Summary Plan Description

FRANKLIN COUNTY BOARD OF COMMISSIONERS
INCENTIVE PLAN FOR
MENTAL HEALTH AND SUBSTANCE USE BENEFITS

Effective: January 1, 2022
Policy Number: 452574

Benefits Provided by: OPTUM™

TABLE OF CONTENTS

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries for Mental Health/Substance Use Disorder Administrator: 1-800-852-1091
- Claims submittal address: Optum- Claims, P.O. Box 30760, Salt Lake City, UT 84130-0760; *(Note-All claims must be submitted within 12 months from the date of service to be processed.)*
- Online assistance: **www.liveandworkwell.com**

Franklin County Board of Commissioners is pleased to provide you with this Summary Plan Description (SPD), which describes the Covered Health Service Benefits available to you and your covered family members. It includes summaries of:

- who is eligible.
- services that are covered, called Covered Health Services.
- services that are not covered, called Exclusions.
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

IMPORTANT

The healthcare service is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *Glossary*.) The fact that a provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Mental Illness, substance-related and addictive disorders, does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Franklin County Board of Commissioners intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

Optum is a private healthcare claims administrator. Optum's goal is to give you the tools you need to make wise healthcare decisions. Optum also helps your employer to administer claims. Although Optum will assist you in many ways, it does not guarantee any Benefits. Franklin County Board of Commissioners is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Franklin County Board of Commissioners' Plan works. If you have questions, contact the Franklin County Benefits and Wellness department, or call 1-614-525-5750.

How To Use This SPD

- Read the entire SPD and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Franklin County Board of Commissioners is also referred to as Plan Sponsor.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

The Franklin County Board of Commissioners (FCC) establishes its own medical plan eligibility, enrollment, and termination criteria. Refer to das.ohio.gov for additional details on eligibility requirements.

Eligible Employees and Dependents

All Employees and dependents that are enrolled in the FCC medical plan are considered eligible.

An eligible Dependent is:

- your Spouse, as defined in Section 14, Glossary.
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- a child age 26 or over who is or becomes disabled and dependent upon you; or
- child of an enrolled dependent, example grandchild of employee.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and Franklin County Board of Commissioners share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions may be deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld -

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and Franklin County Board of Commissioners reserves the right to change your contribution amount from time to time.

How to Enroll

To enroll, call Benefits and Wellness Department within 30 days of the date you first become eligible for medical plan coverage. If you do not enroll within 30 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you can review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Franklin County Benefits and Wellness Department within 30 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections. When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following the completion of a 30-day waiting period (Pickaway County employee coverage will begin following 60 days of employment.) Coverage for Late Enrollees will begin on the date identified by Franklin County Board of Commissioners after Franklin County Board of Commissioners receives the completed enrollment form and any required contribution for coverage. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date of your marriage, provided you notify the Franklin County Benefits and Wellness Department within 30 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify the Franklin County Benefits and Wellness Department within 30 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation, or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage because of loss of eligibility (you must contact Human Resources within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

For change of life event to add someone to the plan or to re-enroll from opt out, the change will become effective as of the event date.

For example, for the life event of marriage, the marriage date will be the new effective date.

For change of life event to remove someone from the plan or to end coverage, the effective date will be the last day of the pay period that the event occurs in.

For example, if our pay period runs from 12-Feb-12 to 25-Feb-12 and the employee gets a divorce on 20-Feb-12, the coverage for the spouse would end on 25-Feb-12.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

Note: Any child under age 19 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all Plan coverage for the child will end when the placement ends.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Franklin County Board of Commissioners' medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Franklin County Board of Commissioners' medical plan with mental health and substance use coverage outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits.
- Eligible Expenses.
- Annual Deductible.
- Out-of-Pocket Maximum; and
- Coinsurance.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the provider you prefer each time you need to receive Mental Health and Substance Use Addictive Related Disorder Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Services from Providers and other licensed professionals who have contracted with Optum to provide those services. For facility services, these are Benefits for Covered Services that are provided at a Network facility under the direction of either a Network or non-Network provider or other licensed professional. Network Benefits include services provided in a Network facility by a Network or a non-Network Emergency room Physician, or provider.

Generally, when you receive Covered Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount more than the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Looking for a Network Provider?
In addition to other helpful information, **www.liveandworkwell.com**, Optum's consumer website, contains a directory of health care professionals and facilities in Optum's Network. While Network status may change from time to time, **www.liveandworkwell.com** has the most current source of Network information. Use **www.liveandworkwell.com** to search for Providers available in your Plan.

Network Providers

Optum or its affiliates arrange for providers to participate in a Network. At your request, Optum will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call Optum at 1-800-852-1091 or log onto **www.liveandworkwell.com**.

Network providers are independent practitioners and are not employees of Franklin County Board of Commissioners or Optum.

Optum's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

Eligible Expenses

Franklin County Board of Commissioners has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Network Benefits for Covered Health Services provided by a non-Network provider (other than Emergency Health Services or services otherwise arranged by Optum), you will be responsible to the non-Network Physician or provider for any amount billed that is greater than the amount Optum determines to be an Eligible Expense as described below.

For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider because of an Emergency or as arranged by Optum, Eligible Expenses are an amount negotiated by Optum or an amount permitted by law. Please contact Optum if you are billed for amounts more than your applicable Coinsurance, Copayment, or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates, or subcontractors, at the Claims Administrator's discretion.
  - If rates have not been negotiated, the following amounts applies based on the claim type:
    - For Mental Health Services and Substance Use Disorder Services the Eligible Expense, based off available CMS rates, will be reduced by 25% for Covered Health Services provided by a master's level counselor and by 15% for Covered Health Services provided by a registered nurse.

      When a rate is not published by *CMS* for the service or data resources of competitive fees in a geographic area are not available, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third-party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk, and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). Optum and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to Optum's website at **www.myOptum.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

      IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The Annual Deductible applies to all Covered Health Services under the Plan, except prescription drugs. There are separate Network and non-Network Annual Deductibles for this Plan for each calendar year. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example
Let's assume that you receive Plan Benefits for an office visit from a non-Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, except prescription drugs. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4- PLAN HIGHLIGHTS

SCHEDULE OF BENEFITS

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network	Non-Network
Annual Deductible[1] ■ Single ■ Family (cumulative Annual Deductible[2]) ■ If more than one person in a family is covered under the Plan, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Deductible applies. No one in the family is eligible to receive Benefits until the family Deductible is satisfied. **Annual OOP Max combines with medical*	 $0 $0	 $400 $1,000
Annual Out-of-Pocket Maximum[1] ■ Single ■ Family (cumulative Out-of-Pocket Maximum[3]) **Annual OOP Max combines with medical* ***Participation in the annual ThriveOn Wellness program may reduce your OOP expenses.*	 $1,000 $2,500	 $2,000 $5,000
Lifetime Maximum Benefit[4] There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[2]The Plan does not require that you or a covered Dependent meet the Individual Deductible to satisfy the family Deductible. For example, if more than one person in a family is covered under the Plan, the single coverage Deductible stated in the table above does not apply if the family, as a whole, has already met the Family deductible in the plan year.

[3]The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum to satisfy the Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the single coverage Out-of-Pocket Maximum stated in the table above does not apply if the family, as a whole, has already met the Out-of-Pocket Maximum. Instead, for family coverage the family Out-of-Pocket Maximum applies.

[4]Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:
Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Employee Assistance Program (EAP) (All family members in the household)	8 visits covered at 100%	N/A
Employee Assistance Program- Onsite (Employees only)	Unlimited visits covered at 100%	N/A
Mental Health Services ■ Inpatient/IOP ■ Outpatient. (30 visits for $0, 30 visits shared among all types of OP care covered under this plan) ■ Intermediate Care	Covered in full Visits 1-30- $0 Visits 31+- $20 copay Covered in full, Days are limited by medical necessity	80% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient/IOP. Outpatient. (30 visits for $0, 30 visits shared among all types of OP care covered under this plan) ■ Intermediate Care	Covered in full Visits 1-30- $0 Visits 31+- $20 copay Covered in full, Days are limited by medical necessity	80% after you meet the Annual Deductible
Substance-Related and Addictive Disorders Services ■ Inpatient/IOP	Covered in full	80% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Network	**Non-Network**
Outpatient. (30 visits for $0, 30 visits shared among all types of OP care covered under this plan) ■ Intermediate Care	Visits 1-30- $0 Visits 31+- $20 copay Covered in full, Days are limited by medical necessity	
Telehealth Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.liveandworkwell.com** or by calling 1-800-852-1091	Covered in full	Non-Network Benefits are not available.

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization (See Section 6 for information about Prior Authorizations).

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with benefit limitations along with Coinsurance, Copays and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 6, *Exclusions and Limitations*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by ~~or under the direction of a properly qualified~~ a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure. .[PBJ1]

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment include room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment, and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- ~~Provider-based case management services.~~[PBJ2]
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization from the Claims Administrator before a scheduled admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; ~~extended outpatient treatment visits, with or without medication management.~~[PBJ3]

See Section 6 for further information regarding prior authorizations.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Certified Applied Behavior Analyst (Ex: COBA, is the Ohio designation) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

For the purpose of this Benefit, Intensive Behavioral Therapy (IBT) means outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age-appropriate skills in people with Autism Spectrum Disorders. The most common IBT is Applied Behavior Analysis (ABA).] [PBJ4]

Benefits include the following levels of care:

- Inpatient Treatment.

- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Inpatient treatment and Residential Treatment include room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment, and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; ~~extended outpatient treatment visits, with or without medication management;~~[PBJ5] Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

See Section 6 for further information regarding prior authorizations.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services

must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient Treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Inpatient treatment and Residential Treatment include room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment, and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; ~~extended outpatient treatment visits, with or without medication management.~~[PBJ6]

See Section 6 for further information regarding further information regarding Prior Authorizations.

Telehealth Visits

Telehealth visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio with video communications or audio only equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myOptum.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Wellness Programs

Employee Assistance Program

Optum provides a program that offers confidential support for everyday challenges. These resources are available 24 hours a day, 7 days a week. Services are available to all benefits-eligible employees and their household. You are not required to be enrolled in the Franklin County Cooperative Health Plan to receive EAP services. Your EAP benefit allows 8 free counseling sessions per presenting problem per plan year. This benefit is provided at no cost to you.

Now with your EAP benefit, it is easier to get assistance than ever before. Get support when you need it in a way that works for you through TalkSpace and Sanvello.

Talkspace allows you to reach out to a licensed, in-network Employee Assistance Program Provider, 24/7.
Sanvello offers clinical techniques and self-help resources to help dial down the symptoms of stress, anxiety, and depression — anytime.

Franklin County Cooperative also has an Onsite EAP Consultant, The onsite consultant is available to all Cooperative agencies and employees. Consultations are free and 100% confidential. Currently consultations are being offered virtually. To access EAP onsite services call 1-800-354-3950.

**Note: Onsite EAP is only available to employees.*

If you are a spouse, dependent or household member of an employee, please access EAP using the information below.

Access EAP resources **at** www.liveandworkwell.com and use the access code EAP. For additional information, call the 24/7 EAP Helpline at 1-800-354-3950.

SECTION 6 - EXCLUSIONS AND LIMITATIONS: WHAT THE PLAN WILL NOT COVER

What this section includes:

- Services, supplies, and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6.

Note regarding Prior Authorizations:

- If you fail to obtain prior authorizations from or provide notifications to the Claims administrator as required, claims will be denied until medical records are received. Once medical records are received, and medical necessity is established the claim will be paid with no penalty.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says, "this includes," or "including but not limited to", it is not Optum's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments and/or Procedures

1. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits may be provided as described in Section 6.

2. Biofeedback

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental, or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device, or

pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is Experimental or Investigational or Unproven in the treatment of that condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6.

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 6, *Exclusions and Limitations*, the exclusions listed directly below apply to services which may be described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, gambling disorder and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living, Sober and Halfway House services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM)* criteria, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

10. Wilderness, Adventure, Outdoor Therapies which include Equine and other Animal Assisted Therapies.
11. Services provided in unlicensed, and, or non-accredited program. Treatment or services that are non-professionally directed.

12. Nutritional counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
13. Travel or transportation expenses unless UBH has requested and arranged for you to be transferred by ambulance from one facility to another.
14. Any charges for record processing except as required by law.
15. Any charges for missed appointments.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent, or child.
2. a provider may perform on himself or herself.
3. performed by a provider with your same legal residence.
4. which are self-directed to a free-standing or Hospital-based diagnostic facility.
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.
6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider; and

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB).*
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it or could have it elected for you.
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.
5. Prescription drugs or over the counter drugs and treatment (Refer to your Pharmacy Benefit Plan for coverage details).

Types of Care

1. Custodial Care as defined in Section 14, *Glossary,* or maintenance care.
2. Domiciliary Care, as defined in Section 14, *Glossary.*

3. Psychiatric or psychological exams, testing, or treatments when:

   - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage, or adoption, or because of incarceration.
   - conducted for purposes of medical research.
   - related to judicial or administrative proceedings or orders; or
   - required to obtain or maintain a license of any type.

SECTION 7 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, Optum will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call Optum at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to Optum for processing. To make sure the claim is ***processed promptly and accurately,*** a completed claim form should be attached and mailed to Optum at the address on your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.liveandworkwell.com**, or calling 1-800-852-1091. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, date of birth, and relationship to the Participant.
- The name, address, and tax identification number of the provider of the service(s).
- License level of the provider
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - The Current Procedural Terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - Date of service(s).
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with Optum® at the following address:

Optum Claim

P.O. Box 30760

Salt Lake City, UT 84130-0760

After Optum has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits

When you assign your Benefits under the Plan to a non-Network provider with Optum's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were provided and were medically necessary.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement but directs that your benefit payment should be made directly to the provider, Optum may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Franklin County Board of Commissioners reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Franklin County Board of Commissioners (including amounts owed because of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

Optum will pay Benefits to you unless:

- The provider submits a claim form to Optum that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

Optum will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that Optum in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which Optum makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which Optum processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Optum. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call Optum at 1-800-852-1091 before requesting a formal appeal. If Optum cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. This communication should include:

- the patient's name and date of birth.
- the provider's name.
- the date of service.
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your enrolled Dependent may send a written request for an appeal to:

Optum - Appeals
P.O. Box 30512
Salt Lake City, 84130-0505

Fax: 1-855-312-1470

Phone: 1-866-556-8166

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits.
- pre-service request for Benefits.
- post-service claim; or
- concurrent claim.

Review of an Appeal

Optum will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if Optum upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Optum within 60 days from receipt of the first level appeal determination. Franklin County Board of Commissioners must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Optum will review all claims in accordance with the rules established by the U.S. Department of Labor. Optum's decision will be final.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Optum, or if Optum fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Optum's determination.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons.

- the exclusions for Experimental or Investigational Services or Unproven Services.
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.
- You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Optum's decision.

An external review request should include all of the following:

- a specific request for an external review.
- the Covered Person's name, address, and insurance ID number.
- your designated representative's name and address, when applicable.
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Optum has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by Optum of the request.
- a referral of the request by Optum to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, Optum will complete a preliminary review to determine whether the individual for whom the request was submitted meets all the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that Optum may process the request.

After Optum completes the preliminary review, Optum will issue a notification in writing to you. If the request is eligible for external review, Optum will assign an IRO to conduct such review. Optum will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

Optum will provide to the assigned IRO the documents and information considered in making Optum's determination. The documents include:

- all relevant medical records.
- all other documents relied upon by Optum; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and Optum will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Optum. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time, and you agree). The IRO will deliver the notice of Final External Review Decision to you and Optum, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Franklin County Board of Commissioners' determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is like a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the

individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Optum will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that Optum may process the request.

After Optum completes the review, Optum will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Optum will assign an IRO in the same manner Optum utilizes to assign standard external reviews to IROs. Optum will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Optum. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to Optum.

You may contact Optum at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Emergency room services, as defined in Section 14, *Glossary*.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify Optum before non-Urgent Care is provided; and

- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and Optum are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, Optum must notify you within:	**24 hours**
You must then provide completed request for Benefits to Optum within:	**48 hours** after receiving notice of additional information required
Optum must notify you of the benefit determination within:	**72 hours**
If Optum denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Optum must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call Optum as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, Optum must notify you within:	**5 days**
If your request for Benefits is incomplete, Optum must notify you within:	**15 days**
You must then provide completed request for Benefits information to Optum within:	**45 days** after receiving an extension notice*
If Optum denies your initial request for Benefits, they must notify you of the denial:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal the request for Benefits denial no later than:	**180 days** after receiving the denial

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
Optum must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Optum must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal*

*Optum may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, Optum must notify you within:	**30 days**
You must then provide completed claim information to Optum within:	**45 days** after receiving an extension notice*
If Optum denies your initial claim, they must notify you of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
Optum must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Optum must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*Optum may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Optum will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Franklin County Board of Commissioners or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Franklin County Board of Commissioners or the Claims Administrator, you must do so within three years from the expiration of the period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Franklin County Board of Commissioners or the Claims Administrator.

You cannot bring any legal action against Franklin County Board of Commissioners or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Franklin County Board of Commissioners or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against Franklin County Board of Commissioners or the Claims Administrator.

Summary of Consolidated Appropriations Provisions

Refer to page 77 for information regarding the Consolidated Appropriations Provisions ("No Surprises Act").

SECTION 8 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care.
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- medical payment benefits under any premise's liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myOptum.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.

- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child.
- plans for active employees pay before plans covering laid-off or retired employees.
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the primary plan's allowable expense.
- if this Plan would have paid the same amount or less than the primary plan paid, this Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Determining the Allowable Expense When This Plan is Secondary

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare.*

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, if the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation

of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience Optum will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Plan Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Optum any facts needed to apply those rules and determine benefits payable. If you do not provide Optum the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, Optum reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid more than the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection with services provided to persons under other plans for which Optum makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 9 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved, or waived in writing.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan because of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury, or damages, or who is legally responsible for the Sickness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury, or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be Benefits advanced.
- If you receive any payment from any party because of Sickness or Injury, and the Plan alleges some or all those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the period of meeting the calendar year Deductible.
- Advanced during the period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 10 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end; and
- Extended coverage; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Franklin County Board of Commissioners will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the Company ends.
- the date the Plan ends.
- the last day of the month you stop making the required contributions.
- the last day of the month you are no longer eligible.
- the last day of the month Optum receives written notice from Franklin County Board of Commissioners to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.
- in the case of divorce coverage ends as of the date of the divorce decree or legal separation.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends.
- the last day of the month you stop making the required contributions.
- the last day of the month Optum receives written notice from Franklin County Board of Commissioners to end your coverage, or the date requested in the notice, if later.
- the last day of the year your Dependent child no longer qualifies as a Dependent under this Plan; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If Optum and Franklin County Board of Commissioners finds that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact Franklin County Board of Commissioners has the right to demand that you pay back all Benefits Franklin County Board of Commissioners paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, if:

- the child is unable to be self-supporting due to a mental or physical handicap or disability.
- the child depends mainly on you for support.
- you provide to Franklin County Board of Commissioners proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age: and
- you provide proof, upon Franklin County Board of Commissioners' request, that the child continues to meet these conditions.

The proof might include medical examinations at Franklin County Board of Commissioners' expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, if the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Pinellas County Board of County Commissioners is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Franklin County Board of County Commissioners files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced, or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information*. The contents of the notice must be such that the Plan Administrator is able to determine the

covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date);
- the date the entire Plan ends; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24-month period beginning on the date of the Participant's absence from work; or

- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 11 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with Optum and Franklin County Board of Commissioners.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with Optum and Franklin County Board of Commissioners

To make choices about your health care coverage and treatment, Franklin County Board of Commissioners believes that it is important for you to understand how Optum interacts with the Plan Sponsor's benefit Plan and how it may affect you. Optum helps administer the Plan Sponsor's benefit Plan in which you are enrolled. Optum does not provide medical services or make treatment decisions. This means:

- Optum communicates to your decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Franklin County Board of Commissioners and Optum may use individually identifiable information about you to identify for you (and you alone) procedures, products, or services that you may find valuable. Franklin County Board of Commissioners and Optum will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. Franklin County Board of Commissioners and Optum will use de-identified data for commercial purposes including research.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and Franklin County Board of Commissioners and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

Franklin County Board of Commissioners and Optum do not provide health care services or supplies, nor do they practice medicine. Instead, Franklin County Board of Commissioners and Optum arranges for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. Optum's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided. They are not Franklin County Board of Commissioners' employees nor are they employees of Optum. Franklin County Board of Commissioners and Optum are not responsible for any act or omission of any provider.

Optum is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Franklin County Board of Commissioners and the Plan Administrator are solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to Optum.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. You:

- are responsible for choosing your own provider.
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.

- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Franklin County Board of Commissioners is that of employer and employee, Dependent or other classification as defined in this SPD.

Interpretation of Benefits

Franklin County Board of Commissioners and Optum have the sole and exclusive discretion to:

- interpret Benefits under the Plan.
- interpret the other terms, conditions, limitations, and exclusions of the Plan, including this SPD and any Summary of Material Modifications and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Franklin County Board of Commissioners and Optum may delegate this discretionary authority to other persons or entities that provide services about the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Franklin County Board of Commissioners may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Franklin County Board of Commissioners does so in any case shall not in any way be deemed to require Franklin County Board of Commissioners to do so in other similar cases.

Information and Records

Franklin County Board of Commissioners and Optum may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Franklin County Board of Commissioners and Optum may request additional information from you to decide your claim for Benefits. Franklin County Board of Commissioners and Optum will keep this information confidential. Franklin County Board of Commissioners and Optum may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Franklin County Board of Commissioners and Optum with all information or copies of records relating to the services provided to you. Franklin County Board of Commissioners and Optum have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether they have signed the Participant's enrollment form. Franklin County Board of Commissioners and Optum agree that such information and records will be considered confidential.

Franklin County Board of Commissioners and Optum have the right to release all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Franklin County Board of Commissioners is required to do by law or regulation. During and after the term of the Plan, Franklin County Board of Commissioners and Optum and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Franklin County Board of Commissioners recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from Optum, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Franklin County Board of Commissioners and Optum will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by Optum to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from Optum for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services

would be subject to the applicable Copayment and/or Coinsurance as described in *Plan Highlights*.

If you have any questions regarding financial incentives, you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-Optum entity. The decision about whether to participate is yours alone but Franklin County Board of Commissioners recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Future of the Plan

Although the Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Plan Sponsor's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Plan Sponsor does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Plan Sponsor decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Plan Sponsor and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative)

may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

Review and Determine Benefits in Accordance with Optum Reimbursement Policies

Optum develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that Optum accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse, and fraud reviews), Optum's reimbursement policies are applied to provider billings. Optum shares its reimbursement policies with Physicians and other providers in Optum's Network through Optum's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by Optum's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of Optum's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of Optum's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.liveandworkwell.com** or by calling 1-800-852-1091.

Optum may apply a reimbursement methodology established by *OptumInsight* and/or a third-party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, Optum will use a comparable methodology(ies). Optum and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to Optum's website at **www.liveandworkwell.com** for information regarding the vendor that provides the applicable methodology.

SECTION 12 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning regarding the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services.
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations, and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests, or activities.

Claims Administrator – Optum and its affiliates, who provide certain claim administration services for the Plan.

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Copayment-the fixed amount you pay for a covered health care service, after you have paid your deductible.

Covered Health Services - those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing, or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease, or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 6, *Exclusions and Limitations*.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "you're" throughout this SPD are references to a Covered Person.

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring, and ambulating).
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with Optum, or with an organization contracting on Optum's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- Optum has identified through Optum's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting Optum at **www.liveandworkwell.com** or calling 1-800-852-1091.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with Optum, or with an organization contracting on Optum's behalf, to deliver Covered Health Services via interactive audio and video modalities.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*

Employer – Franklin County Board of Commissioners.

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the Claims Administrator decides regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6 and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by Optum to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any).
- the allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- any other reductions taken.
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home, or similar institution.

Inpatient Rehabilitation Facility – a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age-appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.[PBJ7]

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Late Enrollee – a Participant or Dependent who enrolls for coverage under the Plan at a time other than:

- within 31 days of the date, you first become eligible for coverage under the Plan.
- during an Open Enrollment; or
- within 31 days of the date, you experience a change in family status as described under *Changing Your Coverage* in Section 2, *Introduction*.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease, or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myOptum.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.OPTUMprovider.com**.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders,* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator – the organization or individual designated by Optum who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders,* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period, determined by Franklin County Board of Commissioners, during which eligible Participants may enroll themselves and their Dependents under the Plan. Franklin County Board of Commissioners determines the period that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Franklin County Board of Commissioners Medical Plan.

Plan Administrator – Franklin County Board of Commissioners or its designee.

Plan Sponsor – Franklin County Board of Commissioners.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
- It has or maintains a written, specific, and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retired Employee – an Employee under age 65 who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Sickness – physical illness, disease, or Pregnancy. The term Sickness as used in this SPD does not include mental illness or substance-related and addictive disorders, regardless of the cause or origin of the mental illness or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel to obtain the specified medical outcome and provide for the safety of the patient.
- a Physician orders them.
- they are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair.
- they require clinical training to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse – an individual to whom you are legally married.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders,* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Total Disability – a Participant's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted

randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Optum has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, Optum issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myOptum.com**.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), Optum may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, Optum must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

The decision about whether such a service can be deemed a Covered Health Service is solely at Optum's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office, or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center – a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required because of an unforeseen Sickness, Injury, or the onset of acute or severe symptom

ATTACHMENT I – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call 1-800-852-1091, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call 1-800-852-1091, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစ လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏇ ᏰᏢ ᏗᏟᏃᏑᏗ ᏗᏎᏍᏗ ᏥᎪᏜᏔ ᎵᏓ ᏣᏤᎵ ᏙᎯ ᏰᎡ ᏗᎫᎪᏙᏗ ᎪᏟᏍᏙᏗ ᏆᎾᎰᏍᏗᎢ, ᏧᏋᏫᏍᏮ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa y<u>a</u>, apela micha nana aiimma yvt nan aivlli keyu h<u>o</u> ish isha hinla kvt chim aiivlhpesa. Tosholi y<u>a</u> asilhha ch<u>i</u> hokmvt ch<u>i</u> achukm<u>a</u>ka holisso kallo iskitini y<u>a</u> tvli aianumpuli holhtena y<u>a</u> ibai achvffa yvt peh pila h<u>o</u> ish <u>i</u> p<u>a</u>ya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo pono‘ī me ka uku ʻole ʻana. E kama‘ilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n’efu n’akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၣ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဝဲလၢတလိၣ်ဟ့ၣ်အပ္ၢ်ဘၣ်နၣ်လီၤ.လၢတၢ်ကယ့န့ၣ်ပှၤကတိၤကျိာ်ထံတၢ်တဂၤအဂီၢ်ကိးဘၣ်လီတဲစိအကျိၤလၢကရၢဖိအတလိၣ်ဟ့ၣ်အပ္ၢ်လၢအအိၣ်လၢနတၢ်အိၣ်ဆူၣ်အိၣ်ချ့အတၢ်ရဲၣ်တၢ်ကျ အကၢ်အလိၤဒီးဆီၣ်လီၤနီၣ်ဂံၢ် 0 တက့ၢ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پێناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meļeļe ilo kajin eo aṃ ilo ejjeļọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrļok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ąh 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit[‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77

Language	Translated Taglines
	bik11' b44sh bee hane'7 t'11 j77k'eh bee hane'7 bik1'7g77 bich'8' hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईंसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wɛ̈rëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia

Language	Translated Taglines
	fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܠܝܫ ܠܟ ܙܟܘܬܐ ܕܬܫܡܫ ܒܝܕ ܥܕܪܬܐ ܘܝܕܥܬܐ ܒܠܫܢܟ ܒܠܐ ܡܚܐܠܐ. ܐܢ ܒܥܝܬ ܠܡܬܪܓܡܢܐ، ܩܪܘ ܠܡܣܬܪ ܕܛܠܦܘܢ ܕܒܪ ܡܢ ܐܝܕ ܟܪܛܝܣ ܕܐܝܕܢܛܝܛܝ ܕܐܬ ܒܟܠ ܬܘܡܟ ܘܠܚܘ 0 ܒܛ ܐܝ ܐܝ. TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంటు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	'Oku ke ma'u 'a e totonu ke ma'u 'a e tokoni mo e 'u fakamatala 'i ho'o lea fakafonua ta'etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta'etotongi ma'ae kau memipa 'a ee 'oku lisi 'I ho'o kaati ID ki ho'o palani ki he mo'uilelei, Lomi'I 'a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non

Language	Translated Taglines
	kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0'a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן קארטל , דרוקט 0. TTY 711 ID
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

Attachment II- Summary of Consolidated Appropriations Provisions

No Surprises Act

Under the *Consolidated Appropriations Act* (the Act), the *No Surprises Act* prohibits balance billing by out-of-Network providers in the following instances:

1) When ancillary services, as described in the Act, are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.
2) When non-ancillary services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria as described in the Act, or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied.
3) When Emergency health care services are provided by an out-of-Network provider.
4) When air ambulance services are provided by an out-of-Network provider.

In these instances, the out-of-Network provider may not bill you for amounts in excess of your applicable Co-payment, Co-insurance or deductible (cost share). Your cost share is based on the recognized amount as described in the Act and as set forth below.

When Covered Health Care Services are received from out-of-Network providers as stated above, Allowed Amounts are based upon one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- *The reimbursement rate as determined by state law.*
- The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

For the purpose of this summary the following terms have the meanings stated below:

"Ancillary services" are items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the *Secretary* (as that term is applied in the Act*)*;
- Provided by such other specialty practitioners as determined by the *Secretary*; and
- Provided by an out-of-Network Physician when no other Network Physician is available.

"Emergency health care services" are the following services with respect to an Emergency:

- An appropriate medical screening exam (as required under section *1867 of the Social Security Act* or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a Hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an independent freestanding emergency department, as applicable, as are required under section *1867 of the Social Security Act,* or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3)* of the *Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency health care services include items and services otherwise covered under the Policy when provided by an out-of-Network provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

  a) The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition

  b) The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

  c) The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

  d) The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

  e) Any other conditions as specified by the *Secretary.*

  The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

"Independent freestanding emergency department" is a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency health care services

"Recognized amount" is the amount which your cost sharing is based on for the below Covered Health Care Services when provided by out-of-Network providers:

- Out-of-Network Emergency health care services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either ancillary services, or non-ancillary services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Ac*t. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the *Secretary*.

The amount is based on one of the following in the order listed below as applicable:

1) An *All-Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

The recognized amount for air ambulance services provided by an out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered Health Care Services that use the recognized amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Continuity of Care

The Act provides that if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

Payment of Benefits

Allowed amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the Act are paid directly to the provider.

Provider Directories

The Act provides that if you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic,

web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from a Network provider.