

The Cleveland Clinic Health Systems Employee Medical Benefit Plan

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Effective: January 1, 2001
Restated: January 1, 2010

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**ESTABLISHMENT OF THE PLAN
ADOPTION OF THE SUMMARY PLAN DESCRIPTION**

THIS SUMMARY PLAN DESCRIPTION, made by the Company, as the Plan Sponsor, as of January 1, 2010, hereby amends and restates the Plan, which was originally adopted by the Company, effective January 1, 2001.

Effective Date

This Summary Plan Description is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as with respect to the Employees covered by such agreement (the "Effective Date").

Adoption of the Summary Plan Description

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Summary Plan Description as the written description of the Plan, which amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan. This Summary Plan Description represents both the Plan Document and the Summary Plan Description which is required by ERISA.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Summary Plan Description to be executed.

The Cleveland Clinic Health System

By: _____

Name: _____

Title: _____

Date: _____

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, on the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor or may be funded solely from the general assets of the Plan Sponsor. Covered Persons in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Summary Plan Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Summary Plan Description is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for medical benefits.

General Plan Information

Name and Type of Plan:	The Cleveland Clinic Health System Employee Benefit Plan
Plan Type:	Exclusive Provider Organization (EPO) Medical
Plan Sponsor:	The Cleveland Clinic Health Systems 9500 Euclid Avenue Cleveland, Ohio 44195
Plan Administrator: (Named Fiduciary)	The Cleveland Clinic Health Systems Plan Administrator 9500 Euclid Avenue Cleveland, Ohio 44195
Type of Plan Administration:	The Plan is managed by the Plan Administrator, with certain ministerial services being provided by the Third Party Administrator.
Third Party Administrator:	Apex Benefits Services, LLC. P.O. Box 3620 Akron, OH 44309-3620 (330) 996-8515
Funding and Source of Contributions:	The Plan is a self-funded plan, with funds provided by the Plan Sponsor.
Plan Year:	January 1st through December 31st
Plan Sponsor Employer Identification Number (EIN):	34-0714585
Agent for Service of	The Cleveland Clinic Health Systems

Process: **Plan Administrator**
9500 Euclid Avenue
Cleveland, Ohio 44195

Participating Employers: **The Cleveland Clinic Health Systems**

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Summary Plan Description and any amendments constitute the terms and provisions of coverage under this Plan. The Summary Plan Description shall not be deemed to constitute a contract of any type between the Company and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Summary Plan Description shall be deemed to give any employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any employee at any time.

DEFINITIONS

The definitions provided below may make it easier for you to understand the words used in this Summary Plan Description. The terms listed, if used, will have the following meanings. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Summary Plan Description for that information.**

Accident

"Accident" shall mean a sudden, unforeseen and unexpected event caused by external trauma to the body.

Actively At Work or Active Employment

"Actively At Work" or "Active Employment" shall mean performance by the Employee of all the regular duties of his occupation at an established business location of the Participating Employer, or at another location to which he may be required to travel to perform the duties of his employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. In no event will an Employee be considered Actively at Work if he has effectively terminated employment.

Activities of Daily Living

"Activities of Daily Living" shall mean the skill and performance of physical and psychological/emotional self care, work and play/leisure activities to a level of independence appropriate to age, life-space and disability.

Acute Medical Condition

"Acute Medical Condition" shall mean a condition or symptom that is of such severity that it does in fact constitute an extremely hazardous medical condition that would result in jeopardy to the Covered Person's life or cause serious harm to his health if not treated immediately by a Provider.

Annual Open Enrollment Period

"Annual Open Enrollment Period" shall mean the annual period during which an Employee who is Actively At Work may enroll himself and his Eligible Dependents in the Plan.

Annual Out-of-Pocket Maximum

"Annual Out-of-Pocket Maximum" shall mean your share in the cost of Eligible Expenses is limited to the annual out-of-pocket maximum listed in the Schedule of Benefits. Only out-of-pocket expenses paid for care managed by your PCP will apply toward the Network annual out-of-pocket maximum.

Calendar Year

"Calendar Year" shall mean a period of one year beginning with January 1st and ending December 31st.

Certificate of Coverage

"Certificate of Coverage" shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Chiropractic Services (Musculoskeletal Care)

"Chiropractic Services (Musculoskeletal Care)" shall mean the actual services provided by a chiropractor for examinations, laboratory and X-rays, spinal manipulation therapy (defined as the manual manipulation of the spine to restore mobility to the joints and to allow vertebrae to assume their normal position), and other modalities of treatment.

Coinsurance

"Coinsurance" shall mean the percentage of Eligible Expenses which you must pay. For example, if the Coinsurance is 70% under the Plan, it means that the Plan will pay 70% of the Eligible Expenses and you will pay 30%.

Company

"Company" shall mean The Cleveland Clinic Health Systems.

Co-payment

"Co-payment" shall mean the amount that you must pay for Eligible Expenses. For example, if the Co-payment is \$10 under the Plan, this means that the Plan will cover the cost at 100%, after you pay \$10. Note: Co-payments do not apply toward the out-of-pocket maximum.

Covered Person

"Covered Person" shall mean an Employee or Eligible Dependent who enrolls, becomes covered and remains covered under this Plan, continuing to meet the Plan's eligibility requirements.

Custodial Care

"Custodial Care" shall mean care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Deductible Amount

"Deductible Amount" shall mean the amount of Eligible Expenses you must pay out-of-pocket each Calendar Year, before the Plan's coverage begins.

Eligible Dependent

"Eligible Dependent" shall mean:

1. Your wife or husband to whom you are lawfully wed and with respect to whom you possess a valid marriage license;
2. Your domestic partner, based upon the following criteria:
 - a. You are each of the same gender.
 - b. You are 18 years of age or older and mentally competent to enter into contracts.
 - c. You reside in the same household with each other.
 - d. You have been in a committed relationship with each other for at least six months, intend to remain in such relationship indefinitely and have no such relationship with anyone other than each other.
 - e. You have joint responsibility for each other's welfare and financial obligations.
 - f. You are not related by blood to a degree that would prohibit marriage under the law of the state in which you reside.
 - g. You are not currently married to any other person under either statutory or common law.

In order to enroll your domestic partner in the EHP, you and your domestic partner must sign an *Affidavit of Domestic Partnership*. Under current Federal and State law, the amount you pay towards the cost of domestic partner coverage must be made on an after-tax basis. Additionally, the full cost of benefits coverage for your domestic partner, less the amount of your after-tax contribution, is added to your income and subject to ordinary Federal, FICA, State, local and any other applicable payroll taxes. This amount of additional taxable income will be shown on your paychecks and reported on your W-2 at the end of the year.

Children of your domestic partner are not eligible for Domestic Partner Benefits;

3. Your unmarried children under age 23;
4. Your unmarried children 19 years or older, provided they are dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must be allowed to declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including tax records. Eligibility terminates when the individual is no longer dependent upon the Employee or at the end of the month in which the child reaches age 23;
5. Your unmarried children 23 years or older, provided they are dependent upon you and, upon attainment of age 23 are mentally or physically incapable of self-support as determined by the Plan Administrator. Eligibility terminates when the individual is no longer mentally or physically incapable of self-support; or
6. A child placed with you for adoption when you have a legal obligation for support. Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

The word "child" or "children" in addition to your natural children includes stepchildren, foster children, legally adopted children, and children for whom you have legal guardianship, all of whom are unmarried.

Eligible Expense

"Eligible Expense" shall mean a charge less than or equal to the Maximum Allowable Charge (with respect to charges by Network Providers) or the Plan's Reasonable and Customary Charge (with respect to Non-Network Providers) that is Incurred by a Covered Person for services and supplies that are:

1. Recommended by a Physician;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Provided after the effective date of coverage under the Plan and prior to the termination of coverage under this Plan; and
4. Are not otherwise excluded from coverage in this Summary Plan Description.

Emergency

"Emergency" shall mean 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 any of the following: placing the health of the individual 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 body part.

Emergency Care Center

"Emergency Care Center" shall mean a public or private establishment with an organized staff of Physicians and with permanent facilities equipped primarily to provide immediate Emergency Accident care and non-acute medical care.

Employee

"Employee" shall mean a person who is a regular full-time Employee of the Participating Company, regularly scheduled to work for the Participating Company in an employer-employee relationship. Such person must be scheduled to work at least 36 hours per week in order to be considered "full-time", or at least 20 hours per week in order to be considered "part-time".

ERISA

"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

Experimental

"Experimental" shall mean services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

Drugs are considered Experimental if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Family Coverage

"Family Coverage" shall mean coverage for you and one or more of your Eligible Dependents.

HIPAA

"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Aide

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

Home Health Care Agency

"Home Health Care Agency" shall mean a public or private agency or organization, or part of one, that primarily 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 Covered Persons. 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

"Home Health Care Plan" shall mean a plan for continued care and treatment of a Covered Person in his home. To qualify, the plan must be established in writing by a Physician who certifies that the Covered Person would require confinement in a Hospital if he did not have the care and treatment stated in the plan. The Home Health Care Plan is subject to review and approval by the Medical Management Program.

Hospice Care Agency

"Hospice Care Agency" shall mean an agency or organization that is properly licensed in the state in which it operates, has hospice care available 24 hours a day, 7 days a week, and provides or arranges for hospice care services or supplies.

Hospice Care Plan

"Hospice Care Plan" shall mean a plan that is supervised by a Physician and involves a team consisting of:

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

The Hospice Care Plan must provide for:

1. The Covered Person's plan of care;

2. Regular reviews of the Covered Person's care;
3. Informing the proper persons of any change in the Covered Person's condition; and
4. Complying with governmental regulations.

Hospice Facility

"Hospice Facility" shall mean a facility that is properly licensed in the state in which it operates and is engaged primarily in providing palliative care to terminally ill Covered Persons.

Hospital

"Hospital" shall mean an acute care medical facility equipped to handle all regular medical and surgical cases. U.S. Veteran's Hospitals are included when the veteran is treated for non-military service-related medical conditions and is legally responsible for charges Incurred. It does not include a psychiatric Hospital unless specifically approved by the Plan Administrator. Further, the term does not include an institution which is principally a rest home, nursing home or home for the aged, or an institution primarily engaged in rehabilitation or the care and treatment of drug addicts or alcoholics.

Illness

"Illness" shall mean any physical or mental sickness or disease that manifests treatable symptoms and that requires treatment of a Physician or other Provider. This definition also includes pregnancy.

Incurred

"Incurred" shall mean that an Eligible Expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Eligible Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Eligible Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury

"Injury" shall mean an Accidental bodily injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

Inpatient

"Inpatient" shall mean a Covered Person is treated in a Hospital as a registered bed patient, incurring a charge for Room and Board, upon the recommendation of a Physician.

Mastectomy

"Mastectomy" shall mean the surgical removal of all or part of a breast.

Maximum Allowable Charge

"Maximum Allowable Charge" shall mean, with respect to a charge by a Network Provider, the charge that is established by an agreement between the Plan and the Network Providers.

Maximum Lifetime Benefit Amount

"Maximum Lifetime Benefit Amount" shall mean the maximum benefits that the Plan will pay for all services received during a Covered Person's lifetime.

Medical Management Program

"Medical Management Program" shall mean a Physician-directed program whose goal is to work with Providers and Covered Persons to achieve efficient and appropriate utilization of health care resources.

Medically Necessary

"Medically Necessary" shall mean services or supplies received while a Covered Person, which are determined by the Plan to be:

1. Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the Illness or Injury;
2. Provided for the diagnosis or direct care and treatment of the Illness or Injury;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for the convenience of the Covered Person, the Covered Person's Physician or another Provider; and
5. The most appropriate supply or level of service which can safely be provided.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

Network

"Network" shall mean the SummaCare Network with the exception of The University Hospital along with affiliated physicians and ancillary providers. For Emergency and Urgent Care only when you are outside of the SummaCare Network you may utilize providers contracted with PHCSD and MultiPlan. For a provider listing please visit www.summacare.com or call Customer Service at (330) 996-8515 or (800) 753-8429.

Network Facility

"Network Facility" shall mean any facility listed in the Network Provider Directory.

Network Provider

"Provider" shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility listed in the Network Provider Directory, or approved by the Plan Administrator.

Outpatient

"Outpatient" shall mean a Covered Person is 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.

Outpatient Day Treatment

"Outpatient Day Treatment" shall mean care received at an approved behavioral health center which is less than four hours in duration within a 24-hour period. Care longer than four hours in duration in a 24-hour period will be considered Inpatient treatment.

Physician

"Physician" shall mean a legally qualified person acting within the scope of his license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Chiropractic (D.C.) or Doctor of Podiatric Medicine (D.P.M.).

Plan

"Plan" shall mean The Cleveland Clinic Health Systems Medical Plan.

Plan Year

"Plan Year" shall mean a period of one year beginning January 1st and ending December 31st.

Primary Care Physician (PCP)

"Primary Care Physician (PCP)" shall mean the Network family practice, internal medicine or pediatric Physician a Covered Person chooses to be his personal Physician.

Provider

"Provider" shall mean a person or organization responsible for furnishing health care services, including a Hospital; Physician; Doctor of Dental Surgery (D.D.S.); Doctor of Podiatry (D.P.M.); Licensed Clinical Psychologist (Ph.D.); Certified Nurse Midwife acting within the scope of his license under the direction and supervision of a licensed Physician; Licensed Physical Therapist (L.P.T.), Licensed Occupational Therapist (L.O.T.), Licensed Speech Therapist (L.S.T.), Licensed Independent Social Worker (L.I.S.W.), Licensed Professional Clinical Counselor (L.P.C.C.), Certified Chemical Dependency Counselor (C.C.D.C.) or Certified Alcohol Counselor (C.A.C.) acting within the scope of his license and performing services ordered by a Doctor of Medicine or Doctor of Osteopathy.

Room and Board

"Room and Board" shall mean 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.

Skilled Nursing Facility

"Skilled Nursing Facility" shall mean a facility, either freestanding or part of a Hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in a Hospital.

Special Care Units

"Special Care Units" shall mean specific Hospital units that provide concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant and continuous attention. This term includes intensive care, coronary care and acute care units of a Hospital but does not include surgical recovery areas or post-operative rooms. The unit must meet the required standards of the Joint Commission on Accreditation of Health Care Organizations for Special Care Units.

Summary Plan Description

"Summary Plan Description" shall mean this Plan Document and Summary Plan Description, which shall represent both the Plan Document and the Summary Plan Description, which is required by ERISA.

Urgent Care

"Urgent Care" shall mean treatment rendered outside the Physician's office for health problems that require immediate medical attention but are not life- or limb-threatening emergencies.

Waiting Period

"Waiting Period" shall mean the period of time, if any, for which you must be in the continuous, Active Employment of the Participating Employer, in an eligible Employee class before you become eligible for coverage under the Plan.

UNDERSTANDING THE PLAN

This Summary Plan Description has been developed to make it easy to understand the benefits that are provided by the Plan. If you have any questions regarding the Plan, please contact Customer Service at (330) 996-8515 or (800) 753-8429 for information.

How the Plan Works

Some of the most effective health care is care that is managed by a single Physician - one who knows you and works with you to maintain your good health. **The Plan recommends that you select a Primary Care Physician (PCP) listed in the Network Provider Directory to be your personal physician. This is the physician you will visit for most of your health care needs. If your PCP determines that you require care from a specialist, need surgery, or should be admitted to the Hospital or some other facility, he will refer you to an appropriate source for that care and obtain any necessary prior authorization.**

By selecting a PCP to manage all of your health care needs, you will feel secure knowing that a single, trusted Physician is managing your health care. In addition to selecting a PCP for yourself, each of your Eligible Dependents may select the same or a different PCP to provide his care.

Payment Level

When your care is managed by your PCP and is provided by a Network Provider, benefits will be paid by the Plan as set forth in the Schedule of Benefits. For almost all types of office visits managed by your PCP, coverage will be 100% of the Eligible Expenses after you make a small office visit Co-payment. Inpatient Hospital charges are covered at 100%, and there is no Deductible Amount for you to meet, when your PCP coordinates your admission to the Hospital. In addition, Network Providers have agreed to accept the Maximum Allowable Charge as full payment for their services. You are responsible for any Co-payments, but you are not required to pay the Provider any amount over the Maximum Allowable Charge. **If your care is not managed by your PCP and provided by a Network Provider, no benefits will be payable under the Plan and you will be responsible for the entire cost of that care.**

Claim Forms

Along with limited out-of-pocket expenses, you enjoy another advantage when your selected PCP manages your medical needs: **when coverage under this Plan is primary**, you do not have to fill out claim forms -- your Network Provider submits claims for you. **However, if you or your Eligible Dependents have other primary coverage through another plan, you must first submit a claim form to obtain benefits under that primary coverage (see Coordination of Benefits Section).** Some providers may submit these forms for you.

Specialized Care

If you require specialized care, your PCP can refer you to a specialist who participates in the Network. If the medical care you need is not available from a Network Provider, your PCP, working with the Plan's Medical Management Program, will coordinate your referral to the Provider most qualified to take care of your condition. This includes qualified Providers throughout the United States. If your PCP refers you to the specialty Provider because that care is not available from a Network Provider and coordinates the referral with the Plan's Management Program, visits to specialty Providers will be covered at 100% after paying the appropriate Co-payment. All other Plan provisions, limitations and exclusions still apply.

Emergency Care

Emergency and ambulance services provided in the event of a life- or limb-threatening Injury do not need to be initially coordinated by your PCP to receive full coverage. However, we recommend you notify your PCP within 48 hours of your Emergency care visit to arrange follow-up care. Emergency and ambulance services from both Network and Non-Network Providers will be covered at 100% after a Co-payment, if they are determined to be Medically Necessary and meet the definition of an "Emergency."

Prior authorization

An important feature of the Plan is providing medical care in the setting that is appropriate for your symptoms or condition, and at the same time, is cost efficient -- such as Outpatient versus Inpatient treatment. The Plan's Medical Management Program uses prior authorization and case management procedures to accomplish this. The Medical Management Program uses both local and national medical standards for health services utilization in managing the prior authorization of Inpatient and Outpatient services to make sure that your Network plan pays only for care that is Medically Necessary.

You don't have to worry about obtaining any necessary prior authorization for a Hospital admission, Outpatient surgery or other service, when these are managed by your PCP. Your PCP will coordinate any necessary prior authorization directly with the Plan's Medical Management Program. In addition, if you are pregnant, your Network Physician is responsible for notifying the Plan of your anticipated delivery date. This approach to delivering health care allows your Physician and the Plan to work together to provide you with quality, cost-effective medical care. Remember, **if you do not coordinate care requiring prior authorization through your PCP, no benefits will be payable under the Plan and you will be responsible for the entire cost of that care.**

Free Choice of Physician and Treatment

The Covered Person shall have free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. The Covered Person, together with his Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of such care. Providers who are members of any network used by the Plan are merely independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Provider. The Plan shall not be liable for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any officer or Employee or on the part of any Physician in the course of performing services for Covered Persons.

ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage

To be eligible for coverage under the Plan, you must meet the Plan's definition of "Employee," have elected to participate in this Plan and have paid your required contribution. If you are a new Employee, benefits will become effective on the date of hire.

Eligibility for Family Coverage

Each Employee will become eligible for coverage under this Plan for his Eligible Dependents on the latest of the following dates:

1. His date of eligibility for coverage for himself under the Plan;
2. The date coverage for his Eligible Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he acquires an Eligible Dependent.

In no event will coverage for your Eligible Dependents become effective before your coverage becomes effective.

Your newborn is not automatically enrolled in the Plan at birth. After the birth, you must complete paperwork and submit it to the Company's Human Resources Department within 31 days of the date of birth or your newborn will not be covered under the Plan. Your next opportunity to enroll your newborn will be at the next Annual Open Enrollment Period.

In no event will any child be covered as an Eligible Dependent of more than one Employee who is covered under the Plan.

Genetic Information Nondiscrimination Act (GINA)

Individuals will be protected from discrimination in health plans on the basis of their genetic information. The Plan will not discriminate against individuals based upon their genetic information, which includes information about genetic tests, the genetic test of family members and the manifestation of a disease or disorder in family members. In addition, genetic information will be considered "health information" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Enrolling in the Plan

If you wish to secure Plan coverage for yourself or yourself and your dependents, you must submit a fully completed enrollment application within 31 days of your eligibility date or during the Plan's Annual Open Enrollment Period which is held each year during the month of November. Otherwise, you must wait until the next Annual Open Enrollment Period to apply for coverage under the Plan. Coverage for individuals enrolling during an Annual Open Enrollment Period will become effective on January 1, unless the Employee has not satisfied the Waiting Period, in which event coverage for the Employee and his Eligible Dependents will become effective on the day following completion of the Waiting Period.

Special Enrollment

- **Special Enrollment for Individuals Losing Coverage**

An Employee is entitled to enroll in the Plan during a Special Enrollment Period if he meets all of the following requirements:

1. The Employee is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee previously declined to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage; and

3. The Employee was covered under such alternative group or other health coverage at the time he signed the waiver, and such coverage is no longer available, for any of the reasons set forth below.

An Eligible Dependent is entitled to enroll in the Plan during a Special Enrollment Period if he meets all of the following requirements:

1. He is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee, the Eligible Dependent or another appropriate person previously declined, on the Eligible Dependent's behalf, to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage; and
3. The Eligible Dependent was covered under such alternative group or other health coverage at the time he signed the waiver, and such coverage is no longer available, for any of the reasons set forth below.

Coverage (other than COBRA continuation coverage) will be considered no longer available when it terminates because of Loss of Eligibility or termination of Company contributions toward the cost of such coverage. COBRA continuation coverage will be considered no longer available when the COBRA coverage is exhausted.

“Loss of Eligibility” shall mean loss of coverage resulting from legal separation, divorce, death, termination of employment, a reduction in the number of hours of employment, or any loss of eligibility after a period that is measured based on any of those events. Loss of Eligibility shall not mean loss of coverage resulting from an individual's failure to pay premiums on a timely basis or any termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of fact in connection with such coverage.)

- **Special Enrollment for New Dependents**

An Employee is entitled to enroll himself and his Eligible Dependents in the Plan during a Special Enrollment Period if all of the following requirements are met:

1. The Employee is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee previously declined to enroll in the Plan; and
3. An individual became an Eligible Dependent of the Employee through marriage, birth, adoption or placement for adoption.

“Special Enrollment Period” shall mean, with respect to individuals losing coverage, the period which ends 30 days after:

1. The date on which the coverage is exhausted, if the coverage was COBRA continuation coverage; or
2. The date on which the coverage terminated because of Loss of Eligibility or termination of Company contributions toward the cost of such coverage, for other individual or group health coverage.

With respect to new dependents, the period which ends 30 days after the date of one of the following, triggers the special enrollment rights:

1. Marriage;
2. Birth;
3. Adoption; or
4. Placement for adoption.

“Special Enrollment Period” shall mean, with respect to CHIPRA, the following:

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

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

Changes in Eligibility Status

After you become a Covered Person, you are responsible for informing the Company's Human Resources Department of any changes in your personal situation that may affect your coverage. **You must report to the Company's Human Resources Department any changes which could affect your eligibility status (including but not limited to): your employee status; your marital status; the number of dependents or the eligibility status of dependents; your spouse's employer or health coverage; or your residence. Notice of such change must be provided within 31 days of such change.**

Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Covered Person.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Person's child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an Employee who is a Covered Person under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Person or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. (a) Identifies either the specific type of coverage or all available group health coverage. If the Company receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Company and the Plan Administrator will assume that all are designated;

(b) Informs the Plan Administrator that, if a group health plan has multiple options and the Covered Person is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Covered Persons without regard to this section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - (a) Whether the child is covered under the Plan; and
 - (b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for himself under this Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The day of the month in, or with respect to which, he requests that such coverage be terminated, provided such request is made on or before such date;
3. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his failure to make, when due, any contribution for coverage for himself to which he has agreed in writing;
4. The date of the month in which he ceases to be eligible for such coverage under the Plan;
5. The date and time of the month in which the termination of employment occurs; or
6. Immediately after an Employee or his Eligible Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Termination Dates of Family Coverage

The coverage for any Eligible Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for dependents under the Plan;
3. When such Eligible Dependent becomes covered as an Employee under the Plan;
4. The date of termination of the Employee's coverage for himself under the Plan;
5. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his failure to make, when due, any contribution for coverage for Eligible Dependents to which he has agreed in writing;
6. In the case of a child for whom coverage is being continued due to mental or physical inability to earn his own living, the earliest to occur of:
 - a. Cessation of such inability;
 - b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
 - c. Upon the child's no longer being dependent on the Employee for his support;
7. On the date an Eligible Dependent child marries, or in the case of a child other than a child for whom coverage is continued due to mental or physical inability to earn his own living, the end of the month in which the child attains the age of 19 years, or the end of the month in which the child reaches the age of 23 years in the case of a child who is regularly attending an accredited high school, junior college, college, university or licensed trade school;
 - a. Federal Law known as Michelle's Law, codified at 29 U.S.C. 1185 (P.L. 110-381), requires that we provide you notice of the opportunity for a full time college student to continue coverage in certain instances. The law provides that a full time college student is eligible to continue coverage under a group health plan if all of the following are met:
 - i. he suffers from a serious illness or injury;
 - ii. his physician certifies the leave of absence or reduction in hours to part-time status is medically necessary; and
 - iii. he would otherwise lose coverage.
 - b. Additionally, the student must have been enrolled in the group health plan before the first day of the leave. The extension of coverage will end at the earliest of one year or the time that the student reaches the attainment age of the plan.
 - c. You must complete the appropriate form to extend this coverage. Please contact the

Plan Sponsor to obtain this form or if you have additional questions.

8. The day immediately preceding the date such person ceases to be an Eligible Dependent, except as may be provided for; or
9. Immediately after an Employee or his Eligible Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Certificates of Coverage

The Plan will automatically provide a Certificate of Coverage to any Covered Person after the individual loses coverage in the Plan. In addition, a Certificate of Coverage will be provided upon request, if the request is made within 24 months after the individual loses coverage under the Plan. In that case, the Certificate of Coverage will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish it.

The Plan will make reasonable efforts to collect information applicable to any Eligible Dependents and to include that information on the Certificate of Coverage, but the Plan will not issue an automatic Certificate of Coverage for Eligible Dependents until the Plan has reason to know that an Eligible Dependent has lost coverage under the Plan.

Pre-Existing Condition Limitation

There are no pre-existing condition limitations.

PRIOR AUTHORIZATION

Network providers must obtain authorization 48 hours prior to rendering service for the procedures listed below. SummaCare bases authorization on plan benefits and appropriateness of care and service. Your provider may submit your request via fax to (330) 996-8501 using our Pre-Service Fax Form.

If Prior authorization is required and not obtained the plan will not make payment on the services rendered.

Inpatient Services
<ul style="list-style-type: none"> • Elective Inpatient Admissions • Acute Inpatient Rehabilitation • SNF, transitional and Sub Acute Care • Human Organ, Bone Marrow and Stem Cell Transplants
Diagnostic Tests
<ul style="list-style-type: none"> • Cat Scan (CT) with exception of CT of sinus • Magnetic Resonance Imaging (MRI, MRA, MRV) • PET/SPECT • Nuclear Cardiac Procedures • Echocardiograms • Genetic Testing
Ambulatory Services
<ul style="list-style-type: none"> • Hospice Care • Pain Management (Initial request for an evaluation must be called in to the Benefit Determination Unit by the ordering physician Additional visits must be pre-authorized by the servicing provider.) • Ambulance Services/Non-Emergent: Call (330)996-8791 or toll free (866)996-8791 • Durable Medical Equipment, Orthotics and Prosthetics: Call (330)996-8428 or toll free at (866)728-8797
Services Requiring Determination of Benefit Coverage
<ul style="list-style-type: none"> • Potentially Cosmetic, Experimental or Investigational Procedure • Infertility • Sclerotherapy • Temporomandibular Joint Testing • Provider administered injectables and infusions

COVERED SERVICES

Subject to the limitations contained in the Summary of Benefits, as well as the Plan's provisions, limitations and exclusions, the Plan provides benefits for the following services and supplies. **Please review the Summary of Benefits carefully, as some of these Services and Supplies may not be covered by the Plan if they are provided out of the Network Service Area or by a Non-Network Provider when care is not managed by your PCP.**

1. **Allergies.** Allergy testing and treatment, including injections but excluding allergy extract;
2. **Ambulance.** Charges for Emergency transportation to the nearest Hospital. In situations that are not an Emergency, ambulance transportation must be pre-authorized by the Medical Management Program. Ambulance transportation must be provided by a professional ambulance service;
3. **Dental Services.** Initial treatment for damage to sound, natural teeth resulting from Accidental Injury. Initial treatment is treatment that is Medically Necessary to stabilize the Injury after trauma. Those Injuries resulting from biting, chewing or eating are not covered to the extent that dental services would be required. Dental services related to treatment for tumors or fractures of the jaw or for correcting a congenital malformation of your covered infant's jaw are also covered;
4. **Diagnostic Services.** Diagnostic services, such as lab, X-ray, etc;
5. **Durable Medical Equipment and Prosthetic Devices.** The rental or purchase of durable medical equipment is covered if the equipment is Medically Necessary. The equipment must be pre-authorized by your Provider through the Medical Management Program. Such items include wheelchairs and hospital beds. Also covered are the first prosthesis and Medically Necessary replacement prosthesis for a Covered Person. To be covered by the Plan, prosthetic devices must be on the Plan's list of approved prosthetic appliances. Deluxe versions will not be covered, unless Medically Necessary;
6. **Emergency and Urgent Care.** Treatment for an Emergency or Urgent Care;
7. **Gynecological Visits.** Office visits to a Network Physician for gynecological exams (a referral from your PCP is not necessary);
8. **Home Health Care Services.** The following home health care services are covered if Medically Necessary. These services must be based upon a written Home Health Care Plan:
 - a. Nursing services provided by a registered or licensed practical nurse;
 - b. Physical, occupational or speech when you are unable to go to a facility to receive these services; and
 - c. Medical social services;
9. **Hospice Care.** The following hospice services are covered if Medically Necessary. Services must be pre-authorized by your Provider through the Medical Management Program:
 - a. All covered home health care services listed above, except nursing services which may be authorized for up to eight hours in any 24-hour period;
 - b. Room and Board while in a Hospice Facility;
 - c. Services and supplies furnished by the Hospice Facility during the admission, including part-time nursing care by or under the supervision of a registered nurse;
 - d. Dietary guidance;
 - e. Durable medical equipment;

- f. Bereavement counseling for family members who are Covered Persons (up to two visits); and
- g. Home Health Aide visits.

Homemaker, volunteer and spiritual counseling services, food or home-delivered meals and Custodial Care, rest care or care for someone's convenience are not covered. Chemotherapy or radiation therapy if other than palliative treatment is not covered under hospice care, but may be covered elsewhere;

10. **Infertility Diagnosis.** Medically Necessary infertility diagnosis and treatment. Coverage does not include infertility drug therapy, monitoring or procedures used to induce pregnancy. (Please refer to the "Exclusions" section of this Summary Plan Description for more information);

11. **Mastectomy.** Charges in connection with a Mastectomy will be covered as follows:

- a. Reconstruction of the breast on which the Mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the Covered Person;

12. **Maternity Services.** Maternity services for you and your Eligible Dependent are covered. You do not need a referral from your PCP for the following services to be covered:

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

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under Federal Law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a Physician obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. This benefit covers up to a 48-hour Hospital admission for routine vaginal delivery and up to a 96-hour admission for routine cesarean section delivery, unless authorization for an extended Hospital stay has been obtained through the Medical Management Program.

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

Also covered is Physician-directed follow-up care, 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 clinical tests; any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals. This coverage applies to services provided in a medical facility and/or through home health care visits. These Physician's or Providers must be knowledgeable and experienced in newborn care.

Emergency deliveries are covered, regardless of Provider. Your Physician or other Provider must notify the Medical Management Program or your PCP within 48 hours after the delivery or as soon thereafter as medically possible;

13. **Mental Health Services.** A referral from your PCP is not necessary. Covered services include individual, group and family therapy. Partial Hospitalization and intensive Outpatient therapies are also covered. The Plan will not cover services for Residential Care;
14. **Nursing Services.** General nursing services;
15. **Office Visits.** Office visits to your PCP, including physical examinations, preventive health care services (that conform to the recommendations of the United States Preventive Services Task Force) and well-child care, including immunizations;
16. **Operating Room.** Operating room, anesthesia and supplies;
17. **Physician Services.** Physician services related to medical treatment or surgery;
18. **Podiatry Services.** Medically Necessary treatment by a podiatrist. Routine foot care and orthotics are not covered unless approved by the Medical Management Program;
19. **Prescribed Drugs.** Prescribed drugs consumed while in the Hospital;
20. **Preventive Health Services.** A variety of periodic health examinations that conform to national guidelines. Examples of preventive health services include, but are not limited to:
 - a. Well baby care;
 - b. Immunizations;
 - c. Cholesterol screening;
 - d. Blood pressure checks;
 - e. Annual screening mammograms beginning at age 35;
 - f. PAP smears; and
 - g. HPV Vaccine Series for females between the ages of 9 and twenty six.
21. **Private-Duty Nurses.** Services provided by private-duty nurses to you or your Eligible Dependent while in the Hospital will be covered only if these services are Medically Necessary;
22. **Rehabilitation Services.** Rehabilitative services, includes physical, occupational, speech and cardio/pulmonary therapies. Speech therapies will be covered only if they are determined to be Medically Necessary by the Medical Management Program and functional improvement can be demonstrated.

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

Cardio/pulmonary rehabilitative services to provide treatment following acute conditions are covered;
23. **Room and Board.** Semi-private Room and Board, private room if Medically Necessary, and Special Care Units;
24. **Second Surgical Opinions.** Second opinions upon referral from your PCP or the Medical Management Program;
25. **Skilled Nursing/Extended Care Facilities.** Skilled Nursing Facility services are covered if the need for services meets Medical Necessity criteria. Services must be pre-authorized through the Medical Management Program.

The Plan will provide reimbursement for skilled nursing care received in a Non-Network Facility if all of the following conditions apply to you or your Eligible Dependent:

- a. You lived or had a contract to live in the facility on or before September 1, 1997;
- b. You, immediately before being hospitalized, lived or had a contract to live in the facility. After Hospitalization you reside in a part of the facility that is a skilled nursing facility, regardless of whether you resided in a different part of the facility before Hospitalization;
- c. The facility provides the level of skilled nursing care that you require; and
- d. The facility is willing to accept from the Plan the same terms and conditions that apply to a Network Facility, including rates;

26. **Specialist Visits.** Office visits to medical or surgical specialists;

27. **Substance Abuse Rehabilitation.** Pre-approved admissions to a facility for intensive chemical dependency detoxification and rehabilitation services in an Inpatient setting or through a structured Outpatient program. A diagnosis of abuse or addiction to alcohol and/or drugs must be established and approved for treatment by the Medical Management Program. Individual or group therapy sessions are covered when required for the treatment of abuse or addiction to alcohol or drugs and authorized for treatment by the Medical Management Program. Refer to your Provider Directory for a listing of approved facilities or call Customer Service at (330) 996-8515 or (800) 753-8429 for more information;

28. **Supplies and Services.** Medically Necessary supplies and services, such as:

- a. Oxygen, including equipment required for its administration;
- b. Blood and blood plasma (if not replaced) and other fluids to be injected into the circulatory system; and,
- c. Braces, crutches, casts, splints, trusses, surgical dressings and ostomy supplies;

29. **Surgery.** Eligible surgical procedures and anesthesia;

30. **Therapy.** Physical, speech, occupational, and cardio/pulmonary therapy;

31. **Transplants.** If you or your covered Dependent requires an organ transplant, the Plan will provide coverage. Only those non-experimental organ transplants approved by Medicare will be covered. In order for transplants to be covered, the treatment program must be pre-authorized through the Medical Management Program, and be recommended by and performed at an approved organ transplant facility.

The donor of an organ for transplant, when the recipient is covered for benefits under the Plan, also will be covered for such benefits as though he were a covered Dependent child of such recipient, but only with respect to charges in connection with the procedure in which such organ is removed from the donor; and

32. **Vision Care.** One refraction (routine vision exam) is covered every 24 months. This service does not require a referral. Covers one retinal eye exam for diabetics every 12 months.

SCHEDULE OF BENEFITS

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions and is subject to the Maximum Lifetime Benefit. All coverage figures are after the Deductible Amount has been satisfied.

The Plan contracts with the Network to access discounted fees for services provided to Covered Persons. Since Network Providers have agreed to accept the Plan's Maximum Allowable Charge as full payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims themselves.

If a Covered Person elects to receive non-emergency medical care from a Non-Network Provider, without first obtaining prior-authorization, the services are not covered.

Deductible, and Out-of-Pocket Maximums

Calendar Year Deductible Individual Family	None
Out-of-Pocket Maximum Individual Family	None

Benefit Maximums

- **Calendar Year Maximums**

Covered Medical Expenses	
Skilled Nursing	100 days per episode
Home Health Care	30 visits
Hospice	30 days
Physical and Occupational Therapy	30 days combined
Speech Therapy	30 days
Vision Care	One per 2 years

Covered Services

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions, including the benefit maximums above. Failure to comply with any pre-authorization requirement will result in a higher cost to the Covered Person. For details on the different benefit levels, see the section entitled "Understanding the Plan."

Covered Services	Co-payments and Coverage
Emergency/Urgent Care Services	
Emergency Room Services	100% after \$50 Co-payment; waived if admitted
Urgent Care Services	\$50 Co-payment

Covered Services	Co-payments and Coverage
Hospital Services	
Inpatient Durable Medical Equipment Physician Services Private Duty Nurses Surgery & Anesthesia Rehabilitative Services Room and Board X-ray & Laboratory Services Medically Necessary Supplies & Services Outpatient Outpatient Surgery	100% semi-private room only 100%
Maternity Services	
Hospital Services	100%
Office Visits	\$15 Co-payment; initial visit only
Mental Health and Substance Abuse	
Inpatient	100%
Outpatient	\$15 Co-payment
Medical/Routine Services	
Allergy Tests and Treatment	\$15 Co-payment – no Co-payment applies for immunotherapy
Annual Physical Exam	\$15 Co-payment
Consultation and Treatment by Specialist	\$15 Co-payment
Gynecological Visits (referral not necessary)	\$15 Co-payment
Office Visits	\$15 Co-payment
Preventive Care (includes all immunizations, well child care)	\$15 Co-payment
Routine Vision Exam	\$15 Co-payment
Infertility	
Diagnosis	\$15 Co-payment
Treatment	100%
All therapy services	\$15 Co-payment
Other Services	
Ambulance Services	\$50 Co-payment; waived if admitted
Dental Services (see Covered Services)	\$15 Co-payment
Durable Medical Equipment	100%
Elective Sterilizations	100%
Home Health Care	100%
Hospice Care	100%
Podiatry Services	\$15 Co-payment
Rehabilitative Services	100% after \$15 Co-payment per visit
Skilled Nursing Care/Extended Care	100%
Transplants	100%
X-ray & Laboratory Services	100%

All Other Covered Services	
All Other Covered Services	100%

GENERAL EXCLUSIONS AND LIMITATIONS

The Plan **will not provide** coverage for:

1. **Abortion.** Expenses Incurred directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise;
2. **Acupuncture, Alternative Medicine.** Acupuncture or other treatment classified as "alternative medicine" unless specifically listed as a covered service in the Schedule of Benefits;
3. **Benefit Maximum.** Services or charges that exceed the Maximum Benefit Amount;
4. **Chiropractic Care.** X-rays or skeletal adjustments;
5. **Claims Submission.** Expenses submitted over 365 days after the charges were Incurred;
6. **Coordination of Benefits.** Amounts which are not payable under the Plan's "Coordination of Benefits" provisions;
7. **Cosmetic.** Treatment or surgery to improve appearance (such as liposuction, breast augmentation, hair transplants, hair growth stimulants, etc.) except when it is needed to correct congenital defects of your covered newborn; or to give breasts a symmetrical appearance after a Mastectomy;
8. **Court Testing.** Testing and/or treatment ordered by a court or agreed to through a plea bargain;
9. **Custodial Care.** Custodial Care, such as sitters, homemaker's services or care in a place that services you primarily as a resident when you do not require skilled nursing;
10. **Educational Treatment.** Treatment of conditions related to autistic disease of childhood or mental retardation; behavioral speech disorders, learning disorders, stuttering, slow speech development, chronic muscle imbalance, and language therapy; charges in connection with any treatment, therapy, teaching technique or program for remedial education, rehabilitation or training that is primarily intended to overcome, improve or compensate for any learning impairment whatsoever, regardless of whether such impairment is diagnosed as functional or organic, except in the case of rehabilitation after a stroke;
11. **Environmental Change.** Hospitalization or treatment for environmental change;
12. **Excess Charges.** Services which exceed the amount of the Plan's Maximum Allowable Charge or Reasonable and Customary Charge;
13. **Experimental/Investigational.** Services which are Experimental or of a research nature;
14. **Eye Care.** Services for the following will not be covered.
 - a. Orthoptics or vision training, subnormal vision aids, aniseikonia lenses, or non-prescription lenses or glasses;
 - b. Biomicroscopy, field charting or aniseikonia investigation;
 - c. Replacement or repair of lenses and frames which are lost, stolen or broken;
 - d. Sunglasses, frames for sunglasses, or safety lenses or goggles;
 - e. Devices to correct vision;
 - f. Frames or lenses; and

- g. Eye examinations required by an employer as a condition of employment or required by a government body or agent.
- 15. **Felony/Illegal Act.** Care or treatment as a result of being engaged in an illegal occupation or activity or in the commission of, or attempted commission of, a felony, assault or other criminal activity;
- 16. **Foot Care.** Foot care that is not Medically Necessary, including:
 - a. Diagnosis and treatment for weak, strained, unstable or flat feet;
 - b. Trimming and care of corns and calluses are not covered except for individuals with diabetes or significant peripheral vascular disease;
 - c. The treatment of corns, calluses or toenails, unless the charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral vascular disease;
- 17. **Foot Orthotics.** Foot orthotics unless approved by the Medical Management Program;
- 18. **Government Provided.** Services in any Hospital operated or controlled by any governmental agency of the United States or any state or political subdivision thereof; treatment provided or furnished by the United States Government or the government of any other country;
- 19. **Hazardous Hobby.** For any condition, illness or injury, or complication thereof, arising out of engaging in a hazardous hobby or activity, which is an unusual activity characterized by a constant threat of danger, such as skydiving, auto racing, hang gliding and bungee jumping. This does not include common recreational activities, such as water or snow skiing, jet ski operating, horseback riding, boating, motorcycling, snowmobiling, all-terrain vehicle riding and team sports;
- 20. **Hearing Aids.** Hearing aids and the expenses incurred for fitting them as well as hearing therapy and any related diagnostic testing;
- 21. **Immediate Relative or Same Household.** Services provided by people who ordinarily reside in your household, or the household of your Eligible Dependent, or who are related by blood or marriage or legal adoption to you or your Eligible Dependent;
- 22. **Impregnation and Infertility.** Contraceptive devices, vitamins, minerals or food supplements);
- 23. **Impregnation and Infertility; Reversal of Sterilization.** In-vitro fertilization, embryo transplant (including surrogate parenting procedures), artificial insemination, test-tube babies, drug therapy for infertility or other treatments to induce pregnancy; reversal of elective sterilization procedures;
- 24. **Intelligence Testing.** Testing for intelligence, aptitude or interest;
- 25. **Job Related.** Care or treatment of an injury or illness for which you or your Eligible Dependent is entitled to benefits under any worker's compensation or occupational disease law, whether or not any coverage for such benefits is actually in force, or whether or not you claimed these benefits;
- 26. **Military Service.** Care or treatment while a member of the armed forces of any state or country;
- 27. **Miscellaneous.** Charges for telephone consultations, missed appointments or the completion of claim forms, medical reports or certifications;
- 28. **No Legal Obligation.** Charges or services for which you or your Eligible Dependent are not legally required to pay, or that would not have been made or provided if no coverage had existed;

29. **No Coverage.** Services which were provided or received after the date you or your Eligible Dependent's coverage is terminated under the Plan or prior to the effective date of coverage under the Plan;
30. **Non-Network Providers.** Services or supplies provided by a Non-Network Provider;
31. **Not Covered.** Any other service or supply which is not specifically referred to herein as a covered benefit or supply;
32. **Not Medically Necessary.** Diagnostic tests and services not related to a specific Injury or Illness or a specific set of symptoms, or for Inpatient admissions primarily for diagnostic therapy; services which are not considered Medically Necessary for your diagnosis and treatment;
33. **Personal Service.** Rest cures, travel, recreation or diversional therapy even though prescribed by a Physician; personal services such as haircuts, shampoos and sets, guest meals and radio/television rentals; personal convenience items such as vacuum cleaners, air conditioners, humidifiers, elevators, chair lifts, physical fitness equipment and other such devices even though prescribed by a Physician;
34. **Prescription Drugs.** Prescription drugs, except those drugs prescribed and administered during a visit to a Physician or during an Inpatient Hospital stay;
35. **Private Room Expenses.** Expenses Incurred for private room accommodations which are in excess of the Hospital's average daily charge for a semi-private room;
36. **Radial Keratotomy.** Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;
37. **Required Examinations.** Sports examinations or physical or psychological examinations required by:
 - a. An employer in order to begin or continue working;
 - b. A school or institution;
 - c. An insurance company in order to obtain insurance; or
 - d. A governmental agency;
38. **Riot.** Care or treatment arising out of your or your Eligible Dependent's participation in a riot;
39. **Sanitarium.** Services provided by a sanitarium;
40. **Sclerotherapy.** Sclerotherapy, unless Medically Necessary. For example; following occurrence of venous stasis ulcers, thromboembolic disease, or history of previous deep venous phlebitis;
41. **Sexual Disorders.** Transsexual surgery or any services leading to or in connection with transsexual surgery, including disturbances of gender identification or any complication thereof;
42. **Smoking Cessation.** The treatment of nicotine dependency and/or smoking cessation programs or clinics;
43. **Subrogation.** For or in connection with any Injury or Illness subject to the "Subrogation and Right of Reimbursement" provision of this Plan, unless and until the required, unaltered subrogation agreement has been properly signed, returned to, and received by the Third Party Administrator;
44. **Teeth or Gums.** Any care or treatment of teeth, gums, alveolar process or gingival tissues, unless such services are provided for the following:

- a. Treatment to repair the effects of an Injury to sound, natural teeth, except those Injuries resulting from biting, chewing or eating are not covered;
 - b. Treatment for the excision of a tumor or cyst, or the incision and drainage of an abscess or cyst; or
 - c. Cosmetic treatment to correct a congenital malformation of your Eligible Dependent;
45. **Therapy.** Marital counseling, sex and vision therapy;
46. **TMJ.** Charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment;
47. **Training and Education.** Services or supplies for training or education, such as prenatal classes, excluding diabetic and cardiac education classes;
48. **Travel.** Travel and lodging, even though prescribed by a Physician;
49. **War.** Charges Incurred as a result of war or 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, or during service by a Covered Person in the armed forces of any country. This exclusion does not apply to any Covered Person who is not a member of the armed forces; and
50. **Weight Control.** Treatment of obesity or weight reduction, including surgical treatment for morbid obesity.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

HEALTH CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan. "Health benefits" includes medical claims.

Health Claims

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that claimant has not Incurred a covered expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

When Health Claims Must Be Filed

Health claims must be filed with the Third Party Administrator within 365 days of the date charges for the services were Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided.

Claims filed later than that date shall be denied.

A claim is considered to be filed when the following information is received by the Third Party Administrator together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of pre-service urgent care claims) from receipt of the request by the claimant. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

- If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible taking into account the medical exigencies, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but no later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, but no later than the earliest of the following dates:
 - If an extension was requested, prior to the end of the extension period; and
 - If additional information was requested during the initial processing period, prior to the end of the extension period, unless additional information was requested during the extension period, then by the date agreed to by the Plan Administrator and the claimant.

Concurrent Claims:

- If the Plan Administrator is notifying the claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments, the claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, the Plan Administrator will decide as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
- If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
- If the request from the claimant does not involve urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

Post-service Claims:

- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the extension period.
- If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless

additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with pre-service urgent care claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a claimant with an explanation of benefits (EOB), either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method), advising that a claim is denied, in whole or in part, and the claimant's right to appeal any denial.

COMPLAINT AND APPEAL PROCEDURE

If you are dissatisfied with a decision about a claim, or have another complaint, you are encouraged to contact SummaCare Customer Service at (330) 996-8515 or (800) 753-8429. A Customer Service representative will ask you questions about your complaint and, if required, investigate the facts. You will receive a verbal response to your complaint within five business days.

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

The Grievance Process

If you are dissatisfied with the care or service you receive from the Plan or any of its contracted healthcare providers, you may address those concerns through our formal grievance process. Some examples of complaints that would be handled as grievances are:

- Excessive time on hold when calling Customer Service;
- Rude treatment by a physician or his office staff;
- You feel that the quality of medical care you received from a contracted provider was inappropriate;
- You believe that your privacy rights have been violated.

To file a formal, written grievance, send your request to:

SummaCare
Appeals/Grievance Department
PO Box 3620
Akron Ohio 44309-3620

You may also fax your appeal to (330) 996-8545, or submit it electronically to appeals@summacare.com.

Please be as clear as possible when describing your grievance. If you need help with your grievance, please call Customer Service for assistance. A Customer Service representative will help you document the substance of your grievance over the phone. If your complaint is about the quality or appropriateness of care, you must file your grievance within 180 days from the date the services were received.

The Plan will investigate your grievance and respond to you in writing within 30 calendar days. Our response will inform you of our findings and any action that is taken as a result of your grievance.

Second Level Grievance Appeals

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

The Appeals Process

You have the right to appeal any decision of the Plan that denies or limits your health care benefits. If a service is denied, reduced, or terminated, or if payment of a claim is fully or partially denied, you may appeal that denial. To file an appeal, send a written request to:

SummaCare
Appeals/Grievance Department
PO Box 3620
Akron Ohio 44309-3620

You may also fax your appeal to (330) 996-8545, or submit it electronically to appeals@summacare.com.

Your appeal must be signed, include the name of the employee/claimant, and the member ID number of the employee/claimant. Please be as clear as possible when describing your appeal. Any additional documentation that supports your request should be submitted with your appeal. If you need help with your appeal, please call Customer Service for assistance. A Customer Service Representative will help you document the substance of your appeal over the phone. If you submit your appeal over the phone, you will still need to follow-up with a signed, written appeal for it to be official.

You must file your appeal within 180 days from the date you first received notice of the adverse determination you want to appeal. The Plan may accept an appeal from you after 180 days for just cause, but is under no obligation to do so. An authorized individual, which may be a friend, family member, doctor, or anyone you choose, may appeal for you, provided the Plan receives a legally acceptable signed and dated authorization form from you, or some other legal documentation (such as a power of attorney) authorizing that person to act on your behalf.

After the Plan investigates the facts, your appeal will be decided by individuals who had no previous involvement with the case, and are not the subordinate of the original decision maker. If your appeal is in any way related to the medical appropriateness of the care or services in question, the appeal will be reviewed by a board certified physician. The Plan may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the case. The appeal reviewer affords no particular deference to the initial decision, and looks at all the submitted information without regard to whether such information was available when the initial determination was made.

The exact time frame for resolving your appeal depends upon a number of factors that are explained below. The period of time within which the Plan's determination will be made begins when the Plan receives a properly signed and authorized appeal as outlined above. The Plan may shorten any of the time frames listed below when medically necessary.

Should the Plan determine that additional information is needed to appropriately resolve your appeal, we may request additional information from you. You have 45 days (48 hours in the case of pre-service urgent care claims) following receipt of a request for additional information to provide such information to the Plan. It is up to you if you want to take this additional time to supply the requested information, or if you want the Plan to proceed without the information and stick to the time frames outlined below.

First Level Post-Service Appeals

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

First Level Pre-Service Appeals

If your appeal is asking that the Plan cover a service or medical item that you have not yet received, the Plan will notify you in writing of the outcome within 15 calendar days.

Expedited or Fast Appeals

The Plan may choose to expedite your appeal and resolve it in 72 hours if you believe that waiting 15 days for a pre-service decision could result in any of the following:

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

Expedited appeals are only granted in medically urgent situations. The Plan does not have to expedite your appeal if we believe that it does not meet any of the three reasons listed above. If the Plan determines that your appeal does not qualify for a fast/expedited review, we will still process it as a standard pre-service appeal, and resolve it within 15 calendar days. If you disagree with the Plan's

decision not to expedite an appeal, you may file a grievance per the process outlined above. If a licensed physician indicates that expedition is necessary for medical reasons, the Plan will automatically expedite your appeal.

If the Plan does expedite your appeal, we will verbally notify you of the decision within 72 hours from the time it is received or as fast as medically necessary, and follow-up that same day in writing. To request that your appeal be expedited, you must call Customer Service at (330) 996-8515 or (800) 753-8429.

There is only one mandatory level of appeal for expedited appeals. Upon completion of your expedited appeal you will have exhausted the mandatory appeal process. You should contact Customer Service to see if there are any additional voluntary appeal processes available to you.

Second Level Appeals

If upon receiving the Plan's first level appeal decision you still disagree, you have up to 60 days to file a second level appeal. At the second level, you are again entitled to a "full and fair review" of any denial made at the first level of appeal and you have the same rights during the second level appeal that you have at the first level of appeal. Your second level written appeal must include all of the elements listed above for first level appeals.

Your second level appeal will be reviewed by a fresh set of individuals who were not involved in either the initial determination or the first level appeal decision, and are not subordinates of such individuals. If your second level appeal is in any way related to the medical appropriateness of the care or services in question, the appeal will be reviewed by a board certified physician or other appropriately licensed healthcare professional in the same or similar specialty that typically treats the medical condition or provides the procedure or treatment in question.

Second Level Post-Service Appeals

The Plan will send you a written response to your second level post-service appeal within 30 calendar days from the date we received your second level request.

Second Level Pre-Service Appeals

The Plan will send you a written response to your second level pre-service appeal within 15 calendar days from the date we received your second level request.

Decision on Second Appeal to be Final

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All non-voluntary claim review procedures provided for in the Plan must be exhausted before any legal action is brought under section 502 of the Employee Retirement Income Security Act (ERISA). Any legal action for the recovery of any benefits must be commenced within one year after the Plan's appeal procedures have been exhausted.

Content of Notification of Adverse Benefit Determination

The written appeal decision will include the following elements:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the Summary Plan Description on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion

was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;

- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, will be provided free of charge upon request;
- A statement describing any additional voluntary appeal procedures offered by the Plan and the right to obtain information regarding any such procedures;
- A description of any additional information necessary to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures;
- A statement of the right to bring an action under section 502(a) of ERISA upon exhaustion of the appeal process.

Access to the Appeal File

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; information regarding any voluntary appeals procedures offered by the Plan; any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances in question.

COORDINATION OF BENEFITS

Coordination with Other Health Care Plans/Non-Duplication of Benefits

This coordination of benefits/non-duplication provision applies to the Plan when you or your Eligible Dependent has health care coverage under more than one plan. The provision does not deny you any benefits to which you are entitled under this Plan, but instead is intended to ensure that duplicate payments are not made when you are covered by this Plan and any other plan. All Eligible Expenses are subject to this provision. You must provide the Third Party Administrator with the facts and information necessary to apply the order-of-benefit determination provisions of this Plan. The Plan may recover any amounts that are determined by it to be excess payments in accordance with these provisions.

When benefits are coordinated, benefits will be equal to the amount payable under this Plan minus the amount paid by the other plan. However, the amount payable can never be more than what this Plan would have paid in the absence of any other plan.

Non-duplication does not apply to individual or private insurance plans.

Which Pays First (Coordination of Benefits)

Under non-duplication rules, the plan that pays benefits first is called the **primary** plan. The plan that pays next is **secondary**. If there are more than two plans providing coverage, non-duplication rules help decide the order of any additional payments.

A plan without non-duplication rules is always primary -- that means it always pays benefits first. If all plans have non-duplication rules, benefits are paid according to the following:

1. A plan covering a person as an employee pays before a plan covering the person as a dependent.
2. A plan covering a person as an active employee pays before a plan covering the person as a laid-off employee or retiree.
3. For dependent children, the plan covering the parent whose birth date (month and day only) occurs earlier in the plan year pays benefits first. For example, let's say the father was born on June 15, and the mother's birth date is March 1. The mother's plan would pay first, because her birthday comes earlier in the year. This rule applies only if both plans have primary plan rules based on birth date. If one of the plans does not use the birthday rule, the father's plan pays first.
4. If you are legally separated or divorced, special coordination rules apply to your children. If a court decree says that one parent must pay for a child's health care, the plan of that parent pays first. Otherwise, benefits are paid in the following order:
 - a. The plan of the parent with custody of the child;
 - b. The plan of the stepparent who is married to the parent with custody of the child; or
 - c. The plan of the parent who does not have custody of the child.
5. If both parents have the same birth date, the plan that has covered the dependent the longest pays first.

Medicare and any other federal, state, or government-sponsored hospital, surgical or medical program (including payments under any "no fault" liability insurance program) will be considered as another Company-sponsored program and will always be considered as a primary program, to the extent permitted by applicable law.

How Your Benefits Are Paid

1. The Plan will pay benefits without regard to the existence of any other plan when this Plan is primary.
2. No plan will pay more than it would have paid in the absence of this non-duplication provision.
3. When this Plan is secondary, any benefits reduced during any claim determination period because of this provision will be reduced proportionately. Only the reduced amount may be charged against any benefit limit of this Plan. A claim determination period is a Calendar Year.
4. The provisions of this Plan will determine which plan is primary and which plan is secondary.
5. The Plan will pay benefits if a member is over 65 years old and Medicare is primary and the member is not enrolled in Part B as if the member were enrolled in Part B.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies

A Covered Person may incur medical or other charges related to Injuries or Illness for which benefits are paid by the Plan. The Injuries or Illness may be caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of any charges Incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or a third party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the Covered Person may have against that other person or third party and will be entitled to Reimbursement. In addition, the Plan shall have a lien against any Recovery to the extent of benefits paid or to be paid and expenses Incurred by the Plan in enforcing this provision. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

1. Assign and subrogate to the Plan his rights to recovery when this provision applies;
2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses Incurred by the Plan in collecting this amount;
3. Immediately reimburse the Plan out of the Recovery made from the other person, the other person's insurer or the third party, 100% of the amount of medical or other benefits paid for the Injuries under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) Incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers, including a subrogation agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. If the Plan pays any medical or other benefits for the Injuries or Illness before these papers are signed and any action taken, the Plan will still be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate and be reimbursed and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. If the Covered Person retains an attorney, the Covered Person agrees to only retain one who will not assert the common-fund or made-whole doctrines. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes, as it deems necessary.

Amount Subject to Subrogation or Reimbursement

All amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses Incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

“Another Party”

“Another Party” shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person’s Injuries or Illness.

“Another Party” shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person’s own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner’s, renter’s or any other liability insurer; a workers’ compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

“Recovery”

“Recovery” shall mean any and all monies paid to the Covered Person by way of judgment, settlement, or otherwise (and no matter how those monies may be characterized or designated) to compensate for all losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

“Subrogation”

“Subrogation” shall mean the Plan’s right to pursue the Covered Person’s claims for medical or other charges paid by the Plan against the other person, the other person’s insurer and the third party.

“Reimbursement”

“Reimbursement” shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses Incurred by the Plan in collecting this benefit amount.

When the Covered Person is a Minor or is Deceased

These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor’s representative has access or control of the Recovery.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to reduce future benefits payable under the Plan by the amount due as Reimbursement to the Plan. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.

CONTINUATION OF PLAN COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may require that you and/or your dependents be provided with the opportunity to continue your group health care coverage on a contributory basis under the following circumstances.

Who May Continue Coverage, When, and for How Long

If your medical care coverage terminates, you and your covered dependents may continue medical care coverage for up to 18 months:

1. If your employment terminates for any reason; or
2. If you lose your health care coverage due to a reduction in your hours of employment; or
3. If you or a dependent become disabled within the first 60 days of COBRA continuation, coverage may be continued for an additional 11 months.

Your covered dependents may continue such coverage under this Plan for up to 36 months:

1. If you die while covered by the Plan; or
2. If you and your spouse are divorced or your marriage is annulled or you are legally separated from your spouse; or
3. If you become eligible for Medicare; or
4. If your dependent child is no longer eligible for coverage under the Plan.

If you are entitled to Medicare benefits at the time coverage terminates due to your termination of employment or reduction in hours, the continuation period for covered Dependents will be the longer of:

1. 18 months from the date coverage terminates due to your termination of employment or reduction of hours; or
2. 36 months from the date you became entitled to Medicare.

When Continued Coverage Ends

The continued coverage will end for any qualified person when:

1. The cost of continued coverage is not paid on or before the date it is due; or
2. That person becomes eligible for Medicare, if later than the date of the COBRA election; or
3. That person becomes covered under another group health plan unless that other plan contains an exclusion or limitation with respect to any pre-existing health condition; or
4. The Plan terminates for all Employees; or
5. You or your dependent are no longer deemed disabled during the additional 11-month extended period; or
6. The last day of the applicable 18, 29 or 36-month time limit.

Similarly Situated Beneficiary

Generally, for purposes of any benefits payable under this continuation coverage, qualified persons will be considered the same as any similarly situated Beneficiary covered under the Plan. A similarly situated Beneficiary means an Employee or Dependent of an Employee.

Notices

Notice will be given when you or your covered dependents become entitled to continue COBRA health care coverage under the Plan. You or your dependents will then have up to 60 days to elect to continue coverage. Each qualified person is entitled to an individual election of COBRA continuation. A qualified person may waive COBRA continuation coverage during the 60-day election period. This waiver of coverage may be revoked at any time before the end of the election period. In this case, coverage will be effective on the date the waiver revocation notice is received by the Company or its representative. Coverage will not be provided retroactively. The written notice from the Company's representative will

include the cost per month of COBRA continuation coverage. Any person who elects this coverage must pay the full cost for periods preceding the election within 45 days after the date of election. The first payment received for COBRA continuation coverage will be applied to those periods. Payments for periods subsequent to the election must be made monthly, no later than the due date determined by the Company, or within the grace period allowed. However, you or your covered spouse or your covered child must notify the Company within 60 days in the event you become divorced or your marriage is annulled when your dependent child no longer qualifies as a covered dependent under the Plan' or after a disability determination has been made and prior to the expiration of the 18 month continuation period. Notification must include a copy of the Social Security Administration determination of disability letter.

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

Because COBRA rules are complicated, if you have any questions about eligibility, contact your human resource representative.

Veteran Reemployment

The Company will also comply with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994. This law enables associates who take leaves of absence to serve in the armed forces to continue their medical coverage in a manner similar to COBRA.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report (if any). The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.
4. Continue health care coverage for yourself, spouse or Eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Eligible Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion for 12 months (18 months for Late Enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

PLAN ADMINISTRATION

Plan Administrator

The Plan is administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

Fraud

The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire family unit of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Gender

The use of masculine pronouns in this Summary Plan Description shall apply to persons of both sexes unless the context clearly indicates otherwise.

Headings

The headings used in this Summary Plan Description are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

Limitation on Actions for Fiduciary Breach

Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the expenses due to Injury or Illness are Incurred or are alleged to have been Incurred.

No Waiver or Estoppel

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Covered Person.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Covered Person's contribution (if any) will be determined from time to time by the Plan Administrator.

Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

Written Notice

Any written notice required under this Plan which, as of the effective date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Illness or Injury, or whose Eligible Dependent's Illness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the Provider; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

Recovery of Payments

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;

5. In anticipation of obtaining a recovery in Subrogation if a Covered Person fails to comply with the provisions stated in the section entitled "Third Party Recovery, Subrogation and Reimbursement;" or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Illness to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by an Employee or by any of his Eligible Dependents if such payment is made with respect to the Employee or any person covered or asserting coverage as an Eligible Dependent of the Employee.

Medicaid Coverage

A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the state Medicaid program; and the Plan will honor any Subrogation rights the state may have with respect to benefits which are payable under the Plan.

Right of Recovery

Whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount.

IMPORTANT TELEPHONE NUMBERS

Company Human Resources Department <ul style="list-style-type: none"> • For questions about eligibility and enrollment 	(216) 448-0600
<ul style="list-style-type: none"> • For information about payroll deductions and purchasing COBRA continuation coverage 	Contact your local HR Department
Customer Service <ul style="list-style-type: none"> • For information about how your Plan works • For questions about specific benefits and coverage • To change your PCP • For questions regarding specific claims paid or not paid • To express a complaint or appeal about your claim 	(330) 996-8515 or (800) 753-8429
24-Hour Nurse Line	(800) 379-5001

Remember, it's always best to contact your PCP first, but for those situations when you need simple medical advice or help in contacting your PCP, call the 24-Hour Nurse Line. A nurse is available 24 hours a day to assist you. Please be aware that the 24-Hour Nurse Line cannot diagnose conditions over the telephone, but they can evaluate symptoms and inform you of the best course of action.

Visit our website at www.summacare.com to:

1. Change your PCP;
2. View claim and authorization status; and
3. View the most up-to-date Network Provider Directory.