

Summa Insurance Company
HMO Individual On the Exchange (Marketplace)
Evidence of Coverage

Administered by SummaCare

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.

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I. Your Good Health

Your good health is the goal of SummaCare. As a licensed Health-Insuring Corporation (HIC) we believe the best health care is care managed by a single doctor who knows you and your medical history.

A. How SummaCare Works

Your relationship with SummaCare (referred to as we, us, our) begins when you choose your Primary Care Physician (PCP) to coordinate your total health care needs. Each covered family member (referred to as you or your) may select a different SummaCare PCP. You may designate a pediatrician as your child's PCP. If you do not select a PCP, one will be assigned to you and your covered dependents. A complete list of the Provider network is available in our online [Provider directory](#).

Your PCP is the person you will visit first for nearly all illnesses or injuries. If your PCP determines you require specialized care, need surgery or should be admitted to a Hospital or other health care facility, he or she may coordinate your care with the appropriate source for that care.

B. Understanding Your Plan

Your SummaCare HMO Plan is simple to use. This booklet, the Evidence of Coverage (EOC), relates to your Schedule of Benefits and explains how your Plan works.

This booklet gives detailed information about your benefits. Your Schedule of Benefits is a summary of the benefits and costs you are responsible for under this Plan. If you refer to one without looking at the other, you might misunderstand your benefits. You can always call Member Services at 330.996.8671 or 833.443.0818 (TTY: 711) if you need further clarification.

SummaCare offers plans that feature two different formularies, with the key difference being the number of drug tiers included in the plan. Please refer to Section VI, Subsection E (Covered Prescription Drug Benefits) for more information.

In your Member Handbook, you will find a list of Member's Rights and Responsibilities. Please read these Rights and Responsibilities. You should understand what you must do and what the Plan must do to make sure you get the most benefits and coverage under your HMO Plan.

Definitions are found in Section XI of this booklet. It lists the definitions of terms used in this EOC and your Schedule of Benefits.

C. Choice of Providers

This Plan covers benefits from Preferred Providers, Emergency Services and limited services not able to be provided by Preferred Providers. Please refer to Section VI, Subsection C (Coverage for Emergency Services/Urgent Care Situations) for more information.

You will be responsible for paying the cost of all care provided by Non-Preferred Providers unless that care is provided by Non-Preferred Providers who are administering emergency or urgent care services, as described in Section VI, Subsection C. This Plan does not require a gatekeeper, usually known as a PCP. You do not need a referral from a PCP before receiving specialist care as long as that specialist is in network.

There are also some Non-Preferred Providers you may be able to see. If you cannot get the medical care you need from a Participating Provider, your PCP must get Prior Authorization from us for you to see a Provider who is not in your SummaCare network. Your benefits for that Physician's care are the same as if a SummaCare Preferred Provider provided the care. To get Covered Services from Non-Preferred Providers, all of the following must apply:

- ☐ Services must be Medically Necessary;
- ☐ A SummaCare Preferred Provider must ask for the services;
- ☐ Services must be pre-authorized by the SummaCare Health Services Management Authorization Unit to make sure those services are covered under your Plan.
- ☐ Services must be those that can not be provided by or through a network health care Provider.

Please talk to your SummaCare Provider before getting service to make sure any necessary Authorization was obtained. It is your responsibility to make sure all necessary Authorizations are obtained before getting out-of-network care. When determining whether a provider is in your network, it is important to assure that you are reviewing the correct network (identified on your ID card) when using [SummaCare's online directory](#).

SummaCare contracts with Providers. Our Providers are neither agents nor employees of SummaCare, nor are we the agent or employee of any Preferred Provider.

Your Provider is responsible for all medical services you may need. Providers operating within their scope of practice cannot be discriminated against.

SummaCare and our employees, officers, trustees or agents shall not be responsible or otherwise liable for any negligence or omission or other liability caused by another. This applies to any Participating or Non-Participating 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 more information about a SummaCare Provider's qualifications, please call Member Services at 330.996.8671 or 833.443.0818 (TTY: 711) or go to our website at www.summacare.com.

D. When Care Is Managed by Your Provider

- ☐ You do not have to submit claim forms. Your SummaCare Provider submits the claim forms for you.
- ☐ Your SummaCare Provider may be required to get Prior Authorization from SummaCare's Health Services Management Authorization Unit for a Hospital admission, Outpatient surgery and certain other services. Please talk with your SummaCare Provider before getting services to be sure they obtain any necessary Authorizations.
- ☐ For services that are not for an emergency, it is your responsibility to be sure health care Providers to which you are sent are participating in your [SummaCare Provider network](#).

If you require specialized care, your SummaCare Provider will coordinate your care with a specialist who is a Preferred Provider. In cases covering a long period of time that are life threatening, degenerative or a disabling illness, your care may be coordinated by a specialist. Please consult with your SummaCare Provider before getting services to make sure any necessary coordination of services was obtained.

If the medical care you need is not available from a SummaCare Provider, your PCP may send you to an appropriate specialist who is not part of the SummaCare network. But, this must be approved by the SummaCare Health Services Management Authorization Unit. Your benefits for that specialist's care will be the same as if the care had been provided by a SummaCare participating specialist. The cost to you will be the same as if you had used a SummaCare Provider. Please check with your SummaCare Provider before getting services to make sure any necessary Prior Authorization was obtained. It is your responsibility to make sure any necessary Prior Authorization is obtained before receiving out-of-network care.

Non-Contracted 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.

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.

Call Member Services at 330.996.8671 or 833.443.0818 (TTY: 711) when you have a question about coverage.

E. Prior Authorization

HEALTH SERVICES MANAGEMENT PRIOR AUTHORIZATION PHONE NUMBER: 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.

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

Please see the Prior Authorization List in your Member Handbook 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. For benefits to be paid:

- ☐ You must be eligible for benefits;
- ☐ Premium must be paid for the time period that the service was rendered (if you are receiving an Advanced Payment Tax Credit (APTC) and have made your first Premium payment, you will be given a three-month grace period; however we will not pay claims in the second and third month if your Premiums are not paid);
- ☐ The service cannot be an excluded service under this policy;
- ☐ The service must be a covered benefit under this policy;
- ☐ You must not have exceeded any applicable benefit limits under this policy.

G. Review Process for a Prior Authorization Request

If the Provider submits the request for Prior Authorization electronically through the SummaCare Authorization Portal, we shall respond to all Prior Authorization requests within 48 hours for urgent care services, or two business days once all necessary information has been received and not to exceed 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 medical care or other services 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 that 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 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.

H. 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
- ☐ Requesting information directly from the manufacturer

SummaCare also continually evaluates new and existing 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.

I. 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 for covered services will pay at 100 percent.

J. Changing Your Selected Primary Care Physician

At SummaCare, we believe your connection with your PCP is personal and key to helping you maintain the best health. If you would like to change your PCP, call Member Services at 330.996.8671 or 833.443.0818 (TTY: 711). You may also submit a PCP change on our website, www.summacare.com. Your changes will be effective within 31 days after the date of request.

K. Services Received Outside of the SummaCare Service Area

If you are traveling outside of the SummaCare Service Area, you must still coordinate your care through your PCP, except for an emergency or an urgent care situation. (See Section VI, Subsection C for more information on Emergency Services and Urgent Care Situations). Your PCP will coordinate any services needed for your condition. Except for emergencies or urgent care situations, care received outside of the SummaCare Service Area that has not been managed by your PCP will not be covered.

If your dependent is a full-time student meeting the eligibility requirements and residing outside of the Service Area, he/she will be covered for emergency and urgent care services while outside the Service Area. Routine care services will not be covered outside of the Service Area. (See Section VI, Subsection C – Coverage for Emergency Services/Urgent Care Situations.)

L. 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 for SummaCare

A. Eligible Individuals on the Marketplace

SummaCare accepts every individual who is either a legal United States citizen living in the SummaCare Service Area or has legal authority to work and live in the SummaCare Service Area and applies for coverage after eligibility verification and subsidies are established by the Marketplace. The Marketplace decides if an applicant is eligible to enroll in a Qualified Health Plan (QHP) through the Marketplace. There is no discrimination due to health status, race, color, national origin, disability, health needs, genetic information, age, sex, gender identity or sexual orientation.

If you are a member of a federally recognized tribe who purchases health insurance through the Marketplace and your income is between 100 percent and 300 percent of the federal poverty level, you can enroll in a zero-cost sharing Plan. In a zero-cost sharing Plan, you do not have to pay co-pays or other cost-sharing.

If you are a member of a federally recognized tribe who purchases health insurance through the Marketplace and your income is below 100 percent or over 300 percent of the federal poverty level, you can enroll in a limited cost sharing Plan. In a limited cost sharing Plan, you do not have to pay out-of-pocket costs if you receive services from an Indian health care Provider or from another Provider if referred from an Indian health care Provider.

NOTE: Members of federally-recognized tribes are allowed to purchase and enroll in Marketplace health insurance coverage monthly rather than just during the yearly open enrollment period. If you aren't a member of a federally recognized tribe and don't qualify for any other special enrollment period, you must enroll during the yearly open enrollment period.

B. Dependent Eligibility

SummaCare shall offer coverage to an individual or an eligible dependent of an individual applying for coverage after eligibility is approved by the Marketplace. All eligible dependents must be listed on the enrollment form completed by you and meet all the eligibility rules below.

Eligible dependents must be:

- ☐ Your legal spouse. In the event of a divorce, you must remove your spouse from your policy upon effective date of the divorce.
- ☐ Your natural born, adopted/placed for adoption dependent or stepchild under 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 policyholder must submit an application within 60 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 disabilities; and,
- Primarily dependent upon the policyholder for support and maintenance.

You must provide proof of such incapacity and dependence within 60 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. A change form is required to add the newborn child to the policy. (Please contact www.HealthCare.gov for forms). Depending upon your current Plan or policy, coverage of your newborn beyond the 31st day may require additional Premiums.

Also, depending upon your current Plan or policy, coverage of your newborn beyond the 31st day will end if we do not receive the form and any required additional Premiums.

Please login to your Health Insurance Marketplace account at www.HealthCare.gov 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 through the 31st day of life 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 60 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 60 days of this event.

III. Enrolling in SummaCare

A. Enrolling in SummaCare's HMO Plan

You must complete an enrollment application to enroll yourself and any eligible dependents in the SummaCare Plan. Please choose a PCP from SummaCare's online [Provider directory](#) for yourself, your spouse and your under-aged dependents by accessing your member account in SummaCare Plan Central. For future reference, you may change your PCP in accordance with the information provided in Section I, Subsection J (Changing Your Selected Primary Care Physician). If you choose not to enroll yourself or your eligible dependents during the Open Enrollment period or within 60 days following the date of any qualifying event, you must wait until the next Annual Open Enrollment period to apply for the Plan.

B. Special Enrollment

Special enrollment periods are outside the Open Enrollment period during which you and your family have the right to sign up for health coverage due to certain circumstances.

There are certain life events that involve a change in family status (for example marriage or divorce or birth of a child or adoption of a child or loss of other health coverage).

The Marketplace and SummaCare will provide a special enrollment period for you to enroll in or change from one QHP to another as a result of the following triggering events:

- ☐ You or a dependent loses minimum essential coverage.
- ☐ You gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption.
- ☐ If you were not previously a citizen, national or lawfully present individual and you gain such status.
- ☐ Your enrollment or non-enrollment in a QHP is unintentional, inadvertent or in error and is the result of the error, misrepresentation or inaction of an officer, employee or agent of the Marketplace or HHS as evaluated and decided by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the error.
- ☐ You adequately demonstrate to the Marketplace that the QHP in which you are enrolled substantially violated a material provision of its contract in relation to you.
- ☐ You become newly eligible or newly ineligible for advance payments of the Premium tax credit or have a change in eligibility for cost-sharing reductions. Regardless of whether you are already enrolled in a QHP, the Marketplace must permit individuals whose existing coverage through an eligible employer-sponsored Plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored Plan.
- ☐ You gain access to new QHPs as a result of a permanent move.
- ☐ An Indian, as defined by Section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month.
- ☐ You demonstrate to the Marketplace, in accordance with guidelines issued by HHS, that you meet other exceptional circumstances as the Marketplace may provide.
- ☐ You have a complex situation related to applying on the Health Insurance Marketplace website.

If you have a change in family status due to marriage, due to birth or adoption or placement for adoption, you may enroll that dependent. This is provided you request enrollment within 60 days. Coverage will begin on the date a qualified dependent first becomes eligible if you apply to add them and we receive the application within 60 days of that date. Any Premium due must be paid before coverage will begin. If you do not qualify for a special enrollment period, you can't buy insurance through SummaCare until the next Open Enrollment period.

The member is responsible to notify www.HealthCare.gov of any changes, which will affect his or her eligibility or that of dependents' eligibility. These changes include:

- ☐ Changes in address, moving outside the SummaCare service area
- ☐ Marriage
- ☐ Divorce/Legal Separation
- ☐ Death

- ❑ Change of dependent disability or dependency status
- ❑ Enrollment or disenrollment in another health policy, Medicaid or Medicare

You have 60 days from the date of the triggering event to enroll due to a qualifying event. Please contact the Marketplace if you feel you qualify for a special enrollment period and a Member Services representative will help you sign up for this special enrollment. Please notify the Marketplace of any changes in your or your dependents' eligibility.

C. Pre-Existing Condition Limitation

There is no pre-existing condition limitation on this SummaCare HMO Plan. SummaCare will accept every individual who applies for coverage. SummaCare may non-renew or discontinue coverage of an individual based on the following reasons:

- ❑ The individual failed to pay Premiums or contributions in accordance with the terms of this policy or SummaCare has not received timely Premium payments.
- ❑ The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this policy.
- ❑ SummaCare is ceasing to offer coverage in the individual market.

D. 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.

IV. When Coverage Ends

A. When Your SummaCare Coverage Ends

When Your and/or Your Dependents' Coverage Will End:

The Marketplace will decide the form and manner in which coverage in a QHP may be terminated. SummaCare shall receive termination notices from the Marketplace.

Termination Events:

The Marketplace or SummaCare must permit you to terminate your coverage in a QHP if you obtain other minimum essential coverage with appropriate notice to the Marketplace or to the QHP. The Insured may terminate coverage at any future point with the QHP. A qualified health Plan or the Marketplace may terminate coverage in the following circumstances:

- ☐ You are no longer eligible for coverage in a QHP through the Marketplace;
- ☐ Non-payment of Premiums for your coverage, after the three-month grace period required for individuals receiving advance payments of the Premiums tax credit has been exhausted, or any other grace period has been exhausted;
- ☐ Your coverage is rescinded;
- ☐ The QHP terminates or is decertified as a QHP;
- ☐ You change from one QHP to another during an Annual Open Enrollment period or special enrollment period;
- ☐ The Insured obtains other minimum essential coverage.

SummaCare and the Marketplace will maintain records of termination. The Marketplace will send termination information to the QHP and to HHS without delay. SummaCare will make reasonable accommodations for all individual with disabilities before terminating coverage for such individual. Both SummaCare and the Marketplace will retain records in order to facilitate audit function of all terminations.

In the case of a termination, the last day of coverage will be:

- ☐ The date supplied to the Plan by www.HealthCare.gov;
- ☐ The termination date specified by you, with reasonable notice, upon contacting the Marketplace at 800.318.2596 (TTY: 711);
- ☐ In the case of termination due to non-payment of Premium, the last day of coverage will be the last day of the first month of the three-month grace period if you receive a subsidy. If you do not receive a subsidy, the last day of coverage will be the day prior to entering the grace period;
- ☐ In the case of termination for any other grace period imposed the last day of coverage shall be consistent with existing state laws regarding grace periods;
- ☐ In the case of termination due to open enrollment of special enrollment the last day of coverage in your prior QHP is the day before the effective date of coverage in your new QHP.

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

- ☐ The date your own coverage ends;
- ☐ The date a dependent is no longer eligible for coverage, according to the eligibility requirements of SummaCare under Section II, Subsection B (Dependent Eligibility);
- ☐ Nonpayment of the required Premium after written notice has been sent to you of the grace period;
- ☐ The end of the year in which your dependent reaches his/her 26th birthday.

For exceptions regarding the above, see "Continuation of SummaCare Coverage" or call Member Services at 330.996.8671 or 833.443.0818 (TTY: 711).

V. Standard Provisions

Entire Contract Changes: This EOC, the Schedule of Benefits (including any endorsements and any attached papers) and the application submitted in connection with this policy constitutes 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.

Grace Period: The policy will be terminated for non-payment; if you are receiving an Advanced Payment Tax Credit (APTC) and have made your first Premium payment, you will be given a three-month grace period; however we will not pay claims in the second and third month if your Premiums are not paid. If you are not receiving an APTC, you will be given a 30-day grace period and be notified in writing of any past due Premiums. If full Premium payment is not received within the above grace period, termination will be effective on the last day on the first month of the grace period.

If you do not receive an APTC, we will not be responsible for payment of any claims incurred after the Premium due date if payment of Premium has not been received. If Premium payment is not received within the above grace period, termination will be effective on the last day for which the Premium payment was received.

If You Obtain Employer Coverage After This Policy: If your coverage ends and you want to re-enroll in SummaCare through an employer and a different Plan (group number), your benefits will be effective as though you are enrolling in SummaCare for the first time.

Cancellation by the Insured - Non-cancellation by the Insurer: The Insured may cancel this policy at any time by written notice delivered or mailed to the Marketplace, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the Insurer will return promptly the unearned portion of any Premium paid. The earned Premium shall be computed by using the short rate table last filed with the state. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. The Insurer may not cancel this policy. This provision nullifies any other provision contained in this policy or in any endorsement hereon or in any rider attached hereto which provides for cancellation of this policy by the Insurer or by the Insured.

Misstatement of Age: If the age of the Insured has been misstated, all amounts payable under this policy shall be such as the Premium paid would have purchased at the correct age.

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), performs an act, practice or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. 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.

You must contact the Marketplace if you would like to cancel your policy. When and how to end your Marketplace plan depends on your situation.

Renewability: SummaCare shall renew or continue in force such coverage at the option of the member. There are instances when coverage can be terminated based on the below occurrences:

- ☐ Non-payment of Premium (after a grace period has been given);
- ☐ Fraud or intentional misrepresentation of material fact;
- ☐ Movement outside the network Service Area;
- ☐ SummaCare discontinues a particular product;
- ☐ SummaCare is not required to renew coverage if an individual is not otherwise eligible for the coverage.

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 policy. See Section IX (Complaint Procedure).

VI. Covered Services

The following services are covered under your SummaCare HMO Plan. Coverage is provided subject to the Copayments, Coinsurance, limitations and exclusions that are specified in this booklet or your Schedule of Benefits. All services must be Medically Necessary and some services are subject to Prior Authorizations rules.

A. Outpatient/Facility Services Covered

1. Office visits to your Provider (primary Physician – includes pediatrician for a child and specialist), including physical exams, well child care, immunizations and other preventive health care services that are based on the recommendations of the United States Preventive Services Task Force. Services are covered to treat an Illness or Injury and include services provided by a nurse Practitioner. 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, appropriate immunizations, anticipatory guidance 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.
3. Lab and other diagnostic services including X-rays.
4. Medically Necessary surgical procedures and anesthesia that are Covered Benefits.
5. Office visits to medical or surgical specialists.
6. Urgent and Emergency care services. (Refer to Section VI, Subsection C (Coverage for Emergency Services/Urgent Care Situations) for more information)
7. Services for mental health and substance abuse detoxification/rehabilitation.
8. Allergy testing and treatment.
9. Physical, occupational and speech therapy.
10. Cardiac and pulmonary rehabilitation therapy/pulmonary therapies.
11. Outpatient facility fee, including services at a hospital or other alternative care facility or ambulatory surgical care center.

B. Inpatient Hospital Services Covered

1. Semi-private Room and Board; private room and Special Care Units if Medically Necessary and prior authorized by the SummaCare Health Services Management Authorization Unit.
2. Provider services related to medical treatment or surgery.
3. General nursing services.
4. Lab and other diagnostic services including X-rays.
5. Operating room, 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.
11. Mental health and substance detoxification/rehabilitation. Refer to your Schedule of Benefits for any benefit limitations.
12. For inpatient skilled nursing services.

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, that is 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 that are 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, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual or the health of a pregnant women or her baby in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

If you experience symptoms that meet the definition of an emergency, call 911 for emergency assistance or go to the nearest Hospital. The following basic health care services shall be covered:

- ☐ Emergency Services provided to you at a Participating Hospital’s emergency department if you present yourself with an Emergency Medical Condition;
- ☐ Emergency Services provided to you at a Non-Participating Hospital’s emergency department if you present yourself with an Emergency Medical Condition and one of the following circumstances applies:
 - Due to circumstances beyond your control, you were unable to utilize a network Hospital’s emergency department without serious threat to life or health;
 - A prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a network Hospital’s emergency department could result in one or more adverse health consequences;
 - A person authorized by SummaCare referred you to an emergency department and did not specify a network Hospital’s emergency department;
 - An ambulance takes you to a non-network Hospital, not at your request;
 - You are unconscious;
 - A natural disaster precluded the use of a network emergency department;
 - The status of a Hospital changed from in-network to out-of-network with respect to Emergency Services during a Calendar Year and no good faith effort was made by SummaCare to inform you of this charge.

If an Emergency Service meets any of these above circumstances, you cannot be balance billed.

In-network and out-of-network emergency care will be paid at the same cost share. A Non-Preferred Provider may send you a bill for charges remaining, called balance billing, after your Plan has paid the maximum allowed amount. 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 D, 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 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 continuation of care and it is Medically Necessary. Emergency room care non-emergent in nature is not covered. An 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 appropriate, 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 that requires 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.

Urgent Care Services must be received from an in-network provider or from a provider in our extended network of urgent care providers. Urgent Care Services from an out-of-network provider not in our extended network will be denied and you will be responsible for those services. Check the back of your Member ID card for more information on the extended network. Refer to your Schedule of Benefits for your Plan’s Copayments for Urgent Care Services.

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.

Non-network ambulance services may only be covered for emergencies or with Prior Authorization. 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 an approved Clinical Trial if the services are otherwise Covered Services under this policy and the Clinical Trial meets all the following criteria:

- ❑ The purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes or the treatment is given with the intention of improving the trial participant's health outcomes, and is not designed exclusively 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 cancer treatment;
 - 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 cancer treatment.
- ❑ The trial is approved by one of the following:
 - The National Institutes of Health (NIH), or one of its cooperative groups or centers under the United States Department of Health and Human Services (HHS);
 - The United States Food and Drug Administration (FDA);
 - The United States Department of Defense (DOD); or
 - The United States Department of Veteran's Affairs (DVA).

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 that is eligible for reimbursement by a person other than the Insurer, including the sponsor of the Cancer Clinical Trial.

3. Chiropractic Services/Osteopathic Manipulation Therapy

Services performed by a licensed chiropractor or a licensed Physician for osteopathic/chiropractic manipulation therapy. **The cost-sharing requirement, on a per day basis, for services rendered by a licensed chiropractor shall not be greater than the cost-sharing requirement for an office visit to a primary care physician or primary care osteopath physician.** Refer to your Schedule of Benefits for benefit limitations. Chiropractic services 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 of 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 the 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.

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

5. Diabetic Education and Testing Supplies

Medically Necessary diabetic education that includes nutritional counseling will be provided for an individual when the following conditions are met: ordered by a Physician and provided by a health professional who is licensed, registered or certified under state law who has obtained certification in diabetes education by the American Diabetes Association. Diabetic testing supplies and equipment are covered under this fully insured HMO policy under the DME benefit or your pharmacy benefit. Medically Necessary orthopedic/therapeutic shoes are also covered for diabetics.

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, certified nurse-midwife, clinical nurse specialist or certified nurse practitioner.

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 reasonable quantity limits for certain supplies, equipment or appliance described below.

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

Augmentative 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.

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

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 and is not considered 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. Hearing Aids

Coverage is provided for the full cost of both of the following without cost sharing:

- ☐ One hearing aid per hearing-impaired ear up to \$2,500 every 48 months for a covered person 21 years of age or younger who is verified as being deaf or hearing impaired by a licensed audiologist or by an otolaryngologist or other licensed physician. "Hearing aid" means any wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing, including all attachments, accessories, and parts thereof, except batteries and cords, that is dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an otolaryngologist;
- ☐ All related services prescribed by an otolaryngologist or recommended by a licensed audiologist and dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter. "Related services" means services necessary to assess, select, and appropriately adjust or fit a hearing aid to ensure optimal performance.

You may choose a higher priced hearing aid and pay the difference in cost above the \$2,500 required coverage required by this section without any financial or contractual penalty to you or to the provider of the hearing aid.

The plan is not required to pay a claim for the cost of a hearing aid if, less than 48 months prior to the date of the claim, you received the coverage required under Section 3902.64 (B) of the Ohio Revised Code from any health benefit plan. The plan shall only provide coverage for hearing aids considered medically appropriate to meet your needs, according to professional standards established by the state speech and hearing professionals board. The plan shall not exclude coverage for any hearing aid that would be considered medically appropriate to meet your needs, according to professional standards established by the state speech and hearing professionals board.

9. 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 ((Please refer to the "Services Provided by Relatives" entry in Section VII "General Exclusions" for more information).
- ☐ 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.

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.

10. 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.

11. 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.

12. 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.

13. 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.
- ☐ Electrocardiograms

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

14. 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 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.

15. Mental Health Services

SummaCare HMO 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 policy for the 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 policy 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.

Mental disabilities or autism services necessary to evaluate and diagnose mental disabilities or autism are excluded except as otherwise covered.

16. Physician Home Visits and Office Services

Covered Services include care provided by a Physician in their office or your home. Refer to the entries in this EOC 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 Section VI, Subsection C (Coverage for Emergency Services/Urgent Care Situations). 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

17. Podiatry Services

SummaCare HMO 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 "Foot Care" in Section VII (General Exclusions).)

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; cosmetic foot care are not covered.

18. Preventive Health Services

SummaCare HMO covers a variety of periodic health examinations that conform 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 Authorization Unit.
- ☐ 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 more information you may go to the federal websites at: <http://uspreventiveservicestaskforce.org/uspstf>.

19. Outpatient Rehabilitation Service/Habilitative Services

Rehabilitative services, including physical, occupational, speech, habilitative and cardiac/pulmonary therapies, will be covered. **The cost-sharing requirement, on a per day basis, for services rendered by an occupational therapist or physical therapist shall not be greater than the cost-sharing requirement imposed by the plan for an office visit to a primary care physician or primary care osteopath physician.** 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 gasses 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 those with a 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). Providers authorized to provide treatment for Autism Spectrum Disorder include a licensed Physician who is a developmental pediatrician, licensed psychologist trained in autism, clinical nurse specialist or certified nurse

practitioner specializing in pediatric health, or clinical nurse specialist or certified nurse practitioner trained in autism who determines the care and related equipment to be medically necessary, including clinical therapeutic intervention, pharmacy care, psychiatric care, psychological care or therapeutic care.

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 therapy 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 that are not related to restoration of a specific loss of function, but are for 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; adaptations 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.

20. 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 due to an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Mastectomy Notice:

A member who is 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 who elects 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.

21. Second Surgical Opinions

SummaCare HMO 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.

22. 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 Authorization Unit. 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.

23. Sterilization

Sterilization is a Covered Service. Reversal of elective sterilization is excluded.

24. 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 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 detoxification requires a Prior Authorization request and we process these requests in a timely manner 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 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.

25. 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.

26. Teladoc Visits

Teladoc allows for visits with Physicians or Providers via phone or video for non-emergency care 24 hours a day, 365 days a year. Covered Services include visits with a mental health provider or a board-certified internal medicine, pediatric or family medicine physician licensed in Ohio. Dermatologists licensed in Ohio are also available remotely for dermatological conditions. Cost share for Teladoc visits 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.

27. 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.

28. 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 be prior authorized.

29. 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 Authorization Unit 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 as to 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

30. 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 not Covered Services. Cost shares are based on where the transsexual surgery and related services are provided.

31. 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 $\geq \pm 6.00$ 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

Some plans cover adult routine vision hardware administered through VSP. Check your Schedule of Benefits to see if you receive this coverage. The covered hardware includes:

- ☐ \$100 allowance for covered hardware every other year;
- ☐ Allowance can be used toward lenses, frames and lens enhancements;
- ☐ Contact lenses (in lieu of frames).

Low Vision: Low vision is 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 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 the 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 or contact lenses for adults except as otherwise specifically stated as a Covered Service.

IMPORTANT: 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.

32. 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 that 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.

E. Covered 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 that 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 medical 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 not 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 his or her 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 5 for Standard plans and Tier 6 for Non-Standard plans 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 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 Section VII of this EOC (General Exclusions) 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 by going to our website at www.summacare.com. You may also call Member Services for assistance at 330.996.8671 or 833.443.0818 (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 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 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 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, as shown in the table below:

	Standard Plans* (5 Tiers)	Non-Standard Plans* (6 Tiers)
Tier 1 Prescription Drugs	This tier contains Zero Cost Share Preventive medications that have a \$0 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	This tier contains Zero Cost Share Preventive medications that have a \$0 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 generic medications	This tier contains preferred generic medications
Tier 3 Prescription Drugs	This tier contains preferred brand medications	This tier contains non-preferred, higher cost generic medications
Tier 4 Prescription Drugs	This tier contains non-preferred, higher cost brand medications	This tier contains preferred brand medications
Tier 5 Prescription Drugs	This tier contains specialty medications	This tier contains non-preferred, higher cost brand medications
Tier 6 Prescription Drugs		This tier contains specialty medications

*- Standard Plans include Standard Bronze, Standard Gold, Standard Silver, Standard Silver-73, Standard Silver-87 and Standard Silver-94. All other plans are considered Non-Standard Plans.

We have a Pharmacy and Therapeutics (P&T) Committee comprising SummaCare staff from our Pharmacy Department; health care professionals, including pharmacists; Physicians; and a patient representative. 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.

VII. General Exclusions

The following section indicates items excluded from benefit consideration and are not considered Covered Services. If the service is not covered but is considered Medically Necessary or a basic health care service, there may be coverage. SummaCare will be the final authority for determining if services or supplies are Medically Necessary.

A. SummaCare 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, bioenergetic 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 decreasing the size of the stomach) or gastric banding procedures. This exclusion does not apply to complications related to medically necessary basic health care services.

4. Charges for Forms or Missed Appointments

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 policy 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. This exclusion does not apply to complications related to medically necessary basic health care services.

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). This exclusion does not apply to complications related to medically necessary basic health care services.

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 EOC. "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. The only exceptions to this are for any of the following:
 - Transplant preparation;
 - Initiation of immunosuppressive,
 - Direct treatment of acute traumatic Injury;
- ☐ Align the dentition within the dental arch, level the curve of SPEE and decompensate the 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 that is 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 EOC. 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 that is 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 II.

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 EOC. 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 that 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 that 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 or 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 by a government body or agent. Refer to the pediatric vision benefit in your Summary 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 EOC; 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 metabolic 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 EOC. 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 that 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 for the reason that the member is under Confinement or is otherwise under the 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 EOC 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 Section VI, Subsection E (Covered Prescription Drug Benefits) 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

- ☐ Experimental and Investigational Indications;
- ☐ Orthognathic surgery for cosmetic and psychological purposes;
- ☐ Orthognathic surgery for speech impairments or articulation disorders in lip or palate conditions;
- ☐ 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 the treatment of 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 policy 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 policy 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 listing in Section VI, Subsection D for private duty nursing in a home setting which is a covered benefit.

36. Reconstructive Services

Reconstructive services except as specifically stated in Section VI (Covered Services) of this EOC or as required by law.

37. Rehabilitation Services

Conditions such as behavioral speech disorders, learning disorders, stuttering, slow speech development, chronic muscle imbalance and language therapy unless covered under the Habilitative Benefit criteria. 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 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; diaphoresis; 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; adaptations to the home such as ramp ways, door widening, automobile adaptations, kitchen adaptation and other types of similar equipment.

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

Pulmonary Rehabilitation - 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.

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

Rest cures, travel, recreation or diversion therapy, even though prescribed by a Provider. Care provided 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 treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement. 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

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, however, will 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 Authorization Unit 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 EOC. 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 policy.

VIII. SummaCare Claims

A. The Usual Procedure

You usually do not have to complete and submit claim forms. Your SummaCare Provider will submit claims 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 get a bill for services from your PCP or from another preferred Physician, Practitioner or other Provider, send the bill to SummaCare, including your member information. You do not have to complete a claim form. You may receive an explanation of benefits (EOB) detailing how much we have paid for the care you received. For contracted Providers there is a one-year filing period to submit your claims.

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

Under this Plan, you must pay for services that are received but not covered under this Plan.

In the event that SummaCare becomes insolvent, you may be responsible for paying for health care services given by a Physician, Practitioner or other Provider or health care facility not under contract with SummaCare. It does not matter if SummaCare authorized the use of this Physician, Practitioner or other Provider or health care facility.

B. Emergency/Urgent Care

In the event of an emergency or urgent care situation, if you receive services from a Physician other than a SummaCare Provider, you may have to pay for those services at the time of service and submit the claim to us. You can obtain claim forms at www.summacare.com. You must attach the doctor and Hospital bills from the Non-SummaCare Provider to your claim form. Refer to Section VI, Subsection C for more information on Emergency/Urgent Care.

C. When Copayments Apply

Your SummaCare Plan 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 your PCP.

Copayments must be reasonable and may not be a barrier to the necessary utilization of services. To ensure Copayments are reasonable and not a barrier to the utilization of basic health care services, we may impose Copayment charges that annually do not exceed 20 percent of the total annual cost to us of providing all covered basic health care services, including Physician office visits, urgent care services and emergency health services, when aggregated as to all persons covered. The total annual cost of providing a health care service is the cost to SummaCare of providing the health care service to our member as reduced by any applicable Provider Discount.

D. Notice of the Claim

We must receive written notice that Covered Services have been given to you in the form of a claim. There is a one-year filing limit from the date of service for the filing of the claim. If the claim submitted does not include sufficient data to process the claim, then 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.

E. Claim Forms

Claim forms are available at www.summacare.com. Forms will also be available at Preferred Provider offices and Preferred Providers will bill us. Information that needs to be included with the claim form includes:

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

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 our receipt of all requested information. If we are unable to complete processing of a claim because 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. 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.

G. 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 Section IX (Complaint Procedure) of this EOC.)
- 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 EOC. If your claim has been denied since 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 1.800.686.1526

Complaints may be filed via the internet at <http://insurance.ohio.gov>

IX. Complaint Procedure

If you are not happy with a decision about a claim, or have another complaint, you can call Member Services at 330.996.8671 or 833.443.0818 (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 five business days.

If you are still not happy, you can pursue your complaint through one of SummaCare's two formal complaint processes. They are the Grievance and the Appeal processes. The Appeal Process is 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 on the following pages.

Grievances

If you are not happy with the care or service you receive from SummaCare or any of our contracted Providers, you may direct 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 office staff;
- ☐ You believe the medical care you received from a SummaCare Provider was not correct;
- ☐ You believe a SummaCare employee has violated your privacy rights.

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.

You must file your grievance within 180 days of 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 satisfied 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 1.800.686.1526 or 614.644.2673.

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 it electronically to appeals@summacare.com.

Please call SummaCare Member Services at 330.996.8671 or 833.443.0818 (TTY: 711) between 8:30 AM and 5:30 PM for assistance. Outside these hours, you may leave us a message and a representative will return your call the next business day. 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 of 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 that are 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, of the date we received your first appeal letter or as fast as is Medically Necessary.

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 the following:
 - A determination that 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 that is 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 that is 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, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- ❑ Serious impairment to bodily functions; or
- ❑ 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 condition of the Covered Person;
 - 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 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 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, that 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 that, 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 the following 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; and
- ☐ 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 that is 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 330.996.8671 or 833.443.0818 (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:

ATTN: Consumer Affairs
Ohio Department of Insurance
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 we receive it after 180 days have passed since the denial leading to your appeal.

Appeals by Members of ERISA Plans

If you are covered under a Group Plan which is 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).

X. 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 Evidence of Coverage. 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 on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- ❑ 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 on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the allowable expense for all Plans. If the Provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary Plan to determine its benefits.
- ❑ 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 have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.
6. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

B. Order of Benefit Determination Rules

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

1. The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
2. (a) Except as provided in paragraph (b), a Plan that does not contain a Coordination of Benefits provision that is consistent with this regulation is always primary unless the provision of both Plans state that the complying 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 that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base Plan Hospital and surgical benefits, and coverage that is written in connection with a closed panel Plan to provide out-of-network benefits.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. Each Plan determines its order of benefits using the first of the following rules that apply:
 - (a) **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent – for example as an employee, member, subscriber or retiree – is the primary Plan, and the Plan that covers the person as a dependent is the secondary Plan. However, 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, 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 a court decree states both parents are responsible for the dependent child's health care expenses or health care coverage, the provision stated above (i) shall determine the order of benefits;
 - c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provision stated in (i) above shall determine the order of benefits;
 - d. 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 provisions above shall determine the order of benefits as if those individuals were the parents of the child.
- (c) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the primary Plan. The Plan covering that same person as a retired or laid-off employee is the secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.
- (d) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (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, 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” 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, 330.996.8671 or 1-833.443.0818 (TTY: 711) or www.summacare.com, and initiate your appeal rights as stated in the Evidence of Coverage. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1.800.686.1526 or visit the Department’s website at www.insurance.ohio.gov.

H. Integration with Medicare

Any benefits covered under both this SummaCare HMO 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, EOC 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 policyholder, 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.

XI. 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 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-employee 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.

Annual Open Enrollment

The annual period during which an individual may enroll himself or herself and his or her eligible dependents in the 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.

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.

Basic Health Care Services

The following services when medically necessary are considered Basic Health Care Services: physician's services, except when such services are supplemental; inpatient hospital services; outpatient medical services; emergency health services, urgent care services; diagnostic laboratory services and diagnostic and therapeutic radiologic services; diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses; preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care and well-child care; and routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to Ohio Revised Code Section 3923.80. Basic Health Care Services does not include experimental procedures.

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.

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.

Coordination of Benefits

The provision that applies when a person is covered under more than one group and/or individual medical Plan. 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 that a Covered Person must pay directly to the Physician, Practitioner or other Provider for certain Covered Services (in addition to Premiums). Note: Copayments for services that are basic health care services will not exceed 30 percent of the total cost of the service, except for Physician office visits, emergency health services and urgent care services.

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 and is eligible for and receives Covered Benefits under the Plan.

Covered Services

The healthcare services and items described in this booklet and updated in the Schedule of Benefits, for which SummaCare provides benefits to Covered Persons.

Creditable Coverage

The period of an individual's coverage under an Individual Marketplace Plan, health insurance, Medicare or any of several other specified health Plans or health insurance sources not interrupted by a 63-day break in coverage.

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 of the following criteria:

- (a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- (b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- (c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- (d) The trial does one of the following:
 - (i) Tests how to administer a health care service, item, or drug for cancer treatment;
 - (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 cancer treatment.
- (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 member or the member's spouse or child who meets the eligibility requirements specified in Section II (Who is Eligible for SummaCare).

Emergency Medical Condition

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 impairment to body functions; or serious dysfunction of any body organ or part.

Emergency Services

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

Episode of Illness or Injury

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

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 that the facility is licensed in the state in which the facility 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

Health care services and supplies you receive in your home under your Provider's orders, not including non-medical tasks such as cooking, cleaning and driving. Service may be provided by nurses, therapists, social workers or other licensed health care Providers.

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 staying in a Hospital if he or she did not have the care and treatment stated in the Plan. The Home Health Care Plan is subject to review and prior approval by the SummaCare Health Services Management Authorization Unit.

Hospice

A coordinated plan of home, inpatient and outpatient care which provides palliative and supportive medical and other health services to terminally ill patients.

Hospice Care Agency

An agency or organization properly licensed in the state in which it operates, has terminal care available 24 hours a day, 7 days a week and provides or arranges for Hospice Care services or supplies.

Hospice Care Plan

A Plan that is supervised by a Participating Physician and involves a team consisting of:

- ☐ A Participating Physician who provides Hospice Care;
- ☐ Licensed nurses;
- ☐ A licensed mental health specialist;
- ☐ 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 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 the required standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

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

- ☐ 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 that requires treatment of a Physician. This definition also includes pregnancy.

Injury

Any bodily damage or harm sustained while the person is covered under the Plan and that requires treatment by a Physician.

Insured

A person protected by an insurance policy.

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 based on generally accepted current medical practice. The fact any 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 as 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 that is needed to provide safe, adequate and appropriate diagnosis or treatment.

Medicare

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

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

Participating Physician, Practitioner or Other Provider

Any Physician, Hospital, or other health services Physician, Practitioner or other Provider who has a contract with SummaCare to provide Covered Services to Covered Persons.

Physician

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

Plan

The SummaCare Plan of health benefits described in this booklet and the Schedule of Benefits.

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.

Premiums

The monthly charge for the coverage provided by SummaCare.

Primary Care Physician

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

A decision by SummaCare that a Covered Service, treatment plan, prescription drug or durable medical equipment is Medically Necessary. SummaCare may require Prior Authorization for certain Covered Services before you receive them, except in an emergency.

Provider

A person or organization responsible for furnishing health care services, including a Hospital, Skilled Nursing Facility, rehabilitation facility, ambulatory surgery center or Physician.

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. Determination of whether or not a charge is Reasonable and Customary will be made by SummaCare.

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

Savings Account

Includes Health Savings Accounts, health reimbursement arrangements, Flexible Savings Accounts, Medical Savings Accounts and similar accounts and arrangements.

Schedule of Benefits

A Schedule of Benefits insert included with this booklet provides information on the limits and maximums of the Plan and Copayment amounts that 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.

Service Area

The geographic area within which Summa Insurance Company is licensed and arranges for the provision of Covered Services by contracting with Providers. The Service Area comprises Medina, Portage, Stark and Summit counties in Ohio.

Skilled Nursing Facility

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

- ☐ Maintains permanent and full-time facilities for bed care of 10 or more resident patients;
- ☐ The 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; 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.

Special Care Units

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

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

Subrogation

The procedure that an insurance company follows to recover from a third party all or part of the benefits paid to an Insured.

Telemedicine

Health care services provided through the use of information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where either of the following is located:

- ☐ The patient receiving the services;
- ☐ Another health care professional with whom the Provider of the services is consulting regarding the patient.

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 contract to reimburse for covered health care services to beneficiaries under the contract.

You, Your

A covered individual or relating to a covered individual.

OBLIGATIONS OF SUMMACARE AND PARTICIPATING PHYSICIAN, PRACTITIONER OR OTHER PROVIDERS

In accordance with the agreement between SummaCare and its Participating Physicians, Practitioners or other Providers, they will not seek compensation from you for any of the Covered Services and supplies described in this booklet or your Schedule of Benefits except for approved Deductibles, Copayments and/or Coinsurance. You are protected from Physicians, Practitioners or other Providers seeking redress from you to the extent of the Hold Harmless Agreement below. You will be notified if a Participating Hospital's or your PCP's agreement with SummaCare ends. Notification will be mailed within 30 days of the termination if you have selected that PCP within the previous 12 months. You will continue to receive Covered Services and supplies as outlined in this booklet and the Schedule of Benefits between the date the Hospital's or your PCP's agreement ends and five business days after notification is mailed to you at your last known address.

You will also be notified by mail within 30 days if a SummaCare agreement with a Hospital ends if you or a dependent have used the Hospital directly within the 12 months preceding termination of the agreement. SummaCare will pay for Covered Services received between the date the Hospital agreement ends and five business days after notification is mailed to you at your last known address. We will allow you to continue an active course of treatment until the treatment is complete or after 90 days, whichever is shorter, at Preferred Provider cost-sharing rates. An active course of treatment includes: (a) 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; (b) 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; (c) the second or third trimester of pregnancy; (d) an ongoing course of treatment for a health condition for which a health care Provider attests discontinuing care would worsen the condition or interfere with anticipated outcomes; or (e) 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.

In the event SummaCare is discontinued, we have arranged for all Covered Services and supplies described in this booklet and your Schedule of Benefits to be provided to you until the coverage would otherwise have ended under your health contract. Such health care coverage may be provided through any one or more of the following methods: (a) insolvency insurance; (b) provisions in Participating Physician, Practitioner or other Provider agreements; (c) agreements with other organizations or Insurers providing automatic conversion rights upon discontinuation of the Plan; and/or (d) other arrangements approved by the Superintendent of Insurance. For more information, call Member Services at 330.996.8671 or 833.443.0818 (TTY: 711).

In the event SummaCare is insolvent, you may have to pay for Covered Services you receive from a Provider or health care facility that is not under contract with us even if we authorized the use of the Provider or facility.

Hold Harmless Agreement

SummaCare's contracts with Providers require that in no event, including but not limited to, nonpayment by SummaCare, insolvency of SummaCare, or breach of this agreement, shall a Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a subscriber, member, person to whom health care services have been provided, or persons acting on behalf of the covered member, for health care services provided pursuant to this agreement. This does not prohibit a Provider from collecting Deductibles, Coinsurance, or Copayments as specifically provided in the Evidence of Coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against SummaCare or its successor.

FRAUD WARNING

Any person who, with intent to defraud or knowing he 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.

Important Phone Numbers

SummaCare Member Services

(Open from 8:30 a.m. to 5:30 p.m., Monday through Friday)

330.996.8671

833.443.0818

(TTY: 711)

SummaCare 24-Hour Nurse Line

800.379.5001