



educational service center
of Central Ohio

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION FOR
OHIO HEALTHCARE PLAN, CENTRAL DIVISION OF OHI – **DENTAL BENEFIT PLAN**
For Employees of
EDUCATIONAL SERVICE CENTER OF CENTRAL OHIO

AMENDED AND RESTATED EFFECTIVE MARCH 1, 2014

TABLE OF CONTENTS

INTRODUCTION.....	1
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS	2
OPEN ENROLLMENT	8
SCHEDULE OF BENEFITS	9
DEFINED TERMS	10
DENTAL BENEFITS	13
HOW TO SUBMIT A CLAIM	17
COORDINATION OF BENEFITS.....	22
RECOVERY PROVISION	27
CONTINUATION COVERAGE RIGHTS UNDER COBRA	28
RESPONSIBILITIES FOR PLAN ADMINISTRATION	35
GENERAL PLAN INFORMATION	39

INTRODUCTION

This document is a description of Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan (the “Plan,” previously referred to as the “Ohio Healthcare Consortium Dental Benefit Plan”). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain other expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

Dental care has become an increasingly common and expensive medical cost in recent years. Yet, dental health can be maintained easily through regular, routine care. Therefore, in addition to reimbursement for much of the cost of major procedures, the Plan encourages preventive and restorative dental care in order to avoid future, more costly major dental expenses.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document describes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day of active employment.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse.

“Spouse” means any person who is lawfully married to a covered Employee under any State law, including individuals married to covered Employees of the same sex who were legally married in a State that recognizes such marriages, but who are domiciled in a State that does not recognize such marriages. For purposes of the foregoing sentence, “State” shall mean any domestic or foreign jurisdiction having legal authority to sanction marriages. The Plan Administrator may require documentation proving a legal marital relationship.

In order to be eligible for coverage under the Plan, any Spouse of an eligible Employee who has coverage available through an employer sponsored group health plan must join that plan on at least a single enrollment basis. A Spouse is considered to have coverage available if:

- 1. The Spouse has access to continuous (non-seasonal) group coverage through employment (other than employment with the ESC of Central Ohio), or would have such access but for a provision of the Spouse’s employer’s plan which determines eligibility with reference to the Spouse’s eligibility to participate in this Plan; and**
- 2. The Spouse works more than 20 hours in an average work week, and**
- 3. The Spouse is not required to pay more than 50% of the premium for coverage.**

- (2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the child's birthday.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

- (3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years. Coverage will end on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

This Plan will comply with provisions set forth in the State of -exOhio budget passed in July 2009 which allows certain dependent children to remain on the Plan up to age 28. The Employee must request coverage under this provision from the Employer. Please refer to the Employer's human resources representative for more information.

FUNDING

Cost of the Plan. The Employer shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll himself for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is also required to enroll for Dependent coverage, if he so chooses.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care and Physician care will be applied toward the Plan of the newborn child. If the

newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

- (1) Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

- (2) Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis".

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

Coverage begins on January 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Ohio Healthcare Plan, Central Division of OHI – Dental Benefits Plan, 2080 Citygate Drive, Columbus, Ohio, 43219

SPECIAL ENROLLMENT PERIODS

An Eligible Employee who declined this coverage for himself or his dependents during the initial 30-day eligibility period may enroll for coverage later if the following conditions are met:

- 1)** The Eligible Employee (and/or dependent) loses coverage under another Group Health Plan or other health insurance coverage, which was in force at the time this coverage was initially declined and was the reason for the declination.
- 2)** The loss of coverage is due to one of the following events:
 - a) Loss of eligibility for coverage is due to cessation of employer contributions, legal separation, divorce or due to a spouse's death, termination of employment or reduction in the number of hours employed. Loss of eligibility does not include any loss due to failure of the individual to pay premiums on a timely basis or termination for cause; or
 - b) COBRA Continuation Coverage from the prior employer has been exhausted.

- c) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
- d) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time Employees).
- e) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual).

A Special Enrollment Period is also offered to any Eligible Employee who previously declined coverage for any reason who later acquires an Eligible Dependent (or additional Eligible Dependent) due to:

- Marriage
- Birth of a child
- Adoption or placement for adoption

In the case of enrollment during a Special Enrollment Period, the Employee must request coverage as outlined in this section within 30 days of the date COBRA Continuation Coverage is exhausted or the other coverage is terminated due to loss of eligibility or of acquiring an Eligible Dependent. The Effective Date of coverage obtained under a Special Enrollment Period will be the date the completed request for enrollment is received by the Plan Administrator. However, in the case of marriage, birth, adoption or placement for adoption, the Effective Date will be the date of marriage, birth, adoption or placement for adoption.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period. This includes the employee paying any required contributions.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or

- (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan, 2080 Citygate Drive, Columbus, Ohio, 43219. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) Coverage on the date in which the Qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) Coverage will end on the date in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)
- (6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

OPEN ENROLLMENT

OPEN ENROLLMENT

During the annual open enrollment period (as determined by Employer), covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

During the annual open enrollment period (as determined by Employer), Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective as of the beginning of the Plan Year immediately following the open enrollment period and remain in effect until the beginning of the next Plan Year or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Benefit choices for Late Enrollees made during the open enrollment period will become effective as of the beginning of the Plan Year immediately following the open enrollment period.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SCHEDULE OF BENEFITS

For **Verification of Eligibility** please refer to the telephone number on the employee's identification card.

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

Please read the section Alternate Treatment in the Dental Plan. You will need to follow this section or reimbursement from the Plan may be reduced.

DENTAL CARE BENEFIT SCHEDULE

DENTAL CARE BENEFIT	
MAXIMUM BENEFIT AMOUNT	BENEFIT
For Class A – Preventive, Class B – Basic, and Class C – Major	\$1,875 per Benefit Year
For Class D – Orthodontia	\$1,000 per Lifetime
COVERED CHARGES	
Classes of Benefits	Percentage Payable
Class A Services - Preventive	100%
Class B Services - Basic	80%
Class C Services - Major	70%
Class D Services - Orthodontia	50%

Additional information on Dental Care can be found in the Dental Benefits section of this document.

NOTE: Dental expenses under the Dental Benefits section of this Plan do not apply to the Benefit Year Deductible or to the Out-of-Pocket Maximum under the medical portion of this Plan.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Educational Service Center of Central Ohio.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medically or Dentally Necessary care and treatment is recommended or approved by a Dentist; is consistent with the patient's condition or accepted standards of good dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan (previously referred to as the “Ohio Healthcare Consortium Dental Benefit Plan”), which is a benefits plan for certain Employees of Educational Service Center of Central Ohio and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year or Benefit Year effective October 1, 2013 through December 31, 2014, the Plan will run on a 15 month Plan and Benefit Year. Every subsequent year starting in 2015, the Plan and Benefit Year shall shift to the Calendar Year and shall begin on January 1 and end on December 31.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Benefit Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Benefit Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Benefit Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

NON-DUPLICATION OF BENEFITS

When dental expenses are eligible for payment under both the medical plan and dental plan benefits for such expenses shall be paid under the medical plan and no payment will be made under the Dental Benefits Plan.

COVERED DENTAL SERVICES

Class A Services: Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each per Benefit Year.
- (2) Two bitewing x-ray series per Benefit Year.
- (3) One full mouth x-ray every 36 months.
- (4) One fluoride treatment for covered Dependent children under age 19 each Benefit Year.
- (5) Space maintainers for covered Dependent children under age 16 to replace primary teeth.
- (6) Emergency palliative treatment for pain.

- (7) Sealants for covered Dependent children under age 16

**Class B Services:
Basic Dental Procedures**

- (1) Dental x-rays not included in Class A.
- (2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
- (3) Periodontics (gum treatments).
- (4) Endodontics (root canals).
- (5) Extractions. This service includes simple extractions and partial impactions, as well as, local anesthesia and routine post-operative care.
- (6) Recementing bridges, crowns or inlays.
- (7) Fillings, other than gold.
- (8) General anesthetics, upon demonstration of Medical Necessity.
- (9) Antibiotic drugs.
- (10) Occlusal guards.

**Class C Services:
Major Dental Procedures**

- (1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- (2) Installation of crowns.
- (3) Installing precision attachments for removable dentures.
- (4) Addition of clasp or rest to existing partial removable dentures.
- (5) Initial installation of fixed bridgework to replace one or more natural teeth.
- (6) Repair of crowns, bridgework and removable dentures.
- (7) Rebasing or relining of removable dentures.
- (8) Implants
- (9) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if:
 - (a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

- (b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

**Class D Services:
Orthodontic Treatment and Appliances**

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be \$300.00 or more, a predetermination of benefits form must be submitted.

The Dentist must itemize all recommended services and costs and include all supporting x-rays and/or charting.

The Dentist should send the form and supporting documentation to the Claims Administrator at this address:

Employee Benefit Management Corp
4789 Rings Road
Dublin, Ohio 43017
(877) 304-0761

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

EXCLUSIONS

A charge for the following is not covered:

- (1) **Analgesia** Charge made by a dentist for analgesia.
- (2) **Bacterial Studies** Services related to bacterial studies submitted under the dental plan.
- (3) **Behavioral Management** Services or supplies related to behavior management and

counsel.

- (4) **Bleaching of discolored teeth** Services or supplies related to whitening of teeth.
- (5) **Caries Susceptibility** Services or supplies to caries susceptibility.
- (6) **Completion of Claim Form** Charges made by dental provider to complete employee dental claim form.
- (7) **Crowns** or teeth that is restorable by other means or for the purpose of Periodontal Splinting.
- (8) **Dietary Planning** Charges received related to counsel and diet planning under the dental plan.
- (9) **Excluded under Medical** Services that are excluded under Medical Plan Exclusions.
- (10) **Emergency Tracheotomy** Charges received under dental plan for emergency tracheotomy.
- (11) **Fabrication of athletic mouthguards** Charges received related to mouthguards.
- (12) **Fractures** (jaw, facial bones, etc.) Charges received under dental plan related to fractures.
- (13) **Histopathologic Exam** Charges received under dental plan related to tissue and pathology exams.
- (14) **Hygiene** Oral hygiene, plaque control programs or dietary instruction.
- (15) **Implants**, including any appliances and/or crowns and the surgical insertion or removal of implants.
- (16) **Medical services** that, to any extent, are payable under any medical expense benefits of the Plan.
- (17) **Myofunctional Appliances** Charges received for application or purchase of myofunctional appliances.
- (18) **Occlusion analysis – mounted case** Services related to occlusion analysis-mounted case.
- (19) **Personalization.** Personalization of dentures.
- (20) **Replacement** of lost or stolen appliances.
- (21) **Splinting** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
- (22) **Stress Breaker** Charges related to a stress breaker.
- (23) **Suturing of wounds** Charges received under the dental plan for services related to the repair of wounds.
- (24) **Temporary Appliances and Temporary Dentures** Charges for services and supplies related to temporary appliances or dentures.

HOW TO SUBMIT A CLAIM PROCEDURE FOR CLAIMING BENEFITS UNDER THE PLAN

All Out-of-Network claims submitted within the timely filing period should be submitted directly to the Claims Administrator. Network providers will submit their expenses directly to the Network. The Covered Person's health plan identification card indicates to providers and Covered Persons how to file a claim.

Note: Cancelled checks, balance-due statements, photocopies, faxes, handwritten claims and payment receipts do not contain sufficient information to meet claim-filing requirements and cannot be accepted.

Complete and current information must be provided for:

- 1) Accident or Injury Claims — Explain how, when and where the Injury occurred and whether any other party was involved or responsible for the accident.
- 2) Other Coverage — List the name, address and telephone number of any other coverage or payer that may provide coverage, including, but not limited to, COBRA, Medicare and any other benefit plan.
- 3) Prescription Drugs — If the Plan has a pharmacy Network indicated on the Covered Person's health plan identification card, present the card when filling a prescription and pay any required co-payment. If the prescription is rejected at the pharmacy or through a mail-order drug program, if applicable, the Covered Person or the pharmacist should call the telephone number for the drug program shown on the health plan identification card for an explanation. If still not resolved, the Covered Person may file a written claim for benefit consideration. In the event the claim is denied, an explanation will be sent **to the Covered Person in writing**. The Covered Person has 180 days in which to file a written appeal and the Plan will respond in writing within 60 days.
- 4) Pre-Existing Conditions — If a Certificate of Prior Creditable Coverage is not submitted to reduce the Plan's Pre-Existing Conditions Limitation time period, the Plan may request additional information from a Covered Person and/or his Physician. This information will be regarding any Pre-Existing Condition treated within the time frame described herein prior to the person's Effective Date. (See the "Pre-Existing Conditions Limitation" section of this booklet.)

If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

If a Covered Person or provider needs help filing a claim or information on the benefits provided under the Plan, he may contact the telephone number listed on the Covered Person's health plan identification card and speak with a Customer Service Representative.

All days mentioned in the previous section refer to "calendar days." All claims for benefits must be submitted within **ONE YEAR** from the incurred date of service to be eligible for benefits under this Plan.

DECISION ON SUBMITTED CLAIMS/PRE-AUTHORIZED SERVICES

Claims for benefits are defined as Pre-Service Claims or Post-Service Claims. Response time may vary according to the type of claim. Pre-Service Claims may be considered "urgent" or "concurrent." An Adverse Benefit Determination includes any decision to deny, reduce, rescind, or terminate coverage or refuse payment and includes eligibility denials and utilization review decisions. Upon written request, the Plan must explain any internal rules, guidelines or protocols, as well as disclose names of medical professionals who were consulted in the review process.

Pre-Service Claim: A Pre-Service Claim requires the Covered Person to pre-certify, notify or receive approval prior to receiving treatment. The Utilization Review Manager must give notice of the decision no later than 15 days after the request for services, with one 15-day extension permitted. An extension is permitted only for reasons beyond control of the Plan and requires the Covered Person be given written notification before the first 15-day period ends.

Urgent Claim: An urgent claim is any claim for medical care or treatment in which the Covered Person's health or life is seriously jeopardized without treatment or which would subject the patient to severe pain if treatment were delayed, as certified by a Physician. The Utilization Review Manager must respond to an urgent claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Concurrent Claim: A concurrent claim is any claim that requires the approval of an ongoing course of treatment to be provided over a period of time or number of treatments (an example of a concurrent claim is physical therapy treatment). If the care is urgent, the Plan must respond to the Covered Person within 24 hours. When approved, if services are to be rendered over an extended period of time, the Covered Person shall be entitled to a review prior to reduction or termination of benefits.

Post-Service Claim: A Post-Service Claim is any claim that is not a Pre-Service Claim. Timely claim filing begins when the Claims Administrator receives a claim with re-priced information from any participating Network, if applicable. The Plan must give notice of approval within 30 days after a Post-Service Claim is received. A Post-Service Claim also allows a 15-day extension for reasons beyond Plan control if proper notice is given prior to the end of the first 30-day period.

No legal action for recovery of benefits allegedly due under any Company Sponsored benefit plan may be commenced by or on behalf of an employee or former employee against the Plan, the Plan Administrator, the Trustee, or successor of the same unless it is filed within one year after the date of the final determination noted in the appeals procedure of the relevant benefit Plan Document.

INCOMPLETE CLAIMS

Urgent Claims: If an urgent claim fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan shall notify the claimant as soon as possible, but not later than 24 hours following receipt of the incomplete claim, of the specific information necessary to complete the claim. The notification may be made orally to the claimant, unless the claimant requests written notice and it shall describe the information necessary to complete the claim. The claimant must submit the requested information as soon as possible, but not later than 48 hours after the claimant receives notice from the Plan of the incomplete claim. The Plan shall decide the claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the due date for the requested information.

Pre-Service Claims: If a Pre-Service Claim Claim fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the claim will be treated as an incomplete claim and the Plan will notify the claimant that additional information is needed to process the claim. The notice shall include a description of the missing information and shall provide the claimant no more than 45 days in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the notice is received by the claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan shall decide the claim no later than 15 days after the missing information is received by the Plan. If the requested information is not provided, the claim may be decided without such information.

Post-Service Claims: If a Post-Service Claim fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the claim will be treated as an incomplete claim and the Plan will notify the claimant that additional information is needed to process the claim. The notice shall include a description of the missing information and shall provide the claimant no more than 180 days in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the notice is received by the claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan shall decide the claim no later than 15 days after the missing information is received by the Plan. If the requested information is not provided, the claim may be decided without such information.

ADVERSE BENEFIT DETERMINATIONS AND APPEAL PROCEDURES

If a benefit is denied, in whole or in part, it is considered an Adverse Benefit Determination, as defined. When an Adverse Benefit Determination is made, the claimant will receive written or electronic notification of the following:

- 1) The specific reason(s) for the Adverse Benefit Determination;
- 2) Reference to relevant Plan provisions used in making the determination;
- 3) A description of additional information necessary for the claimant to perfect the claim and an explanation of why the additional information is necessary;
- 4) A description of the Plan's appeal procedures applicable to the claim, including any applicable time limits;

- 5) If the Adverse Benefit Determination reflected was based upon an internal rule, guideline or protocol, a copy of the rule, guideline or protocol will be provided free of charge upon written request. In addition, if the determination was based on a limitation or exclusion that the treatment was experimental or not medically necessary, an explanation of the scientific or clinical judgment relied upon will be sent free of charge upon written request; and
- 6) In the case of an Urgent Care Claim, an explanation of the expedited review methods available for such claims. Notification of the Plan's adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished no later than three (3) days after the oral notice.

If the Covered Person (or the Covered Person's authorized representative) is dissatisfied with a benefit determination, he has 180 days following receipt of an Adverse Benefit Determination to submit a written appeal to the Plan Sponsor. If an appeal relates to an Urgent Care Claim, the Covered Person will be notified of the benefit determination on review as soon as possible, but not later than 72 hours after receipt of the appeal request. If an appeal relates to a non-urgent Pre-Service Claim, the Covered Person will be notified of the benefit determination on appeal not later than 30 days after receipt of the appeal request. If the appeal relates to a Post-Service Claim, the Covered Person will be notified of the benefit determination on review not later than 60 days after receipt of the appeal request. If a medical professional was consulted for the initial denial, then an independent reviewer must be used for the appeal. The "Definitions" section contains definitions for Adverse Benefit Determination, Urgent Care Claim, Pre-Service Claim and Post-Service Claim.

As part of the appeal process, a full and fair review of each claim will be provided on an unbiased basis. Any individual involved in the initial determination may not participate in an appeal of the initial determination. Documents and other information relating to the claim may be submitted. Upon written request (and free of charge), reasonable access to the Plan's Documents and information relevant to the appealed claim will also be provided. A Covered Person may also submit a written appeal of his notice regarding Creditable Coverage applied to reduce any Pre-Existing Conditions Limitation in the Plan. The Claims Administrator will review this report and a written report will be sent to the Plan Administrator. The Plan will render a decision within 60 days of the appeal with specific reasons for the conclusions reached. If the Plan considers, relies on or generates any new evidence during the appeal process, or bases its determination on appeal on a new rationale, the Plan must furnish new evidence or rationale to the Covered Person as soon as possible and free of charge. Such documentation must be provided sufficiently in advance of the final determination so that the Covered Person has a reasonable opportunity to respond before the final determination is made.

Standard External Review Procedures

A Covered Person may make a written request to the Plan for an external review no later than one-hundred eighty (180) days after the date in which a Covered Person receives notice of the final internal adverse benefit determination.

A Covered Person shall have the right to an external review provided:

- (a) The denial involves a medical judgment or is based on medical information (i.e., determined not to be medically necessary); or
- (b) the denial indicates that the service is experimental or investigational and the treating physician certifies one of the following: (i) standard health care services have not been effective; (ii) standard health care services are not medically appropriate; and (iii) there is no available standard health care services covered by the plan that are more beneficial than the requested service; or
- (c) denial is based on a contractual issue not involving a medical judgment or medical information; or
- (d) denial indicates that emergency services did not meet definition of emergency and the decision has been upheld through external review by an independent review organization ("IRO"); and
- (e) The Covered Person has exhausted the Plan's internal appeal process.

If the Plan denies an external review request due to failure to exhaust the Plan's internal appeals process, the Covered Person may request an explanation and the Plan shall provide an explanation no later than ten (10) days after the request. The Covered Person may request review by the Ohio Department of Insurance of the Plan's explanation. If the Ohio Department of Insurance affirms the Plan's explanation, the Covered Person may re-submit and pursue the Plan's internal appeal process no later than ten (10) days after the Covered Person receives notice from the Ohio Department of Insurance.

Immediately following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether the request is complete and eligible for external review. Immediately after completion of the preliminary review, the Plan must issue a notification in writing to the Covered Person of whether the claim is complete and is eligible for external review.

If a request for an external review is complete, but not eligible for external review, the Plan must issue a notification in writing to the Covered Person stating the reasons for the ineligibility and informing the Covered Person that the denial may be appealed to the Ohio Department of Insurance. If the Ohio Department of Insurance determines that the request is eligible for external review, the request shall be referred for external review.

If a request for an external review is incomplete, the Plan must issue a notification in writing to the Covered Person that describes the information or materials needed to complete the request.

If a request for an external review is complete (and the Covered Person is entitled to exercise that option), the Plan must immediately initiate the external review process. The Plan must forward all documents and related information used in making the final adverse benefit determination to the Ohio Department of Insurance or IRO within five (5) days after the external review is requested.

The IRO will provide written notice to the Covered Person, to the Ohio Department of Insurance and to the Plan of the final external review decision with thirty (30) days after the IRO receives the request for the external review. If an IRO reverses the Plan's decision, the Plan must immediately provide the requested coverage or pay the claims at issue.

The IRO's notice will contain:

- (a) A general description of the reason for the external review, including information sufficient to identify the claim;
- (b) The date the IRO received the assignment to conduct the external review, the date the external review was conducted and the date of the IRO's decision;
- (c) References to the evidence or documentation the IRO considered in reaching its decision;
- (d) A discussion of the principal reason(s) for the IRO's decision, including what, if applicable, evidence-based standards were a basis for its decision and the rationale for its decision.

Expedited External Review Procedures

A Covered Person may request an expedited external review at the time the Covered Person receives:

- (a) An initial adverse benefit determination if (i) the treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person if treatment is delayed until after the time of expedited internal appeal or standard external review and (ii) the Covered Person requests an expedited internal review; or
- (b) A final internal adverse benefit determination if (i) the treating physician certifies that adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treated after the time period for a standard external review or (ii) the final adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which the Covered Person received emergency services, but has not yet been discharged.

Immediately upon receipt of a request for an expedited external review, the Plan must determine whether the request satisfies the reviewability requirements, described above, for a standard external review and immediately send a notice of the Plan's eligibility determination.

If the Plan determines that the claim is eligible for an expedited external review:

- (a) The Plan must immediately initiate the external review process;
- (b) The Plan must immediately provide all necessary documents and information to the IRO in an expeditious manner (e.g., e-mail, fax, phone);
- (c) The IRO must consider the following in reaching its decision, to the extent the information or documents are available and to the extent the IRO considers them appropriate:
 - (i) The Covered Person's medical records;

- (ii) The attending health care professional's recommendation;
- (iii) Consulting reports from the appropriate health care professionals and other documents submitted by the health carrier, Covered Person or Covered Person's treating physician;
- (iv) The terms of coverage under the Plan;
- (v) The most appropriate practice guidelines, which shall include evidence based standards, and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- (vi) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse benefit determinations; and
- (vii) The opinion of the IRO's clinical reviewers after considering (i) – (vi), above, to the extent the information and documents are available and the clinical reviewer(s) consider appropriate.

The IRO must provide a notice of the final external review decision as expeditiously as the Covered Person's medical condition or circumstance require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

An expedited external review may be requested by a Covered Person by oral or by electronic means. If made by oral or electronic means, the Covered Person must provide written confirmation of the request to the Plan not later than five (5) days after the initial request was made.

COORDINATION OF BENEFITS

The Coordination of Benefits provision applies when a person has health care coverage under more than one Plan. “Plan” for the purpose of the Coordination of Benefits provisions is defined below.

This Plan has been designed to help meet the cost of Illness or Injury. The amount of benefits payable under this Plan will take into account any coverage under other Plans and be coordinated with the benefits of the other Plans. The objective is to make sure the combined payments of all Plans are no more than your actual expenses.

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

This Plan will always pay either its regular benefits in full if it is determined to be the Primary Plan (Plan primarily responsible for payment) or, if the Plan is determined to be the Secondary Plan, a reduced amount which, when added to the benefits payable by the Primary Plan, will equal no more than the Allowable Benefit under This Plan.

When you or your family members are covered by another group Plan in addition to this one, This Plan will follow Ohio Coordination of Benefits rules to determine which Plan is the Primary Plan and which Plan is the Secondary Plan. You must submit all bills first to the Primary Plan. The Primary Plan must pay its full benefits as if you had no other coverage. If the Primary Plan denies the claim or does not pay the full bill, you may then submit the balance to the Secondary Plan.

This Plan pays for health care only when you follow This Plan's rules and procedures. If This Plan's rules conflict with those of another Plan, it may be impossible to receive benefits from both Plans, and you will be forced to choose which Plan to use.

DEFINITIONS

Plan. For purposes of the Coordination of Benefits provisions, the term Plan includes any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no Coordination of Benefits among those separate contracts.

Plan includes: group and nongroup insurance contracts, health insuring corporation contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; some supplemental coverages; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplemental policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage above is a separate Plan. If a Plan has two parts and Coordination of Benefits rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan. “This Plan” means the part of healthcare Plan offered by the Employer providing the health care benefits to which the Coordination of Benefits provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one Coordination of Benefits provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another Coordination of Benefits provision to coordinate other benefits.

The “order of benefit determination rules” (see below) are used to determine whether This Plan is a primary Plan or a secondary Plan when a person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits.

When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

The following are examples that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursements or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

Custodial Parent. The parent awarded custody by a court decree, or in the absence of a court decree, is the parent with whom the child resides for more than one half of the calendar year excluding any temporary visitation.

Closed Panel Plan. A Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

ORDER OF BENEFIT DETERMINATION RULES – Which Plan is Primary?

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

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in Paragraph C. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
- C. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written

in connection with a Closed Panel Plan to provide out-of-network benefits.

- D. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- E. Each Plan determines its order of benefits using the first of the following rules that apply:
1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example, as an employee, member, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as a employee, member, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan, the order of benefits is determined as follows:
 - a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan;
 - (3) However, if one spouse's Plan has some other coordination rule (for example a "gender rule" which says that the father's Plan is always primary), the rules of that Plan will be followed.
 - b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, and the Plan of that parent has actual knowledge of those terms, the Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - (2) If a court decree states that: (a) both parents are responsible for the dependent child's health care expenses or health care coverage, or (b) the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a. above shall determine the order of benefits; or
 - (3) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the custodial parent;
 - (b) The Plan covering the spouse of the custodial parent;
 - (c) The Plan covering the non-custodial parent; and then

- (d) The Plan covering the spouse of the non-custodial parent.
- c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraphs a. or b. above shall determine the order of benefits as if those individuals were the parents of the child.
3. Active Employee or Retired or Laid-Off Employee. The Plan that covers a person as an active employee is the Primary Plan. The Plan covering the same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule regarding dependents and non-dependents can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person, whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law, is covered under another Plan, the Plan covering the person as a employee, member, subscriber or retiree, or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or other continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the rule regarding dependents and non-dependents can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.
7. With regard to any Covered Person eligible to elect Medicare, except an actively-at-work eligible employee age sixty-five (65) or older, or an eligible covered dependent spouse of an active eligible employee who is within the same age bracket, Medicare benefits will be considered as having been paid whether or not the Covered Person has applied for Medicare coverage or submitted a claim for Medicare benefits. It is the Covered Person's responsibility to apply for and maintain Parts A, B and D of Medicare coverage. If Medicare is elected primary, Medicare requires that This Plan not provide any benefits that supplement Medicare for active employees for whom coverage under This Plan would be primary to Medicare if such coverage were elected.

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

PAYMENT TO OTHERS / RIGHT OF RECOVERY

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Claims Administrator may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. The Claims Administrator will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services. If the amount of the payments made by the Claims Administrator is more than it should have paid under these Coordination of Benefits provisions, the Claims Administrator may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting the Claims Administrator:

Employee Benefits Management Corp
4789 Rings Road
Dublin, Ohio 43017-1599
(877) 304-0761 (Toll-Free)
www.ebmconline.com (website).

Additional claims information may be found under the heading “Claims Procedures-Adverse Benefit Determinations and Appeal Procedures”.

Call 1-800-686-1526, or visit the Ohio Department of Insurance website at <http://insurance.ohio.gov>.

RECOVERY PROVISION

INTRODUCTION

The Plan has the right to recover in full the medical benefits (and disability benefits if provided by the Plan) paid for injuries caused by the act or omission of any party. The Plan's right of recovery, as explained below, may be from the Covered Person, the third party, any liability or other insurance covering the third party, the Covered Person's own uninsured motorist benefits, underinsured motorist benefits or any medical pay or no-fault benefits which are paid or payable to the Covered Person from any source whatsoever. The Plan's right to any monies recovered (through either reimbursement or subrogation) takes priority over any other party's right (including that of the Covered Person) to monies recovered, regardless of whether the amount recovered constitutes a partial or full recovery of the benefits paid by the Plan.

RIGHT OF REIMBURSEMENT

To the extent of the payment of benefits by the Plan, the Covered Person shall reimburse the Plan from money recovered by or on behalf of the Covered Person from any source, including, but not limited to, any third party, any liability or other insurance covering the third party, the Covered Person's own uninsured motorist benefits, underinsured motorist benefits or any medical pay or no-fault automobile benefits. The Covered Person's obligation to make restitution to the Plan applies whether the Covered Person has received partial or complete recovery and whether or not the Covered Person is made whole. Accordingly, the Plan hereby expressly disclaims the make-whole doctrine.

Out of the first payment(s) or recovery of compensation or benefits by a third party, the full amount of compensation benefits paid by the Plan must be repaid to the Plan, regardless of the ultimate amount of any recovery, up to and including the amount that such payment(s) or recovery equals the amounts paid by the Plan. The Plan's right of reimbursement is a first-priority right to monies recovered by the Covered Person by way of any settlement of the Covered Person's claim, a judgment in any court proceeding or otherwise. The Plan's recovery rights shall apply to any funds, regardless of how these funds were categorized. Any amounts recovered by the Covered Person shall be held in trust for the exclusive benefit of the Plan, until the Plan's rights, as set forth in this section, have been fully resolved.

The Plan will not pay or share in any attorneys' fees, expenses or costs associated with any claim or lawsuit brought by or on behalf of any Covered Person. Specifically, the Plan does not permit a deduction in any amount to which it is subrogated or to which it is entitled to reimbursement for attorneys' fees, costs or expenses expended by or on behalf of a Covered Person to obtain a settlement, payment, judgment or other recovery.

SUBROGATION

Whether or not the Covered Person pursues recovery from the liable third party or the Covered Person's individual policies, the Plan is subrogated to the rights of the Covered Person and may pursue the claim on its own. The Plan's right to subrogation applies regardless of whether the Covered Person has received partial or complete recovery and regardless of whether or not the Covered Person has been made whole. The Covered Person agrees to cooperate with the Plan's representative who is pursuing the subrogation recovery. The Plan may, but is not obligated to, take legal action against the third party, any liability insurer covering the third party or the Covered Person's own insurer to recover the benefits the Plan has paid. The Covered Person's failure to comply with the requirements of this section may, at the Plan Administrator's discretion, result in a forfeiture of benefits under the Plan.

IN GENERAL

The Covered Person further agrees that he will not release any third party or his insurer without prior written approval from the Plan and will take no action that prejudices the Plan's recovery right. The Covered Person agrees to include the Plan's name as a co-payee on any settlement check. The Covered Person agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's recovery lien.

Payment of any claims to or on behalf of the Covered Person may be delayed, withheld or denied unless the Covered Person cooperates fully and enters into any requested reimbursement/subrogation agreement.

The Covered Person is obligated to inform his attorney of the right of reimbursement/subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan, 2080 Citygate Drive, Columbus, Ohio, 43219. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or

the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the Employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan
2080 Citygate Drive
Columbus, Ohio 43219

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan is the benefit plan of Educational Service Center of Central Ohio. An individual or committee may be appointed by the Plan to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, the Plan shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean

activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
- (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
 - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
 - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
 - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
 - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan (previously, the “Ohio Healthcare Consortium Dental Benefit Plan”)

TAX ID NUMBER: 31-0914093

ORIGINAL PLAN EFFECTIVE DATE: October 1, 2012

PLAN YEAR ENDS: December 31

ADOPTING EMPLOYER INFORMATION

Educational Service Center of Central Ohio
2080 Citygate Drive
Columbus, Ohio 43219

PLAN ADMINISTRATOR

Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan
2080 Citygate Drive
Columbus, Ohio 43219

CLAIMS ADMINISTRATOR

Employee Benefit Management Corp
4789 Rings Road
Dublin, Ohio 43017
(877) 304-0761

IN WITNESS WHEREOF, this Amended and Restated Plan Document for the Ohio Healthcare Plan, Central Division of OHI – Dental Benefit Plan was executed by a duly authorized officer of Educational Service Center of Central Ohio as of date written below, to be effective as of March 1, 2014.

By _____

Its _____

Date _____