; Human Papillomavirus testing;
  - Counseling for sexually transmitted infections;
  - Counseling and screening for human immune-deficiency virus; contraceptive methods and counseling;
  - Breastfeeding support, supplies and counseling;
  - Screening and counseling for interpersonal and domestic violence.

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least 60 days in advance, if any item or service is removed from the preventive list of eligible service. Eligible service will be updated annually to include any new recommendations or guidelines.

You may call our Member Services Department using the number on your ID Card for additional information about these preventive services. Also for further information you may go to the federal websites at: http://uspreventiveservicestaskforce.org/uspstf.

18. Outpatient Rehabilitation Service/Habilitative Services

Rehabilitative services, including physical, occupational, speech, habilitative and cardiac/pulmonary therapies, will be covered. Refer to your Schedule of Benefits for limitations. Also other rehab facilities including Room and Board charges, Physician fees, imaging and testing are covered and include coverage for day rehab programs which are provided in an inpatient setting and are limited to 60-day limit with inpatient services. See total limits on rehabilitative benefits on your Schedule of Benefits (116 total visits).

Physical therapy includes treatment by physical means, hydrotherapy, heat or similar modalities. This therapy is given to relieve pain, restore function or prevent disability following an Illness, Injury or loss of a body part.

Speech therapy is designed to provide the correction of a speech impairment (e.g., cleft palates).

Occupational therapy is for the treatment of a physically disabled person by means of constructive activities designed and adopted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

Cardiac rehabilitation is to restore a member's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

Pulmonary rehabilitation is to restore the functional status after an Illness or Injury and includes short term respiratory services. Also covered is inhalation therapy administered in a Physician's office including, but not limited to, breathing exercise, exercise not elsewhere classified and other counseling.

Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases or anesthetics by inhalation. Covered Services include, but are not limited to, intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medications; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CHP) chest percussion; therapeutic use of medical gases or drugs in the form of aerosols and equipment such as a resuscitator, oxygen tents and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Radiation and chemotherapy as well as dialysis treatments will be covered under this Plan. Refer to infusion therapy and our dialysis benefit.

Habilitative services include, but are not limited to, habilitative services for children up to the age of 21 with a medical diagnosis of Autism Spectrum Disorder which shall include: Outpatient physical rehabilitation including speech and language therapies and occupational therapy performed by a licensed therapist, limited to 20 visits each per year for speech and language therapy or occupational therapy and clinical therapeutic intervention defined as therapies supported by empirical evidence, which include, but are not limited to, Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan (20 hours per week).

Mental/behavioral health Outpatient services performed by a licensed psychologist, psychiatrist or Physician to provide consultation, assessment, development and oversight of treatment plans are not subject to annual dollar limits.

Habilitative services are defined as health care services and devices that help a person keep, learn or improve skills and functioning for daily living. These services may include occupational therapy, speech and language pathology and other services for members with disabilities in a variety of inpatient and/or Outpatient settings. Other physical, occupational and speech therapies other than those for Autism Spectrum Disorder apply; refer to the Rehabilitative benefit for limits. The annual visit limits are not combined with your rehabilitative benefit. Services are contingent upon the member receiving both Prior Authorization and the services being prescribed by a developmental pediatrician or a psychologist trained in autism.

Non-Covered Rehabilitative Services:
Conditions such as behavioral speech disorders, learning disorders, stuttering, slow speech development, chronic muscle imbalance and language therapy are excluded, except as covered for autism spectrum disorder. Treatment for maintenance physical therapy, given when no additional progress is apparent or expected to occur, is excluded. Maintenance physical therapy includes treatment that preserves and prevents loss of your present level of functioning, but does not result in any additional improvement, is excluded. Manipulation therapy rendered in the home as part of home care services is excluded.

Physical Therapy
Maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or Illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercise not related to restoring a specific loss of function, but maintaining a range of motion in paralyzed extremities; general exercise program; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse and work hardening.

Occupational Therapy
Does not include coverage for diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non-Covered Services include: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

Cardiac Rehab
Pulmonary rehabilitation in the acute inpatient rehabilitation setting is not a covered service.

General Exclusions
Non-Covered Services for physical medicine and rehabilitation include, but are not limited to: admission to a Hospital mainly for physical therapy; long-term rehabilitation in an inpatient setting.

19. Reconstructive Breast Surgery and Other Reconstructive Services

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, Illness, Injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a covered service under this Plan.

Mastectomy Notice:

A member receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy under the Women's Health and Cancer Rights Act and electing breast reconstruction will also receive coverage for:

- ❑ 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
- ❑ Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

20. Second Surgical Opinions

SummaCare PPO covers second opinions if the services needed meet medical necessity guidelines. Cost shares for second opinions are based on where the second opinions are provided.

21. Skilled Nursing

Skilled nursing services are covered if the need for services meets medical necessity criteria. Services must be pre-authorized by your Physician, Practitioner or other Provider through SummaCare's Health Services Management Program. Items and services provided as an inpatient in a skilled nursing bed or Skilled Nursing Facility or Hospital, including Room and Board in a semi-private room, rehabilitative services and drugs, biologicals and supplies furnished for use in the Skilled Nursing Facility and other Medically Necessary services and supplies are covered.

Non-Covered Services:

Custodial Care in a Skilled Nursing Facility or any other facility is not covered except as rendered as part of Hospice Care.

22. Sterilization

Sterilization is a covered service. Reversal of elective sterilization is excluded.

23. Substance Abuse/Alcohol Abuse/Opioid Abuse

Detoxification and rehabilitation services are provided for the treatment of substance and alcohol abuse. Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008, this Plan will offer mental Illness and substance use disorder benefit in no more restrictive way than all other medical and surgical benefits covered under this Plan.

Upon enrollment, members are supplied with the Plan's Provider directory. The directory identifies both the network Practitioners and Providers members may see for Behavioral Health and Substance Abuse Services. The member can also use the Plan's online Provider directory to search for network Practitioners for Behavioral Health and Substance Abuse.

The Plan allows all members direct access for behavioral health and/or substance abuse treatment and does not require members to obtain a referral from his or her Primary Care Physician (PCP).

Members can call Member Services to request assistance from a SummaCare Case Manager in finding an appropriate treatment center, provider or community resource. Following an inpatient stay, all members with an Opioid addiction are contacted by a SummaCare Case Manager to review their care plan and coordinate outpatient care. Members can also visit https://www.summahealth.org/search?q=opioid+ or contact their local public health department for more information on initiatives to combat Opioid addiction.

Covered Services:

Inpatient Detoxification is usually a result of an admission for excessive alcohol use or severe withdrawal symptoms. The length of the inpatient stay is based on medical necessity for that stay. This benefit would apply to the inpatient substance abuse limit. Inpatient detoxification requires a Prior Authorization request, and we process these requests in a timely manner and are in line with all regulatory guidelines and turnaround times.

Inpatient Rehabilitation is an elective admission for chemical dependency and alcohol. This rehabilitation admission usually occurs after a member is detoxified. Inpatient rehabilitation requires a Prior Authorization request and we process these requests in a timely manner and are in line with all regulatory guidelines and turnaround times.

Partial Hospitalization Program is an elective Outpatient program. Program hours are usually over four hours daily, sometimes five to seven days per week.

Intensive Outpatient Program is an elective Outpatient program. Program hours are under four hours daily, usually three to four times per week.

Residential Treatment Centers are covered when medical necessity criteria are met. Admission to a residential treatment center requires a Prior Authorization request and we process these requests in a timely manner and are in line with all regulatory guidelines and turnaround times.

Non-Covered Services:

- Wilderness camps are excluded.
- Custodial or domiciliary care.
- Supervised living or halfway houses.
- Room and Board charges unless the treatment provided meets medical necessary criteria for inpatient admission.
- Services or care provided by a school, halfway house, for drug and alcohol, or outward bound programs, even if psychotherapy is included.
- Marital and sexual counseling/therapy and wilderness camps.

24. Surgical Services

Covered surgical services include, but are not limited to:

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocation;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Operative and cutting procedures and other invasive procedures.

25. Telemedicine Services

Covered Services include coverage for telemedicine services on the same basis and to the same extent coverage is provided for in-person healthcare services. Cost share for telemedicine services will be no greater than for in-person healthcare services. Annual and lifetime maximums will be no greater than a maximum for all benefits offered under the plan.

26. Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders. Coverage must follow our Health Services Management criteria and must be prior authorized.

27. Transplants/Human Organ and Tissue Transplant Services

Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as approved by us will be covered. When a human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive the benefits of the health Plan. Additional Covered Services include unrelated donor searches and transportation and lodging.

Non-experimental organ and tissue transplants are covered for the Insured recipient if the recommended treatment program, including all pre-operative assessments, is prior authorized and approved by the SummaCare Health Services Management Program and performed at an approved transplant “Centers of Excellence” facility. Please note the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider, necessary acquisition procedure, the harvest and storage of bone marrow/stem cells and necessary preparatory myeloablative therapy is included in the covered transplant procedure benefit regardless of the date of the service. Coverage for unrelated donor search services is limited to $30,000 per transplant.

Live Donor Health Services
Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Charge, including complications from the donor procedure for up to six weeks from the date of procurement.

Please note there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination of what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate medical necessity determination will be made for the transplant procedure.

Transplant Travel
Transportation and lodging are covered per our internal policy and are covered up to a $10,000 benefit limit per transplant.

Reasonable and necessary travel and lodging Expenses are covered for the Insured recipient if the transplant is received out of area and the recipient is required to travel more than 75 miles from the residence to reach the facility where the covered transplant procedure will be performed. Assistance with travel Expenses includes transportation to and from the facility and lodging for the patient and one companion. If the member receiving treatment is a minor, then reasonable and necessary Expenses for transportation and lodging may be allowed for two companions.

Non-Covered Transplant Travel Services include:
- ❑ Childcare
- ❑ Mileage within the transplant city, parking
- ❑ Rental cars, buses, taxis or shuttle service, except as specifically approved
- ❑ Frequent flyer miles, coupons, voucher or travel tickets
- ❑ Prepayments or deposits
- ❑ Services for a condition not directly related to or a direct result of the transplant
- ❑ Telephone calls, laundry, postage
- ❑ Entertainment
- ❑ Meals
- ❑ Interim visit to a medical facility while waiting for the actual transplant procedure
- ❑ Travel Expenses for donor companion/caregiver
- ❑ Return visits for the donor for a treatment of a condition found during evaluation

28. Transsexual Surgery
Transsexual surgery and related services including pre and post-surgery diagnostics, treatments and drug therapy must be prior authorized and will be covered based upon medical necessity. Procedures performed for the sole purpose of improving or altering appearance or self-esteem related to one's appearance are considered cosmetic in nature, not Medically Necessary and are not Covered Services. Cost shares are based on where the transsexual surgery and related services are provided.

29. Vision Care
Benefits are available for medical and surgical treatment of the eye as a result of Injury or diseases affecting the eye for adult or child. A diabetic eye exam is covered once per Calendar Year.

Vision corrections after surgeries or as a result of accidental Injury to the eye and treatment of intraocular implantation for the treatment of cataract or aphakia will be covered. Coverage includes contact lenses and prescription glasses following lens implantation. The first pair of contact lenses or eyeglasses which replace the function of the human lens for conditions caused by cataract surgery or Injury is covered. A donor lens is not the first lens.

Pediatric vision services are covered for members through the end of the month that the member turns age 19. Pediatric vision services are administered through VSP and include:
- ❑ Well vision exam with dilation as necessary - one exam available per Calendar Year covered in full at a network pediatric vision Provider;
- ❑ Vision acuity screening;

- ❑ Frames - designated available frame from Pediatric Vision Plan collection. Members can choose from select frame styles and colors. One frame per Calendar Year covered in full by a network pediatric vision Provider;
- ❑ Standard prescription lenses - polycarbonate plastic or glass scratch-resistant and ultraviolet lenses are covered. One set of lenses (single vision, lined bifocal, lined trifocal or lenticular lenses) per Calendar Year covered in full at a network pediatric vision Provider;
- ❑ Contact lens fitting and evaluation and lenses - contact lens fitting and evaluation is covered in full at a network pediatric vision Provider;
- ❑ Standard contact lens fitting and evaluation;
- ❑ Premium contact lens fitting and evaluation;
- ❑ Elective contact lenses are covered in full at a Preferred Provider for the following:
  - Standard (one pair per Calendar Year; one contact lens per eye for total of two lenses)
  - Monthly (six month supply: six lenses per eye for a total of 12 lenses)
  - Bi-weekly (three-month supply: six lenses per eye for a total of 12 lenses)
  - Dailies (one-month supply: 30 lenses per eye for a total of 60 lenses)
- ❑ Contact lenses are in lieu of frame and lenses;
- ❑ Members can choose from any available prescription contact lenses;
- ❑ Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction.
- ❑ Optional lenses and treatments include:
  - Ultraviolet protective coating
  - Polycarbonate lenses (if not child, monocular or prescription $\geq$+/-6.00 diopters)
  - Blended segment lenses
  - Intermediate vision lenses
  - Standard progressives
  - Premium progressives (Varilux®, etc.)
  - Photochromic glass lenses
  - Plastic photosensitive lenses (Transitions®)
  - Polarized lenses
  - Standard Anti-Reflective (AR) coating
  - Premium AR coating
  - Ultra AR coating
  - Hi-Index lenses

Low Vision: A significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. After pre-authorization, covered low vision services (in- and out-of-network) will include one comprehensive low vision evaluation every five years; maximum low vision aid allowance for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period. Participating Providers will obtain necessary pre-authorization for these services.

Plan limitations:
- ❑ Two pairs of glasses instead of bifocals;
- ❑ Replacement of lenses, frames or contacts;
- ❑ Medical or surgical treatment;
- ❑ Orthoptics vision training or supplemental testing.

Items not covered under the contact lens coverage:
- ❑ Insurance policies or service agreements;
- ❑ Artistically painted or non-prescription lenses;
- ❑ Additional office visits for contact lens pathology;
- ❑ Contact lens modification, polishing or cleaning.

Non-Covered Services:
Prescription, fitting or purchase of eyeglasses of contact lenses for adults except as otherwise specifically stated as a covered service.

If you opt to receive vision care services or vision care materials that are not Covered Benefits under this Plan, a participating vision care Provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not Covered Benefits, the vision care Provider will provide you with an estimated cost for each service or material upon your request.

30. Wellness Programs

SummaCare may offer a wellness or health improvement program as approved that provides rewards or incentives, including merchandise; gift cards; debit cards; Premium Discounts or rebates; contributions to a Health Savings Account; modifications to Copayment, deductible or Coinsurance amounts; or any combination of these incentives, to encourage participation or to reward participation in a wellness program. Under our wellness programs, the Insured may be required to provide verification, such as a statement from his/her Physician a medical condition makes it unreasonably difficult or medically inadvisable for the individual to participate in the wellness or health improvement program. Nothing shall prohibit SummaCare from offering incentives or rewards to members for adherence to wellness or health improvement programs if otherwise allowed by federal law. Wellness programs will be presented to your Employer group at the time of your Open Enrollment session.

E. Other Covered Benefits - Prescription Drug Benefits

Under the Affordable Care Act, prescription drugs are an Essential Health Benefit and part of your medical benefit. Please refer to your Schedule of Benefits for any deductible, Coinsurance, Copayment and benefit limitations on your pharmacy benefit.

Management of Your Pharmacy Benefit

Your pharmacy benefits are managed by our Pharmacy Department and our Pharmacy Benefits Manager (PBM). Our PBM is contracted by us to manage your pharmacy and specialty drug benefits and it has a nationwide network of retail pharmacies and a mail order pharmacy to meet your needs. Clinical management in consultation with SummaCare's Pharmacy Department is also provided by our PBM. SummaCare and the PBM will make recommendations to and facilitate the updating of our formulary (our drug list). We will also provide services to enforce the appropriate use of the pharmacy benefits and review of excessive use, recognize dosage regimens and drug interactions. You may request a copy of our formulary by calling Member Services or accessing the formulary on our website at www.summacare.com. Your pharmacy coverage shall not limit or exclude coverage for any drug approved by the United States Food and Drug Administration (FDA) on the basis the drug had not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature that meets the criteria. Criteria includes two articles from major peer-review professional medical journals which have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed; no major peer-reviewed professional medical journal has concluded, based on scientific or medial criteria, the drug is unsafe or ineffective or the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed. Each article meets the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services, as amended, as acceptable peer-reviewed medical literature. The drug must be Medically Necessary, cannot be contraindicated for the treatment for which the drug has been prescribed; cannot be experimental or alter any law with regard to provision limiting the coverage of drugs that have not been approved by the FDA.

Covered Services include prescription drugs obtained at a Participating Pharmacy. If your prescription is filled at a Non-Participating Pharmacy, you will pay the retail (cash) price of the prescription at the time the prescription is filled. You may submit a request for reimbursement of a prescription filled at Non-Participating Pharmacies. Read more about this process in the "How to Obtain Prescription Drugs at a Non-Network Pharmacy" portion of this subsection.

A member must present a valid SummaCare ID Card at the time the prescription is dispensed.

Covered pharmacy benefits will be determined based on medical necessity, quantity and/or age limits, Prior Authorization requirements and step therapy protocols established by SummaCare, our PBM, our Pharmacy and Therapeutics Committee and utilization guidelines. Prior Authorization may be required for specific drugs. Refer to our formulary and Pharmacy Benefit Guidelines or contact Member Services at the number listed on your ID Card if you have questions. Your Preferred Provider will handle Prior Authorization of certain drugs. For a Prior Authorization related to a chronic condition, we will honor a Prior Authorization approval for an approved drug for the lesser of the following from the date of the approval: (i) 12 months; (ii) The last day of your eligibility under the Policy or Plan.

A 12-month approval does not apply to and is not required for any of the following:

- ❑ Medications that are prescribed for a non-maintenance condition;
- ❑ Medications that have a typical treatment of less than one year;
- ❑ Medications that require an initial trial period to determine effectiveness and tolerability, beyond which a one-year, or greater, Prior Authorization period will be given;
- ❑ Medications where there is medical or scientific evidence as defined in Section 3922.01 of the Ohio Revised Code that do not support a 12-month prior approval;
- ❑ Medications that are a Schedule I or II controlled substance or any opioid analgesic or benzodiazepine, as defined in Section 3719.01 of the Ohio Revised Code;
- ❑ Medications not prescribed by a Preferred Provider as part of the care management program.

Pursuant to a step therapy exemption request initiated or an appeal made, SummaCare shall grant a step therapy exemption if any of the following are met:

- ❑ The required prescription drug is contraindicated for that specific patient, pursuant to the drug's FDA prescribing information;
- ❑ The patient has tried the required prescription drug while under their current, or a previous, health benefit plan, or another FDA-approved AB-rated prescription drug, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event;
- ❑ The patient is stable on a prescription drug selected by the patient's health care provider for the medical condition under consideration, regardless of whether or not the drug was prescribed when the patient was covered under the current or a previous health benefit plan, or has already gone through a step therapy protocol. However, SummaCare may require a stable patient to try a pharmaceutical alternative, per the FDA's orange book, purple book or their successors, prior to providing coverage for the prescribed drug.

SummaCare will utilize a Drug Utilization Review (DUR) program to ensure appropriate utilization and medical necessity of opioid analgesics prescribed for the treatment of chronic pain. This DUR program may utilize point of service edits, where applicable, to the case in which the opioid analgesic is prescribed if either or both of the following apply:

- ❑ If the course of treatment with the drug continues for more than 90 days, the requirements of Section 4731.052 of the Ohio Revised Code will apply;
- ❑ If the morphine equivalent daily dose for the drug exceeds 80 milligrams or the individual is being treated with a benzodiazepine at the time the opioid analgesic is prescribed, the guidelines established by the Governor's Cabinet Opiate Action Team and presented in the document titled "Ohio Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-terminal Pain 80 mg of a Morphine Equivalent Daily Dose (MED) 'Trigger Point'" or a successor document, unless the guidelines are no longer in effect at the time the opioid analgesic is prescribed.

When the drug is prescribed under one of the following circumstances, SummaCare will provide a standing Prior Authorization or other appropriate approval:

- ❑ To an individual who is a Hospice patient in a Hospice Care program;
- ❑ To an individual who has been diagnosed with a terminal condition but is not a Hospice patient in a Hospice Care program;
- ❑ To an individual who has cancer or another condition associated with the individual's cancer or history of cancer.

Our Outpatient prescription drug benefit is a generic-based program. You will receive a generic drug unless no generic equivalent exists or the prescribing Physician indicates there cannot be a generic substitute for a specific brand name product by indicating Dispense As Written (DAW) on the prescription. If your physician indicates a DAW on the prescription you may be charged the difference in cost between the brand and the generic product. There are a few exceptions to this program, where SummaCare covers a brand drug in place of the generic equivalent drug.

Our formulary is subject to periodic review and amendments. Refer to your Schedule of Benefits and your prescription drug benefit for specific information on coverage, limitations and exclusions.

Specialty Drugs

Specialty drugs are prescription drugs designated as such due to high cost; the need for special handling or restricted preparation, distribution, or administration; and/or the need for personalized clinical management or patient support. Specialty drugs are covered on your Prescription Drug benefit. These specialty drugs when obtained through the SummaCare preferred specialty pharmacy are limited to a maximum of a 30-day supply. These drugs are indicated

on the SummaCare Drug Formulary as Tier 6 and typically require Prior Authorization. Once authorized, a notice is sent to the preferred specialty pharmacy that will facilitate the delivery or pick up of the specialty drugs. Specialty drugs obtained through any other pharmacy without Prior Authorization are not covered under this prescription drug benefit.

Specialty MedImpact Assist™ Copay Assistance Program
Variable Copay for Specialty Drugs
In order for the plan to better manage available manufacturer-funded copay assistance, copays for certain specialty medications may vary and be set to approximate the maximum of any available manufacturer-funded copay assistance programs. However, in no case will true out-of-pocket costs to the participant be greater than the maximum copayment published in the Plan Document and Summary Plan Description. Finally, manufacturer-funded copay assistance received for specialty medications will not be credited to your annual deductible or maximum out-of-pocket requirement.

Accumulator Adjustment for Specialty Drugs
Discounts, coupons or similar financial assistance provided by drug manufacturers or pharmacies to assist you in covering the cost of your specialty medications (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription) will not count towards your annual deductible or maximum out-of-pocket requirement. Only the amount you pay separate and apart from the financial assistance will be credited as true out-of-pocket payment that will apply to your annual deductible and maximum out-of-pocket requirement.

Example:
If your specialty medication costs $100, and you use an $80 coupon or debit card and then pay the remaining $20 out of pocket, only the $20 will apply to your annual deductible or maximum out-of-pocket limits.

Orally Administered Cancer Drugs
In accordance with Ohio law, effective on or after January 1, 2015, orally administered cancer medication will not be covered at a less favorable benefit than the cost sharing imposed for intravenously administered or injected cancer medications. Under a Qualified High Deductible Health Plan, Coinsurance or Copays for both IV cancer drugs and oral cancer drugs will be subject to the deductible on the Plan prior to cost share being satisfied.

Mail Order Pharmacy
Some medications may not be available through the mail order pharmacy. Please refer to your mail service pharmacy brochure for more information**.** Refer to your Schedule of Benefits for details on specific Copays, Coinsurances, deductibles and limitations of your specific pharmacy benefit.

Over-the-Counter Medications
Medications that do not require a prescription are excluded with the exception of over-the-counter drugs covered as part of a step therapy or for over-the-counter drugs, as stated below, which are covered under the ACA preventive benefit. These over-the-counter drugs are indicated on the SummaCare Drug Formulary and are only covered when a prescription is presented to a Participating Pharmacy.

Injectable Drugs
Certain injectable drugs are administered in a Provider's office or other Outpatient setting and will be covered under your medical benefit. Please contact either your Physician or Member Services for details on the procedures for the administration of these injectable drugs.

Preventive Medications
In compliance with the Affordable Care Act, the following preventive medications are covered at no cost share to the member as part of your comprehensive preventive medical benefits, when a prescription is presented to the Participating Pharmacy:

- ❑ Generic fluoride supplements for children up to the age of 6 years old.
- ❑ Generic folic acid supplements for women between the ages of 16 and 50.
- ❑ Generic aspirin formulations for members between the ages of 45 and 79 (quantity limits apply).
- ❑ Generic iron supplements for members ages 6 months to 1 year old.
- ❑ Generic oral, vaginal ring, contraceptive patch and injectable contraceptive products, contraceptive devices, (Prior Authorization or quantity limits may apply) and all other brand formulations where a generic alternative is not available (Except for employer groups who qualify for a religious exception as outlined under federal law).
    - ❑ An exception for a brand with a generic alternative will be made if the attending Provider recommends a particular brand contraceptive product based on a determination of medical necessity.

- ❑ Prescription smoking cessation products; varenicline (up to 180 days in a 365-day period), bupropion (generic only), nicotine nasal spray and inhaler forms (up to 90 days of therapy in a 365-day period).
- ❑ Prescription medications tamoxifen and raloxifene when prescribed for preventing breast cancer.
- ❑ Preventive vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP), as identified on the formulary; limits may apply.
- ❑ Pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are determined to be at high risk of Human immunodeficiency Virus (HIV) acquisition.

Definitions used for your Prescription Drug Benefit

- ❑ **Dispense As Written (DAW) -** The Physician's handwritten indication on the face of a covered prescription that a generic *substitution* cannot be given for a specific brand name product.
- ❑ **Participating Pharmacy -** A licensed pharmacy contracted to provide prescription drug services to members of SummaCare.
- ❑ **Prescription Drug -** Any medicinal substance that, according to the Federal Food, Drug and Cosmetics Act, must be sold in a container marked with the legend: "Caution, Federal Law Prohibits Dispensing Without Prescription."
- ❑ **Non-Participating Pharmacy (Out-of-Network Pharmacy) -** A licensed pharmacy which is not participating in the contracted pharmacy network**.**
- ❑ **Specialty Drug -** Specialty drugs are prescription drugs designated as such due to high cost; the need for special handling or restricted preparation, distribution or administration; and/or the need for personalized clinical management or patient support. Specialty drugs are used to treat chronic or genetic conditions including, but not limited to, Multiple Sclerosis, Psoriasis, Rheumatoid Arthritis and Viral Hepatitis. Prescriptions for specialty drugs must be filled by the preferred SummaCare Specialty Pharmacy.

Exclusions for the Prescription Drug Benefits – (Refer to the Exclusion Section of This Certificate for other Non-Covered Services)

- ❑ All infertility medications, regardless of indication for use;
- ❑ Any charge for the administration of a prescription drug;
- ❑ Any drugs used for cosmetic purposes, including but not limited to products used for hair loss, excessive hair growth, skin discoloration, wrinkles and eyelash growth;
- ❑ Any prescription vitamin, mineral or dietary supplement preventive fluoride treatment regardless of indications for use, except for generic prenatal vitamins and those products that appear on the Preventive Medication List under the ACA;
- ❑ Investigational drugs, which the Plan determines; (a) are in a testing stage or in early field trials on animals or humans; (b) do not have required final federal regulatory approval (by the FDA) for commercial distribution for the specific indications and methods of use assessed; (c) are not generally prescribed in the course of acceptable medical practice; or (d) have not yet been shown to be consistently effective for the diagnosis or treatment of the member's condition as indicated in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services;
- ❑ Costs associated with the replacement of lost, stolen or spilled medications;
- ❑ Devices and supplies (except insulin needles and syringes) of any type, including but not limited to, therapeutic devices, artificial appliances, support garments and blood glucose test meters; devices and supplies required by law are covered under your medical benefits - they are not covered as part of this prescription drug benefit;
- ❑ Drugs or medication which do not require a prescription (over-the-counter drugs); exceptions include over-the-counter drugs as stated in the ACA for preventive use.
- ❑ Allergy antigens, immunization agents, immunoglobulin, biological sera, blood or blood plasma (these may be covered under your medical benefit);
- ❑ Total parenteral nutrition (TPN) nutritional supplements (this benefit is covered as part of Home Infusion Therapy under Home Health Care Services in Section VI, Subsection D) and medical foods;
- ❑ Compounded prescriptions comprised of ingredients for which the only FDA-approved indication is for use in bulk compounding.

Day Supply and Payment of Benefits

The number of day supply of a drug you may receive is limited to a 90-day supply at a Participating Retail Pharmacy and a 90-day supply through our mail order pharmacy. Specialty drugs are limited to a 30-day supply. The amount of benefits paid is based on which tier SummaCare has classified the prescription drug or specialty drug. Please refer to your Schedule of Benefits for the tier assignments, deductibles when appropriate,

Copayments, Coinsurance and day supply applies. You will be responsible for any deductible amounts, Copayments or Coinsurance as stated on your specific pharmacy benefit as stated in your Schedule of Benefits.

Network Pharmacies
A list of network pharmacies can be accessed by referring to the online Provider directory or going to our website at www.summacare.com. You may also call Member Services for assistance at 330.996.8700 or 800.996.8701 (TTY: 711).

Exception Process for Non-Formulary Drugs
SummaCare has procedures in place for enrollees to request and gain access to clinically appropriate drugs when these drugs are not covered on our formulary. This is called our Exception Process and allows an enrollee to request and gain access to a drug not on the Plan's formulary.

There are two types of requests for this exception process. The first one is an Expedited Exception Request, which is defined under exigent circumstances only and if the drug is not approved may seriously jeopardize life, health or ability to regain maximum function, or may jeopardize undergoing current treatment using a non-formulary drug. The second is a Standard Exception Request. We must notify you and your Provider of our decision no more than 24 hours after the receipt of an expedited request and 72 hours after the receipt of a Standard Exception Request.

If your request is denied, we have a process in place that will allow you or your designee or the prescribing Physician to request that the denied exception request be reviewed by SummaCare or an Independent Review Organization. The enrollee and Provider will be notified of SummaCare's or the Independent Review Organization's decision no later than 48 hours following receipt of an expedited request and 10 calendar days following receipt of a Standard Exception Request. If the exception request is granted, we will treat the excepted drug as an Essential Health Benefit and the cost share will be counted towards your annual limitation on cost-sharing and we will cover the drug for the duration of the prescription including refills. Please contact our Pharmacy Benefits Manager or our Member Services Department to review this exception process.

Tiers
Your Copayment/Coinsurance amount may vary based on what tier the prescription drug has been categorized. The determination of tier placement is made by SummaCare based upon clinical information, and, where appropriate, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. Refer to your Schedule of Benefits for the appropriate tiers that are covered and the Copayment or Coinsurance which refers to that tier.

Tier Explanation: Pharmacy riders may have up to six tiers:

- ❑ Tier 1 Prescription Drugs – This tier contains Zero Cost Share Preventive medications that have a zero dollar Copayment. This tier includes the preventive medications listed above and a select list of medications for the treatment of blood pressure, cholesterol, diabetes and depression.
- ❑ Tier 2 Prescription Drugs – This tier contains preferred generic medications.
- ❑ Tier 3 Prescription Drugs – This tier contains non-preferred, higher cost generic medications.
- ❑ Tier 4 Prescription Drugs – This tier contains preferred brand medications.
- ❑ Tier 5 Prescription Drugs – This tier contains non-preferred, higher cost brand medications.
- ❑ Tier 6 Prescription Drugs – This tier contains specialty medications.

We have established a Pharmacy and Therapeutics (P&T) Committee consisting of SummaCare staff from our Pharmacy Department; health care professionals, including pharmacists; and Physicians. This committee assists in determining clinical appropriateness of drugs, determines the tier assignments of drugs and advises on programs and quality of care, and the availability of over-the-counter alternatives, generic availability and the degree of utilization of one drug over another.

How to Obtain Prescription Drugs at a:
Network Pharmacy
SummaCare has national network pharmacies across the United States. Please refer to your Provider directory for a network pharmacy closest to you. When you use a network pharmacy, simply present your prescription and your member ID Card to the pharmacist at a network pharmacy. The pharmacy will file your claims for you. You will be charged at the point of purchase for any applicable deductible and/or Copayment or Coinsurance amount.

Specialty Pharmacy
Your Physician can order your specialty drugs directly from our preferred specialty pharmacy. These specialty

drugs may require Prior Authorization and if you or your Physician have any questions regarding these specialty drugs, you may call Member Services at the number on your member ID Card.

Non-Network Pharmacy
SummaCare has national network pharmacies and these pharmacies should be utilized when possible.

If your prescription is filled at a Non-Participating Pharmacy, you will pay the retail (cash) price of the prescription at the time the prescription is filled. You may submit a request for reimbursement of a prescription filled at Non-Participating Pharmacies. You must submit a prescription drug claim form to SummaCare for reimbursement along with a copy of the prescription label and receipt. For covered drugs purchased at a Non-Participating Pharmacy, you will be reimbursed the amount that would be covered at a Participating Pharmacy and you will be responsible for the difference in cost and be charged the out-of-network Copayment or Coinsurance. You must present a valid SummaCare ID Card at the time the prescription is dispensed.

Mail Order Pharmacy
SummaCare has contracted with a mail order pharmacy for easy-to-use pharmacy delivery services that work with your SummaCare pharmacy benefits. Use the mail order pharmacy for medications you take regularly, both for new prescriptions and refills. This benefit saves you time with no trips to the pharmacy, no waiting in line, fast convenient service ordering fewer times per year and free delivery to your door.

You can activate this Mail Order Pharmacy by calling 855.873.8739 or mailing your prescription and enrollment form to:

Birdi™
P.O. Box 51580
Phoenix, AZ 85076-1580

You can also enroll online at www.medimpact.com. At the time of your enrollment you will receive a mail order brochure that will provide you detailed instructions on how to utilize our mail order options.

IX. General Exclusions

The following section indicates items excluded from benefit consideration and are not considered Covered Services. Excluded items will not be covered even if the service, supply or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon or a complete listing of such items considered not to be a Covered Service. SummaCare will be the final authority for determining if services or supplies are Medically Necessary.

A. SummaCare PPO *Will Not* Provide Coverage For:

1. Abortions (Elective)

Elective abortions, whether surgically or pharmaceutically induced, except when continuation of pregnancy poses a serious health hazard to the mother or the fetus has a congenital malformation incompatible with life or in the case of incest or rape.

2. Acupuncture, Alternative Medicine

Acupuncture or other treatment classified as "alternative medicine" or complementary medicine unless specifically listed as covered in the Schedule of Benefits. Examples of these excluded services include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, neurofeedback and biofeedback.

3. Bariatric Surgery

Bariatric surgery regardless of the purpose for which it is proposed or performed. This includes Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgeries (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum and section of the small intestine extending from the duodenum), gastroplasty (surgical procedures that decrease the size of the stomach) or gastric banding procedures. Complications directly related to the bariatric surgery that results in an inpatient stay or an extended inpatient stay for the bariatric surgery, as determined by Us, are not covered but complications unrelated to the surgery may be covered.

4. Charges for Forms, Missed Appointments and Research

Charges for missed appointments or the completion of claim forms, medical reports, records or certifications. Charges for research with Providers not responsible for your care or received by an individual that is not a Provider defined by this Plan and charges not documented in Provider records.

5. Complications

Complications directly related to a service or treatment not covered under this Certificate because it was determined by us to be experimental/investigational or non-Medically Necessary. Directly related means the service or treatment occurred as a direct result of the experimental/investigational or non-Medically Necessary service and would not have taken place in the absence of the experimental/investigational or non-Medically Necessary service. Complications related to the surgery are not covered, but complications unrelated to the surgery may be covered.

6. Convenience Items, Health Spas, Exercise Programs

Personal hygiene, environmental control, convenience items including but not limited to:

- ❑ Air conditioners, humidifiers, air purifiers;
- ❑ Personal comfort and convenience items during an inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- ❑ Charges for non-medical self-care except as otherwise stated;
- ❑ Purchase or rental of supplies for common household use, such as water purifiers;
- ❑ Allergenic pillows, cervical neck pillows, special mattresses or waterbeds;
- ❑ Infant helmets to treat positional plagiocephaly;
- ❑ Safety helmets for members with neuromuscular diseases;
- ❑ Sports helmets;
- ❑ For chair lifts, physical fitness equipment and instructors, health care memberships in health spas, personal trainers, exercise programs and other such items or memberships even though prescribed by a Provider.

7. Cosmetic Surgery

For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications related to the surgery are not covered, but complications unrelated to the surgery may be covered.

8. Court Ordered Treatment

Testing or treatment ordered by a court or agreed to through a plea bargain unless deemed by SummaCare to be Medically Necessary.

9. Custodial Care

Custodial Care includes, but is not limited to sitters, homemaker services or care in a place that serves you primarily as a resident when you do not require skilled services. Services provided by volunteers or housekeeping services are also excluded. Domiciliary care provided in a treatment center, halfway house is excluded. Food, housing, homemaker services and home delivered meals; home or Outpatient hemodialysis services; Physician charges; helpful environmental materials; services of a registered nurse or other health workers who are not acting as Employees or under approved arrangements with a contracting home health care Provider; services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors and services related to outside, occupational and social activities while in a home health care setting; Custodial Care in a Skilled Nursing Facility or any other facility is not covered except as rendered as part of Hospice Care.

10. Dental Care

Dental treatment regardless of origin or cause, except as specified elsewhere in this Certificate. "Dental treatment" includes, but is not limited to: preventive care, diagnosis, treatment of or related to the teeth, jawbones (except TMJ) or gums, including but not limited to extraction restoration and replacement of teeth.

Non-Covered Services:

The following components can be considered dental in nature and excluded from coverage:

- ❑ Dental implants;
- ❑ Dental braces;
- ❑ Dental x-rays, supplies and appliances and all associated Expenses, including hospitalization and anesthesia, except as required by law.
- ❑ Transplant preparation;
- ❑ Initiation of immunosuppressive,
- ❑ Align dentition within the dental arch, level the curve of SPEE and decompensate anterior dentition;
- ❑ Segmental osteotomies;
- ❑ Post-surgical orthodontic treatment;
- ❑ Dental alignment with the relative position of the skeletal bases in their final position;
- ❑ Close any remaining interdental spaces and bring the dentition into maximum intercuspal relationship;
- ❑ Oral surgery that is dental in origin, removal of impacted wisdom teeth;
- ❑ For treatment of the teeth, jawbone or gums required as a result of a medical condition except as expressly required by law or stated as a covered service;
- ❑ Treatment of congenitally missing, malpositioned or super numeracy teeth, even if part of a congenital anomaly.

11. Educational, Training Materials, Administrative Fees, Non-Provider Recognized

Service or supplies primarily for education, vocational or self-help training and other forms of non-medical self-care, except as otherwise specified in this Certificate. For education, research screenings or stand by charges of a Physician, charges and administrative fees for calls to a patient to provide test results or completion of medical records or reports unless required by law. Services received from any individual not defined as a Provider and recognized by SummaCare. Charges for missed or canceled appointments.

12. Effective Date, Termination Date

Services provided or charges incurred before the effective date of coverage under this Policy or after coverage ends, subject to the specific exception noted in Section V.

13. Emergency Room Care for Non-Emergent Situations

For care received in an emergency room which is not emergency care except as specified in this Certificate. Example would be removal of suture in the emergency room.

14. Experimental/Investigational Services and Treatment

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, Injury, Illness or other health condition which we determine in our sole discretion to be experimental/investigative is not covered under this Plan.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be Experimental/Investigative if we determine one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- ❑ Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or other licensing or regulatory agency and such final approval has not been granted;
- ❑ Has been determined by the FDA to be contraindicated for the specific use; or
- ❑ Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
- ❑ Is subject to review and approval of an Institutional Review Board (IRB) or other body servicing a similar function; or
- ❑ Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental/ investigative or otherwise indicate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- ❑ The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- ❑ The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- ❑ The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- ❑ The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

Any information considered or evaluated by us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental/investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- ❑ Published authoritative, peer-reviewed medical or scientific literature or the absence thereof; or
- ❑ Evaluations of national medical associations, consensus panels and other technology evaluation bodies; or
- ❑ Documents issued by and/or filed with the FDA or other federal, state of local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
- ❑ Documents of the IRB or other similar body performing substantially the same function; or
- ❑ Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product equipment, procedure, treatment, service or supply; or
- ❑ Medical records; or
- ❑ The opinions of consulting Providers and other experts in the field.

15. Eye Services and Hardware

For eye surgery to correct errors of refraction, such as near-sightedness, includes without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy. Expenses Incurred by adults for eyeglass lenses or frames; fitting of eyeglass lenses or frames; orthoptic or vision training;

bio microscopy; field charting or aniseikonia investigation; devices to correct vision; or other refractive surgery or eye examinations required by an Employer as a condition of employment or by virtue of a labor agreement or required by a government body or agent. Refer to the pediatric vision benefit in your Schedule of Benefits for coverage of vision and eye hardware for a child.

This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition.

16. **Foot Care**
    Foot care that is not Medically Necessary, including diagnostic treatment for weak, strained, unstable or flat feet; foot orthotics, unless specified in this Certificate; routine foot care (including cutting or removal of corns, calluses) or trimming, cutting or debriding of toenails, unless the charge was for the removal of nail roots or in conjunction with the treatment of a diabetic or peripheral vascular disease. Treatment of tarsalgia, metatarsalgia, hyperkeratosis. Any type of cosmetic foot or routine foot care, including hygienic and preventive maintenance foot care, including cleaning and soaking the feet; applying skin creams in order to maintain skin tone; other services performed when there is not a localized Illness, Injury or symptom involving the foot.

17. **Government Provided Treatment**
    Treatment provided or furnished by any agency of the United States Government, the government of any other country or any state or political subdivision except approved by law.

18. **Growth Hormones**
    Human Growth Hormone for children born small for gestational age. It is only a covered service in other situations when allowed by us through Prior Authorization.

19. **Gynecomastia**
    Surgical treatment of gynecomastia.

20. **Hearing Aids**
    Expenses Incurred for hearing aids, the examination for prescribing and fitting them unless otherwise specified in this Certificate. Hearing therapy and any related diagnostic hearing tests. Hearing tests for newborns are covered.

21. **Hyperhidrosis**
    Treatment of hyperhidrosis (excessive sweating).

22. **Illegal Charges, Charges that You are Not Responsible to Pay**
    Charges for services for which you or your covered dependents are not legally required to pay or would not have been made if no coverage existed.

23. **Infertility**
    Infertility drug therapy or monitoring or procedures used to induce pregnancy. See also “Pregnancy Inducement/Surrogate Parenting.”

24. **Injury or Illness While Under Confinement or Custody of Law Enforcement**
    SummaCare shall not limit or exclude coverage because the member is under Confinement or otherwise under custody of a law enforcement officer and a governmental entity is wholly or primarily responsible for rendering or arranging for the rendering of health care for the member. SummaCare may limit or exclude coverage for health care rendered to a member resulting from an action or omission for which the governmental entity operating the correctional facility or governmental entity with which the law enforcement officer is affiliated is liable.

25. **Marital Therapy/Counseling**
    Marital counseling or therapy is excluded.

26. **Maximum Limit and Maximum Allowable Amount**
    Services or charges that exceed a maximum limit and Maximum Allowable amount as specified in this booklet or your Schedule of Benefits.

27. **Not Medically Necessary**
    Services and supplies not considered Medically Necessary for your diagnosis and treatment.

28. Nutritional, Vitamin, Food Supplements

Nutritional and/or dietary supplements, except as provided in this Certificate or as required by law. This includes, but is not limited to, nutritional formulas and dietary supplements purchased over the counter and do not require a written prescription or dispensing by a licensed pharmacist. Please refer to the Pharmacy section of this Certificate as certain over-the-counter drugs and supplements may be provided under the ACA preventive mandate. Refer to http://uspreventiveservicestaskforce.org/uspstf for a complete listing of preventive benefits that are covered.

29. Occupational

Care and treatment of any Injury or Illness that is occupational, that is arising from or a result of work for wages or profits including self-employment if benefits are available under any Workers' Compensation Act or other similar law. Services received from a dental or medical department on behalf of an Employer, benefit association, union, trust or similar person or group. For routine physical exams required for enrollment in any insurance program, as a condition of employment, for licensing or for other purposes.

30. Orthognathic Surgery

- ❑ Orthognathic surgery for cosmetic and psychological purposes;
- ❑ Orthognathic surgery for speech impairments;
- ❑ Use of condylar positioning devices in orthognathic surgery;
- ❑ Services that do not meet SummaCare's medical necessity criteria.

31. Over-the-Counter Drugs

Except as covered under this Policy and required under the federal preventive care services, over-the-counter drugs and drugs with over-the-counter equivalents and any drugs, devices, products or supplies therapeutically comparable to an over-the-counter drug, device, product or supply; stop smoking aids; nutritional and/or dietary supplement drugs for treating sexual or erectile dysfunction or inadequacies; fertility drugs; human growth hormone for children born small for gestational age; and treatment of onychomycosis.

32. Payments That Are Your Responsibility

For any service for which you are responsible under this Certificate to pay such Copayments, Coinsurance or deductibles. Also for any waived charges from a Non-Preferred Provider you are responsible to pay.

33. Personal Service Items in a Home of Inpatient Setting

Personal services such as haircuts, shampoos and sets, guest meals and radio/television rentals. In a home setting food, housing, homemaker and home delivered meals. Allergenic pillows, cervical neck pillows waterbeds, infant helmets and safety helmets with neuromuscular diseases.

34. Pregnancy Inducement/Surrogate Parenting

Any medically unnecessary treatment to bring about pregnancy, including drug therapy and monitoring, embryo transplants, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any other test tube baby production procedures. Any services or supplies provided to a person not covered under this certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

35. Private-Duty Nurses

Private-duty nurses in an inpatient Hospital or Skilled Nursing Facility setting. Refer to the Home Health Care section of this Certificate for private duty nursing in a home setting which is a covered benefit.

36. Reconstructive Services

Reconstructive services except as specifically stated in the Covered Services section of this Certificate or as required by law.

37. Rehabilitation Services, Therapies

Treatment for maintenance physical therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance physical therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement. For manipulation therapy rendered in the home as part of home care services.

Physical Therapy – Non-Covered Services include: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or Illness; repetitive exercise to improve

movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

Occupational Therapy - does not include coverage for divisional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non-Covered Services include: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercise to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as ramp ways, door widening, automobile adaptions, kitchen adaptation and other types of similar equipment.

Cardiac Rehab - home programs, on-going conditioning and maintenance are not covered.

Pulmonary Rehabilitation - pulmonary rehabilitation in the acute inpatient rehabilitation setting is not a covered service.

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to, admission to a Hospital mainly for physical therapy; long-term rehabilitation in an inpatient setting.

38. Rest Cures, Travel, Recreational Therapy, Convalescent Home

Rest cures, travel, recreation or diversion therapy, even though prescribed by a Provider. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home for the aged are excluded services. Costs for wilderness camps, services or care provided or billed by a school, Custodial Care center for the developmentally disabled or outward bound programs even if psychotherapy is included.

39. Riot

Any condition, disability or Expense resulting from any Injury or Illness caused by or participating in a civil disobedience, nuclear explosion or nuclear Accident or riot.

40. Sclerotherapy, Dermal Veins

Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy may be covered if prior authorized for medical necessity. Treatment of telangiectatic dermal veins (spider veins) by any method is an exclusion.

41. Services Provided by Relatives

Services prescribed, ordered or referred by or received from a member of your immediate family, including but not limited to, your spouse, child, brother, step-brother, sister, step-sister, parent, in-law or self.

42. Sex Therapy

All services for sex therapy.

43. Sexual Dysfunction

Male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. Medical complications may be covered when meeting Medically Necessary criteria determined by the Health Services Management Authorization Unit. Medications implants, hormone therapy, surgery and medical or psychiatric treatment are not covered. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction. Prescription drugs and all other procedures and equipment developed for or used in the treatment of impotency and all related diagnosis testing.

44. Sports and Special Employee Related Exams or Report

Sports, premarital examinations, physical or psychological examinations or IQ testing required by: a) a school for sports exams; b) an Employer in order to begin or continue working; c) an insurance company in order to obtain insurance; d) a government agency; e) any request received by a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group. Sports helmets. All preventive care exams will, however, be covered.

45. Sterilization Reversals

Reversal of voluntary elective sterilization.

46. Travel and Lodging, Meals

Travel, lodging, and meals even though a Physician prescribes care, except reasonable lodging and travel costs needed for out-of-area transplant Expenses for Insured recipient at "Centers of Excellence" approved facilities only as approved by the SummaCare Health Services Management Program and in compliance with the transplant policy. Immunizations for travel are excluded.

47. War

Charges incurred as a result of any Illness or Injury that occurs while serving in the armed forces, including as a result of any act of war, whether declared or undeclared or any act of aggression, when the Covered Person is a member of the armed forces of any country.

48. Weight Loss Programs

Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (e.g., Weight Watchers, Jenny Craig, and LA Weight Loss) and fasting programs.

49. General

Any charge or Expense not expressly covered by this Certificate.

X. Claims

A. The Usual Procedure

Your Preferred Provider will submit a claim for Covered Services to us for you. 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, including your member information. You may 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 claims form to:

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

You must attach the Provider's bills to your claim form.

We use the most current CPT and ICD-10 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 Summa Insurance Company becomes insolvent, you may be responsible for paying for health care services given by a Provider or health care facility not under contract with SummaCare. It does not matter if we authorized the use of the Provider or health care facility.

B. How Benefits Are Paid

We pay for Covered Services at the maximum allowed amount, the maximum amount of reimbursement we will allow for a Covered Service that meets our definition of a Covered Service and is not excluded, is Medically Necessary and is provided in accordance with requirements as set forth in this Certificate. You will be required to pay a portion of the maximum allowed amount if you have not met your deductible or have a Copayment or Coinsurance. In addition, when you receive a covered service from a Non-Preferred Provider, you may be responsible for paying any difference between the maximum allowed amount and the Provider's actual charges. This is called balance billing. When you receive covered services, we will apply claims processing rules to the claim submitted. If we determine the claim was submitted inconsistently with procedure coding rules, we will pay the claim at the reimbursement level according to our policies. This allows bundling coding into one Maximum Allowable Charge instead of multiple codes being billed and paid and ultimately saves on health care costs.

C. Emergency/Urgent Care/Non-Preferred Provider

In the event of an emergency or urgent care situation, if you receive services from a Non-Preferred 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 your Employer or SummaCare. You must attach the doctor and Hospital bills from the Non-Preferred Provider to your claim form. Refer to the Emergency/Urgent Care section under Covered Services for more information regarding emergent and urgent care.

D. When Copayments Apply

Your SummaCare Certificate includes certain services that involve Copayments. These services and their Copayment amounts are listed in your Schedule of Benefits. For example, you may have to pay a $10 Copayment for an office visit to a Preferred Provider. You are responsible for any Copayment at the time the service is provided.

E. Notice of the Claim

We must receive written notice Covered Services have been given to you in the form of a claim. There is a one-year filing limit for the filing of the claim. If the claim submitted does not include sufficient data to process the claim, the necessary data must be submitted to us within the time frames in this provision or no benefits will be payable except as otherwise required by law. If we have not received the information to process the claim, we will ask for the

additional information necessary to complete the claim. We will make our request for additional information within 30 days of our initial receipt of the claim and will complete our processing of the claim within 15 days after receiving all requested information. If we are unable to complete processing of a claim because either you or your Provider fails to provide us with the additional information within 60 days of the request, the claim will be denied. We will reopen and process the claim if additional information is received. Note: Under Ohio law, you have the right to obtain an itemized copy of your Billed Charges from the Hospital or facility which provided the service.

F. Claims Forms

Claim forms will be available at Preferred Provider offices and Preferred Providers will bill us. If you need a claim form for an out-of-network service, please contact Member Services at 330.996.8700 or 800.996.8701 (TTY: 711) or go to our website at www.summacare.com. Information that needs included with the claim form includes:

- Name of Patient
- Plan Identification number
- Date, type and place of service – including appropriate procedure and diagnosis coding
- The Provider name, address, national Provider identifier and tax identification number

G. Proof of Loss

Written proof of loss must be furnished to the Insurer at its office in case of claim for loss for which this Policy provides any periodic contingent upon continuing loss within 90 days after the termination of the period for which the Insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Claims: Except for periodic payments, claims must be paid immediately or within 30 days of receipt of proof of loss.

Legal actions: Legal actions are permitted 60 days after written proof of loss has been submitted and no later than three years after written proof of loss is required to be submitted.

H. Explanation of Benefits (EOB)

After we pay your claim, you will receive an Explanation of Benefits (EOB). This EOB summarizes the coverage you received. It is not a bill, but a statement from SummaCare to help you understand the coverage you received. It shows:

- Total amounts charged for the service;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information and your appeals rights and the appeals process.

I. Unfair Health Claim Practices

SummaCare shall:

- Establish and maintain a procedure for the expeditious resolution of electronic, written and oral complaints initiated by a member or Provider.
- Include our complaint procedure in every Certificate. (Refer to the Appeals and Grievance section of this Certificate.)
- Keep records of written complaints from and responses to members and Providers.
- Include the following or similar statement in all notifications of claim denials: “If you wish to dispute the company’s decision on this claim, you may register a complaint by filing a grievance or appeal at 1200 East Market Street, Suite 400, Akron, Ohio 44305-4018. In reviewing your complaint, SummaCare will follow the complaint procedure described in this Certificate. If your claim has been denied because it is not a covered service, you have the right to file a complaint with:

  Ohio Department of Insurance Consumer Services Division
  50 West Town Street
  Third Floor, Suite 300
  Columbus, Ohio 43215

  Phone: 614.644.2673, Toll Free in Ohio 800.686.1526 (TTY: 711)
  Complaints may be filed via the internet at http://insurance.ohio.gov

XI. Complaint Procedure

If you are not happy with a decision about a claim or have another complaint, you can call Member Services at 330.996.8700 or 800.996.8701 (TTY: 711). A Member Services representative will ask you questions about your complaint and investigate the facts. You will receive a verbal response to your complaint within one business day.

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 process 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:

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 Member Services;
- ❑ Rude treatment by a Provider or his/her office staff;
- ❑ You believe the care you received from a SummaCare Provider was not appropriate;
- ❑ You believe a SummaCare Employee has violated your privacy.

To file a grievance, send your request to:

SummaCare Grievance Department
P.O. Box 1107
Akron, Ohio 44309-1107

You may also fax your grievance to 330.996.8545 or submit it electronically to appeals@summacare.com. Please be as clear as possible when describing your grievance.

If you need help with your grievance, please call SummaCare Member Services at 330.996.8700 or 800.996.8701 (TTY: 711) between 8:30 AM and 5:30 PM. Outside these hours, you may leave us a message and a representative will return your call the next business day.

A Member Services representative will help document the details of your grievance over the phone. You must file your grievance within 180 days from the date you received the service. We have 30 calendar days to investigate your grievance and will respond to you in writing with our findings and any action we have taken or will take as a result of your grievance.

If you are not happy with our response, 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 (TTY: 711).

Appeal Procedures

You have the right to appeal an Adverse Benefit Determination (ABD) made by SummaCare through our internal appeals process. There is no minimum dollar amount for the service required to file an internal appeal. You will be instructed of your appeal rights and the filing process in the SummaCare Notice of Adverse Determination.

An ABD is a decision by SummaCare:

- ❑ To deny, reduce or terminate a requested health care service or payment in whole or in part, including all the following:
  - A determination the health care service does not meet SummaCare requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, including experimental or investigational treatments;
  - A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-Employer group, to participate in a Plan or health insurance coverage;
  - A determination that a health care service is not a covered benefit;

- The imposition of an exclusion, including exclusions for pre-existing conditions, source of Injury, network or any other limitation on benefits that would otherwise be covered.

❑ Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-Employer group;

❑ To rescind coverage on a health benefit Plan.

To file an appeal, send a written request to:

SummaCare Appeals Department
P.O. Box 1107
Akron, Ohio 44309-1107

You may also fax your appeal to 330.996.8545 or submit electronically to appeals@summacare.com.

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 Member Services for assistance. A Member Services representative will help document the details of your appeal over the phone. You will still need to send a signed, written appeal within five days of your request. You must file your appeal within 180 days from the date you first received notice of the denial you want 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. If a Physician requests expedited review of an appeal on your behalf, the Physician will be deemed to be your designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form.

Internal Appeals
An initial determination by us can be appealed for internal review. The Plan will advise you of your rights to appeal to the next level if a denial occurs after an initial determination.

We will accept oral or written comments, documents or other information relating to an appeal from the member or the member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the member's appeal.

Appeals
Appeals are reviewed by persons who did not make the initial determination and are not the subordinates of the initial reviewer. If a clinical issue is involved, we will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review your medical records and determine if the service is covered by your benefit document. If the clinical peer determines the service is covered by your benefit document, we must pay for the service. If the clinical peer determines the service is not covered, we may deny the services.

The exact time frame for resolving your appeal depends upon a number of factors explained below. However, in every case, we will resolve your internal appeal within 10 calendar days for a pre-service appeal and within 30 calendar days for a post-service appeal from the date we received your first appeal letter or as fast as is Medically Necessary.

There are two SummaCare levels to the internal appeals process and there is only one level in the internal appeals process for an expedited appeal.

Expedited Reviews
Expedited review of an appeal may be initiated orally, in writing or by other reasonable means available to you or your Provider. Expedited review is available only if the medical care for which coverage is being denied has not yet been rendered. We will complete expedited review of an appeal as soon as possible given the medical urgency but no later than 48 hours after our receipt of the request and will communicate our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of our determination to you, your attending Physician or ordering Provider and the facility rendering the service.

You may request an expedited review for:

❑ Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or,

- In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

❑ Any claim a Physician with knowledge of your medical condition determines is a claim involving urgent care. Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Exhaustion of Internal Appeals Process

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

❑ We agree to waive the exhaustion requirement;

❑ You did not receive a written decision of our internal appeal within the required time frame; or

❑ We failed to meet all requirements of the internal appeal process unless the failure:

- Was de minimis (minor);
- Does not cause or is not likely to cause prejudice or harm to you;
- Was for good cause and beyond our control;
- Is not reflective of a pattern or practice of non-compliance; or
- An expedited external review is sought simultaneously with an expedited internal review.

External Review

Definitions as used in the External Review section include the following:

"Adverse Benefit Determination" means a decision by a health Plan issuer:

❑ To deny, reduce or terminate a requested health care service or payment in whole or in part, including all of the following:

- A determination the health care service does not meet the health Plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, including experimental or investigational treatments;
- A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-Employer group, to participate in a Plan or health insurance coverage;
- A determination that a health care service is not a covered benefit;
- The imposition of an exclusion, including source of Injury, network or any other limitation on benefits that would otherwise be covered.

❑ Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-Employer group;

❑ To rescind coverage on a health benefit Plan.

"Authorized Representative" means an individual who represents a Covered Person in an internal appeal or external review process of an ABD who is any of the following:

❑ A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an ABD;

❑ A person authorized by law to provide substituted consent for a covered individual;

❑ A family member or a treating health care professional, but only when the Covered Person is unable to provide consent.

"Covered Person" means a Policyholder, subscriber, enrollee, member or individual covered by a health benefit Plan. "Covered Person" does include the Covered Person's Authorized Representative with regard to an internal appeal or external review.

"Covered Benefits" or **"Benefits"** means those health care services to which a Covered Person is entitled under the terms of a health benefit Plan.

"Final Adverse Benefit Determination" means an ABD upheld at the completion of a health Plan issuer's internal appeals process.

"Health benefit Plan" means a Policy, contract, certificate or agreement offered by a health Plan issuer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

"Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, Illness, Injury or disease.

"Health Plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Superintendent of Insurance, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services under a health benefit Plan, including a sickness and Accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple Employer welfare arrangement or a non-federal government health Plan. "Health Plan issuer" includes a third party administrator to the extent the benefits such an entity is contracted to administer under a health benefit Plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

"Independent review organization" means an entity accredited to conduct independent external reviews of ABDs.

"Rescission" or **"to rescind"** means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage effective retroactively to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

"Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, no material deterioration of a Covered Person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- ❑ Placing the health of the Covered Person or that of a pregnant woman or her unborn child in serious jeopardy;
- ❑ Serious impairment to bodily functions;
- ❑ Serious dysfunction of any bodily organ or part.

In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

"Superintendent" means the Superintendent of Insurance.

Understanding the External Review Process
Under Chapter 3922 of the Ohio Revised Code, all health Plan issuers must provide a process that allows a person covered under a health benefit Plan or a person applying for health benefit Plan coverage to request an independent external review of an ABD. This is a summary of that external review process. An ABD is a decision by us to deny benefits because services are not covered, are excluded or limited under the Plan or the Covered Person is not eligible to receive the benefit. The ABD may involve an issue of medical necessity, appropriateness, health care setting or level of care or effectiveness. An ABD can also be a decision to deny health benefit Plan coverage or to rescind coverage.

Opportunity for External Review
An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The Covered Person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the Covered Person must generally exhaust the health Plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the ABD.

External Review by an IRO - A Covered Person is entitled to an external review by an IRO in the following instances:

- ❑ The ABD involves a medical judgment or is based on any medical information;
- ❑ The ABD indicates the requested service is experimental or investigational;
- ❑ The requested health care service is not explicitly excluded in the Covered Person's health benefit Plan and the treating Physician certifies at least one of the following:
  - Standard health care services have not been effective in improving the Covered Person's condition;
  - Standard health care services are not medically appropriate for the Covered Person; or
  - No available standard health care service covered by us is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 48 hours and can be requested if any of the following applies:

- ❑ The Covered Person's treating Physician certifies the ABD involves a medical condition that could seriously jeopardize the Covered Person's life or health or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal;

- ❑ The Covered Person's treating Physician certifies the final ABD involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review;
- ❑ The final ABD concerns an admission, availability of care, continued stay or health care service for which the Covered Person received Emergency Services, but has not yet been discharged from a facility; or
- ❑ An expedited internal appeal is already in progress for an ABD of experimental or investigational treatment and the Covered Person's treating Physician certifies in writing the recommended health care service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective final ABDs (meaning the health care service has already been provided to the Covered Person).

External Review by the Ohio Department of Insurance - A Covered Person is entitled to an external review by the Department in either of the following instances:

- ❑ The ABD is based on a contractual issue that does not involve a medical judgment or medical information.
- ❑ The ABD for an Emergency Medical Condition indicates that medical condition did not meet the definition of emergency AND our decision has already been upheld through an external review by an IRO.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the Covered Person, or an Authorized Representative, must request an external review through us within 180 days of the date of the notice of final ABD issued by us. All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally. The Covered Person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete, we will initiate the external review and notify the Covered Person in writing, or immediately in the case of an expedited review, the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the Covered Person, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. We will also forward all documents and information used to make the ABD to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete, we will inform the Covered Person in writing and specify what information is needed to make the request complete. If we determine the ABD is not eligible for external review, we must notify the Covered Person in writing and provide the Covered Person with the reason for the denial and inform the Covered Person the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by us and require the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit Plan and all applicable provisions of the law.

IRO Assignment

When we initiate an external review by an IRO, the Ohio Department of Insurance web-based system randomly assigns the review to an accredited IRO qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with us, the Covered Person, the health care Provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by us in making the Adverse Benefit Determination, any information submitted by the Covered Person and other information such as; the Covered Person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit Plan, the most appropriate practice guidelines, clinical review criteria used by the health Plan issuer or its utilization review organization and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by us of a request for a standard review or within 48 hours of receipt by us of a request for an expedited review. This notice will be sent to the Covered Person, us and the Ohio Department of Insurance and must include this information:

- ❑ A general description of the reason for the request for external review.
- ❑ The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- ❑ The dates over which the external review was conducted.
- ❑ The date on which the independent review organization's decision was made.
- ❑ The rationale for its decision.
- ❑ References to the evidence or documentation, including any evidence-based standards, used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an ABD that involves a health care treatment or service stated to be experimental or investigational also includes the principal reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision
An external review decision is binding on us except to the extent we have other remedies available under state law. The decision is also binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable state or federal law. A Covered Person may not file a subsequent request for an external review involving the same ABD previously reviewed unless new medical or scientific evidence is submitted to us.

If You Have Questions About Your Rights or Need Assistance
You may contact SummaCare:

SummaCare Appeals Department
P.O. Box 1107
Akron, OH 44309-1107

You may also fax your appeal to 330.996.8545 or submit electronically to appeals@summacare.com.

Please call SummaCare Member Services at 330.996.8700 or 800.996.8701 (TTY: 711) between 8:30 AM and 5:30 PM if you need assistance with your grievance. Outside these hours, you may leave us a message and a representative will return your call the next business day.

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, OH 43215
800.686.1526/614.644.2673
614.644.3744 (fax)
614.644.3745 (TDD)

Contact ODI Consumer Affairs:
https://gateway.insurance.ohio.gov/UI/ODI.CS.Public.UI/Comment.mvc/DisplayCommentSubmission

File a Consumer Complaint:
https://gateway.insurance.ohio.gov/UI/ODI.CS.Public.UI/Complaint.mvc/DisplayConsumerComplaintForm

Appeal Filing Time Limit
We expect you will use good faith to file an appeal on a timely basis. However, we will not review an appeal if it is received by us after 180 days have passed since the incident leading to your appeal.

Appeals by Members of ERISA Plans
If you are covered under a group Plan subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file an appeal prior to bringing a civil action under 29 U.S.C. 1132§502(a).

XII. 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 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 payments from all Plans do not exceed 100 percent 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.

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.

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 Ohio 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 listed 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 all Plan benefits do not exceed 100 percent of the total allowable Expense.

4. Allowable Expense is a health care Expense, including deductible, Coinsurance and Copayments, 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 not covered by any Plan covering the person is not an allowable Expense. In addition, any Expense 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:

- ❑ 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.
- ❑ If a person is covered by two or more Plans that compute their benefit payments based on 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.
- ❑ 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.
- ❑ If a person is covered by one Plan that calculates its benefits or services based on usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that bases its benefits or services on 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 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.
- ❑ 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 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, 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 consistent with this regulation is always primary unless the provision of both Plans states the complying Plan is primary.

   (b) Coverage obtained by virtue of membership in a group designed to supplement a part of a basic package of benefits and provides 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 superimposed over base Plan Hospital and surgical benefits and coverage 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 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:
- 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 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 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 the parents have joint custody without specifying 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, one 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 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 unpaid by the primary Plan. The secondary Plan may then reduce its payment by the amount so 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 we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at SummaCare, 330.996.8700 or 800.996.8701 (TTY: 711) or via email at appeals@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 800.686.1526 or visit the Department’s website at www.insurance.ohio.gov.

H. Integration with Medicare

Any benefits covered under both this SummaCare PPO Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations and Centers for Medicare & Medicaid Services (CMS) guidelines,

subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate provisions and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Certificate for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled.

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 including uninsured/ underinsured motorist coverage, 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, organization or Insurer for uninsured/underinsured motorist coverage, through reimbursement, assignment or Subrogation for the same Injury, Illness or other loss for which payment is made. SummaCare's right to recovery shall be binding upon the Certificate Holder, Insured dependent, beneficiary or legal representative.

SummaCare has the right to be repaid first from any settlement, judgment, or other payment the covered individual has received as a result of all Injuries, Illnesses or other damages for which SummaCare has paid benefits, up to the amount expended on the Covered Person's behalf. This right shall exist regardless of whether such settlement, judgment, or other payment is characterized as; compensation for medical bills, pain and suffering, lost wages, or other special, economic, consequential, punitive or exemplary damages. This right shall exist regardless of whether the Covered Person has alleged, proven in a court of law, or otherwise substantiated his or her damages. SummaCare has the right to be repaid first for any and all amounts expended to, or on behalf of, a Covered Person. If less than the full value of the action is recovered for comparative negligence; diminished due to a party's liability under sections 2307.22 to 2307.28 of the Ohio Revised Code; or by reason of the collectability of the full value of the claim for Injury, death or loss to person resulting from limited liability insurance or any other cause, SummaCare's claim may be diminished in the same proportion as the injured party's interest is diminished.

SummaCare will not bear any costs, Expenses, 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.

XIII. Continuation of Coverage

A. COBRA Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires certain Employers provide Employees and their dependents with the opportunity to continue SummaCare PPO coverage under the Employer's group contract for a period of months after it would otherwise terminate, provided the Employee pays the full cost of such coverage. Contact your Employer's personnel or Employee benefits office to determine if your Employer offers continuation coverage.

If you or any of your dependents elect coverage under COBRA, each individual making the election will receive the medical coverage in effect for such individual when the coverage was otherwise scheduled to terminate. If you have any questions about COBRA continuation coverage, do not hesitate to contact your Employer.

The length of time COBRA coverage lasts depends on the reason coverage ended. You and your covered dependents have a right to choose COBRA continuation coverage for up to 18 months if you lose your group health coverage because of any of the following qualifying events:

- A reduction in your hours of employment; or
- The termination of your employment, for reasons other than gross misconduct on your part.

If you or a dependent are disabled (as set forth in Title II or XVI of the Social Security Act) when coverage ends for any of these reasons, coverage may be continued for the disabled person for an additional 11 months; but the disabled person must notify the Employer within 60 days after the determination of disability was made and prior to the end of the initial 18-month coverage period. This means a possible total continuation period of up to 29 months for the disabled person. When the additional 11 months of coverage begins, the cost of coverage for the disabled person increases to the amount permitted by law.

COBRA regulations may change from time to time. The continuation of coverage will be provided in accordance with current law.

In addition, your covered eligible dependent has the right to choose COBRA continuation coverage for up to 36 months if such dependent loses coverage because of any of the following qualifying events:

- Your death;
- Your divorce, legal separation or annulment of your marriage;
- You become covered under Medicare; or
- Your dependent ceases to meet SummaCare PPO eligibility requirements.

Generally, losing coverage under SummaCare PPO as a result of a qualifying event entitles you and/or your spouse or dependent child to become a qualified beneficiary under COBRA.

Under the law, a qualified beneficiary must notify the Employer of the following qualifying events within 60 days of the qualifying event:

- Divorce or legal separation of Employee and spouse; or
- A dependent child's loss of eligibility.

Also, a qualified beneficiary must notify the Employer within 60 days of the Social Security determination the qualified beneficiary was disabled at the time of the Employee's termination or reduction in hours.

The Employer must notify:

- Each covered Employee and his or her spouse (if any) of his/her right to continue coverage when the SummaCare PPO Plan becomes subject to COBRA;
- Each new Employee and his or her spouse (if any) of his/her COBRA rights when he/she becomes covered under the Plan; and
- Each qualified beneficiary of his or her COBRA rights within 14 days of having been informed of or having a record of a qualifying event.

A qualified beneficiary may elect to continue coverage under the SummaCare PPO Plan up to 60 days after the later of:

- The date coverage would otherwise end; or
- The date notice of continuation rights is provided by the Employer.

Each qualified beneficiary may elect to continue any or all of the benefits for which he or she was enrolled at the time of the qualifying event. An Employee or spouse may elect to cover all eligible qualified beneficiaries under one continuation enrollment.

Contact your Employer's personnel or Employee benefits office to determine the cost for your continuation of coverage and to elect continuation of coverage. A qualified beneficiary is required to make the payment in monthly installments (normally due on the first day of each month). Your Employer may not require any payment retroactive to the date of the qualifying event until 45 days after the qualified beneficiary timely elects COBRA coverage.

The amount of the payment may be adjusted once every 12 months. The cost will be determined in advance of the 12-month period.

The law provides the COBRA coverage will end on the earliest date of the following events:

- Eighteen months after the date of the Employee's termination of employment or reduction in hours (an additional 18 months if another qualifying event occurs during such 18-month period), unless the Social Security Administration determines a qualified beneficiary was disabled at the time of termination or reduction of hours and the qualified beneficiary so informs his/her Employer (as described previously) before the end of the 18-month period. In this case, coverage may be extended (at an additional cost) until the month that begins more than 30 days after the final determination by the Social Security Administration the disability has ended, to a maximum of 29 months;
- Thirty-six months after any other qualifying event, even in the event of multiple qualifying events;
- The Employer no longer provides group health coverage to any of its Employees;
- The qualified beneficiary does not pay for continuation coverage in a timely fashion;
- The qualified beneficiary becomes covered under another group health Plan;
- The qualified beneficiary becomes covered under Medicare.

B. Ohio Law

- Section 3923.38 of the Ohio Revised Code requires Ohio Employers to provide involuntarily terminated Employees, when the termination of employment is not a result of any gross misconduct on the part of the Employee, the option to continue his/her group medical coverage for up to 12 months after the date the insurance coverage would otherwise terminate by reason of the termination of the Employee's employment. Continuation need not include dental, vision care or any other benefits provided under the Policy in addition to its Hospital, surgical or major medical benefits. The Employer shall notify the Insurer if the Employee elects continuation of coverage under this section. The director of insurance shall publish guidance for Employers and Insurers regarding the contents of such documentation. Therefore, if this law affects you, you are eligible to continue SummaCare PPO coverage for you and your covered dependents for up to 12 months after termination, provided the Premiums for such coverage are paid. Upon termination, the Employer shall notify the Employee of the right to continuation. This notice shall inform the Employee of the amount of contribution. The Employee shall file a written election of continuation with the Employer and pay the Employer the first contribution required. The request and payment must be received by the Employer no later than the earlier of:
  - Thirty-one days after the date on which the Employee's coverage would otherwise terminate;
  - Ten days after the date on which the Employee's coverage would otherwise terminate, if the Employer has notified the Employee of the right of continuation prior to such date;
  - Ten days after the Employer notifies the Employee of the right of continuation, if the notice is given after the date on which the Employee's coverage would otherwise terminate.

  You are eligible for this continuation of coverage if you meet all the following requirements:
  - You have been continuously covered by this SummaCare PPO Plan or any prior similar group coverage replaced by this SummaCare PPO Plan during the three-month period before termination of your employment;
  - The Employee did not voluntarily terminate the Employee's employment and the termination of employment is not a result of any gross misconduct;
  - You are neither eligible for nor covered by Medicare; and
  - You are neither eligible for nor covered by any other insured or uninsured arrangement that provides Hospital, surgical or medical coverage for individuals in a group.

The Employee's privilege to continue coverage ceases if any of the following occurs:

- The Employee ceases to be an eligible Employee by virtue of being eligible for coverage by Medicare under Title XVIII of the Social Security Act or being eligible for coverage by any other insured or uninsured arrangement that provides hospital, surgical, or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination;
- A period of 12 months expires after the date the Employee's insurance under the Policy would otherwise have terminated because of the termination of employment;
- The Employee fails to make a timely payment of a required contribution, in which event the coverage shall cease at the end of the coverage for which contributions were made;
- The Policy is terminated or the Employer terminates participation under the Policy unless the Employer replaces the coverage by similar coverage under another group Policy or other group health arrangement.

❑ Section 3923.381 of the Ohio Revised Code requires Ohio Employers to provide Employees who are reservists called or ordered to active duty, and covered dependents of any such reservists, the option to continue their group medical coverage for up to 18 months after the date the coverage would otherwise terminate because the reservist is called or ordered to active duty. Therefore, all Covered Persons who would be affected by this law are eligible to continue their group coverage under this SummaCare PPO Plan for up to 18 months, provided the Premiums for such coverage are paid. Coverage may be continued for up to 36 months if any of the following events occur during the 18-month period:

- The death of the reservist, divorce or separation of the reservist; or
- The reservist's covered dependent child ceases to meet the eligibility criteria set forth in this Certificate.

All the following apply to any continuation of coverage or the extension of any continuation of coverage:

❑ The continuation of coverage shall provide the same benefits as those provided to any similarly situated Eligible Person who is covered under the same group Policy and an Employee who has not been called or ordered to active duty.

❑ An Employer shall notify each Employee of the right to continuation of coverage at the time of employment. At the time the reservist is called or ordered to active duty, the Employer shall notify each Eligible Person of the requirements for the continuation of coverage.

Your Employer must mandate you to file a written election of continuation of coverage for you, your spouse and dependent child and pay the first contribution required for the extension of coverage. The written election and payment must be received no later than 31 days after the date on which the coverage would otherwise terminate.

You, your spouse and/or dependent child must pay to the Employer, on a monthly basis and in advance, the amount of contribution required by the Employer. The amount shall not exceed 102 percent of the group rate for the coverage being continued under the group Policy. The Employer may pay a portion or all of the Eligible Person's contribution. A reservist called or ordered to active duty for less than 31 days shall not be required to pay more than the Eligible Person's contribution, if any, for the coverage.

An Eligible Person's right to any continuation of coverage, or the extension of any coverage, ceases on the date on which any of the following occurs:

❑ The Eligible Person enrolls in another group Policy that does not include the civilian health and medical program of the Uniformed Services;

❑ The period of either 18 months or 36 months expires;

❑ The Eligible Person fails to make timely payment of the required contribution; or

❑ The group Policy is terminated.

Upon the reservist's release from active duty and return to employment for the Employer by whom the reservist was employed at the time of being called or ordered to active duty, both of the following apply:

❑ Every Eligible Person is entitled, without any Waiting Period, to coverage under the Employer's group Policy that is in effect at the time of the reservist's return to employment; and,

❑ Every Eligible Person is entitled to all benefits under the group Policy.

XIV. 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.

Adverse Benefit Determination
A decision by SummaCare:

- To deny, reduce or terminate a requested health care service or payment in whole or in part, including all the following:
  - A determination that the health care service does not meet SummaCare requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, including experimental or investigational treatments;
  - A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-Employer group, to participate in a Plan or health insurance coverage;
  - A determination that a health care service is not a covered benefit;
  - The imposition of an exclusion, including exclusions for pre-existing conditions, source of Injury, network or any other limitation on benefits that would otherwise be covered.
- A determination not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-Employer group;
- A determination to rescind coverage on a health benefit Plan.

Annual Open Enrollment
The annual period during which an eligible Employee may enroll himself or herself and his or her eligible dependents in this SummaCare Plan.

Applied Behavior Analysis
The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Authorized Representative
An individual who represents a Covered Person in an internal appeal or external review process of an Adverse Benefit Determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent him or her in an internal appeals process or external review process of an Adverse Benefit Determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating health care professional, but only when the Covered Person is unable to provide consent.

Autism Spectrum Disorder
Any of the pervasive developmental disorders or Autism Spectrum Disorder as defined by the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association available at the time an individual is first evaluated for suspected developmental delay.

Benefit Period
The length of time during which a benefit is paid. For this plan, the Benefit Period is the Calendar Year.

Billed Charges
The non-discounted schedule of charges for services that the health care Provider would use to invoice a patient for services rendered.

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

Calendar Year Out-of-Pocket Maximum
The most you'll have to pay for Covered Services in a Policy period (usually one year). After you reach this amount, the Plan will pay 100 percent.

Certificate Holder
You or the Employees of a group who are covered under a group master Policy, negotiated by the Employer group, referred to as the Master Policyholder.

Certificate of Insurance
A benefit handbook given to the Certificate Holder which explains the group benefits and provides instructions on the use of the group insurance master Policy.

Confinement
Any period of time during which a person is in the custody or under the supervision of the Department of Rehabilitation and Correction or is confined in a local jail, workhouse or other correctional facility.

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

Coordination of Benefits
The provision that applies when a person is covered under more than one group and/or individual medical program. It requires that payment of benefits will be coordinated by all programs to eliminate over insurance or duplication of benefits.

Copayment/Coinsurance
The dollar amount and/or percentage of costs shown in the Schedule of Benefits a Certificate Holder 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 due at the time the service is delivered. Coinsurance, a percent as stated in the Schedule of Benefits, is due after the Certificate Holder or Insured dependent receives his/her Explanation of Benefits.

Covered Benefits
Health care services to which a Covered Person is entitled under the terms of the health benefit Plan.

Covered Person
An Eligible Person who enrolls, is eligible for and receives Covered Benefits under the group Policy. A Covered Person may include a Policyholder, subscriber, enrollee, member or individual covered by a health benefit Plan. “Covered Person” does include the Covered Person’s Authorized Representative with regard to an internal appeal or external review.

Covered Services
The healthcare services and items described in this booklet and updated in the Schedule of Benefits for which the SummaCare 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, provided to an individual, whether disabled or not, primarily to assist in the activities of daily living.

Discount
Any negotiated reduction or variation from the schedule of Billed Charges (including capitation) a health care Provider otherwise would require a patient and/or the patient’s Third Party Payer to pay to that health care Provider.

Eligible Cancer Clinical Trial
A Cancer Clinical Trial that meets all 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 Employee or the Employee's spouse or child who meets the eligibility requirements specified in Section II of this booklet.

Emergency Medical Condition
A medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, 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 that of a pregnant woman or her baby in serious jeopardy; serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Emergency Services
These include the following:
- A medical screening examination, as required by federal law, within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
- Such further medical examination and treatment required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

Employees
Includes the officers, managers and Employees of the Employer, the partners, if the Employer is a partnership, the officers, managers and Employees of subsidiary or affiliated corporations of a corporation Employer and the individual proprietors, partners and Employees of individuals and firm, the business of which is controlled by the Insured Employer through stock ownership contract, or otherwise.

Employer
Includes any municipal or governmental corporation, unit, agency or department thereof, as well as private individuals, partnerships and corporations.

Enrollment Date
With respect to an individual covered under a group health benefit Plan, the date of enrollment of the individual in the Plan or, if earlier, the first day of the Waiting Period of such enrollment.

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) 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 the Covered Person is furnished healthcare services related to that diagnosis and any condition directly related to that diagnosis.

Essential Health Benefits
These include ambulatory patient services, Emergency Services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and chronic disease management and pediatric services including oral and vision care. Essential Health Benefits provided under this Certificate are not subject to lifetime or annual dollar maximums. Essential Health Benefits are subject to the terms and conditions permitted under federal law as set forth in this Certificate. Certain non-Essential Health Benefits, however, are subject to annual dollar maximums.

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

Experimental/Investigational
SummaCare will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be Experimental/Investigative if we determine one or more criteria apply when the service is rendered with respect to the use for which benefits are sought. See the listing for "Experimental/Investigational Services and Treatment" in Section VII (General Exclusions) for a list of the criteria and the information considered or evaluated by us in making that determination.

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

Health Delivery Organization
A(n):

- Alcoholism or drug addiction treatment facility;
- Psychiatric Hospital;
- Ambulatory surgical facility;
- Freestanding birth center; or
- Hospice facility, provided the facility is licensed in the state in which it operates and is operating within the scope of its license.

Home Health Aide
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 the Covered Person would require 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 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 supervised by a Participating Physician and involves a team consisting of:

- A Participating Physician who provides Hospice Care;
- Licensed nurses;
- A licensed mental health specialist; and
- A licensed social worker.

The Hospice Care Plan must:

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

Hospice Facility
A facility 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:

- Provides medical care and treatment of sick and injured persons on an inpatient basis;
- Is properly licensed or permitted legally to operate as such;
- Has a Physician on call at all times;
- Has licensed graduate registered nurses on duty 24 hours a day;
- Maintains facilities for the diagnosis and treatment of Illness and for major surgery; and
- Meets 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:

- A rest facility;
- A nursing facility;
- A facility for the aged; or
- A place for Custodial Care.

Illness
Any physical or mental sickness or disease that manifests treatable symptoms and 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 requires treatment by a Physician.

Insured
A person protected by an insurance Policy or certificate.

Insurer
A life insurance company, sickness and accident Insurer, multiple employer welfare arrangement, public employee benefit plan or health insuring corporation.

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:

- It is provided only as a convenience to the Covered Person;
- It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
- It exceeds (in scope, duration or intensity) that level of care 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.

No Surprises Act
Federal legislation that eliminates Provider balance billing and limits your out-of-pocket liability for emergency services and ancillary services provided by a Non-Preferred Provider at an in-network facility.

Outpatient
A Covered Person 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.).

Plan
Refer to the definition of Plan in Section XII, Coordination of Benefits.

Policy
The contract between the Employer group which sets forth the terms of the group Policy (includes the master Policy) with the insurance company. The Employer group is the Policyholder.

Policyholder (or Master Policyholder)
The Employer group who negotiates the terms and conditions of the insurance Policy. The master Policyholder can reduce or change the benefits and coverage, increase the Certificate Holder's share of Premium, switch to another insurance company or stop providing coverage completely.

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 to the employer for the coverage provided under the SummaCare PPO Policy.

Primary Care Physician (PCP)
The SummaCare participating family practice, internal medicine, OB-GYN or pediatric Physician you choose to be your personal Physician or your dependent's personal Physician.

Prior Authorization
Approval that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by the Plan.

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.

Qualified Payment Amount (QPA)
The plan's median contracted rate for the procedure in the same geographic area provided by the same or similar provider type.

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 those are received. SummaCare will make the sole determination as to what is the Reasonable and Customary charge.

Reimbursement Rates
Any rates that apply to a payment made by us for charges covered by a health benefit Plan.

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, typically covered for a cancer patient who is not enrolled in a Cancer Clinical Trial and was not necessitated solely because of the trial.

Savings Account
These include Health Savings Accounts, health reimbursement arrangements, Flexible Savings Accounts, Medical Savings Accounts and similar accounts and arrangements.

Schedule of Benefits
An insert included with this booklet that provides information on the limits and maximums of the Plan and Copayment and Coinsurance amounts you must pay.

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.

Skilled Nursing Facility
Any institution, other than a Hospital, which meets all the following requirements:

- Maintains permanent and full-time facilities for bed care of 10 or more resident patients;
- Provides services of a Physician;
- Has a registered nurse (RN) or Physician on full-time duty in charge of patient care and one or more RNs or licensed vocational nurses (LVNs) or licensed practical nurses (LPNs) on duty at all times;
- Maintains a daily medical record for each patient;
- Is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their Illness or Injury;
- 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 (JCAHO); and
- 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 the care and treatment of alcoholism, drug addiction, tuberculosis or mental illness; or (d) a hotel or similar place be considered a Skilled Nursing Facility.

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 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.

Telemedicine
A mode of providing health care services through information and communication technology – either with or without a fixed time interval – by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

Third Party Payer
Applies to any of the following:

- An insurance company;
- A Preferred Provider organization;
- A labor organization;
- An Employer;
- An administrator subject to Section 3959.01 to 3959.16 of the Ohio Revised Code;
- Any other person that is obligated pursuant to a benefits contact to reimburse for covered health care services to beneficiaries under the contract.

Waiting Period
The period of time, if any, for which you must be continuously employed with the Employer in an eligible Employee class before you become eligible for coverage under the Plan.

You, Your
A covered Employee, Certificate Holder or relating to a covered Employee.

Important Phone Numbers

SummaCare Member Services	**330.996.8700** **800.996.8701**
SummaCare 24 – Hour Nurse Line	**800.379.5001**

FRAUD WARNING

Any person who, with intent to defraud or knowing 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.