

**City of Columbus
Employee Benefits Booklet
FOP**

UNITED HEALTH CARE (MEDICAL)		
<ul style="list-style-type: none"> • Claims 	UHC Claims P.O. Box 981502 El Paso, TX 79998-1502	1-800-681-3849 Claim questions
<ul style="list-style-type: none"> • Appeals 	UHC Appeals P.O. Box 740816 Atlanta, GA 30374-0816	Filing an appeal
<ul style="list-style-type: none"> • Optum/Nurseline 		1-877-365-7922
<ul style="list-style-type: none"> • Student Status Letters 	UHC P.O. Box 981502 El Paso, TX 79998-1502	
<ul style="list-style-type: none"> • United Behavioral Health 	UBH Claims P.O. Box 30755 Salt Lake City, UT 84130-0757	1-800-358-0365 Behavioral health, substance abuse and psychiatric treatments
<ul style="list-style-type: none"> • Pharmacy/ UHC mail order (MEDCO) 	Direct reimbursement claims: Retail Paid Prescriptions, LLC Medco Health Solutions PO Box 2096 Lee's Summit, MO 64063-7096 Mail order Prescriptions Medco Health Solutions PO Box 747000 Cincinnati, OH 45274-7000	1-800-681-3849
<ul style="list-style-type: none"> • Website 	www.myuhc.com	
DELTA DENTAL (DENTAL)		
<ul style="list-style-type: none"> • Claims 	Delta Dental of Ohio P.O. Box 9085 Farmington Hills, MI 48333-9085	Group number : 5866
<ul style="list-style-type: none"> • Website 	www.deltadentaloh.com	PPO & Premier Networks
<ul style="list-style-type: none"> • Orthodontic Claims 	Delta Dental of Ohio P.O. Box 9085 Farmington Hills, MI 48333-9085	
VISION SERVICE PLAN (VISION)		
<ul style="list-style-type: none"> • Website 	www.vsp.com	1-800-877-7195
<ul style="list-style-type: none"> • Out-of Network claim 		VSP Out of Network Claims Dept P.O Box 997105 Sacramento, CA 95899-7105

UNITED HEALTH CARE (COBRA)		1-800-318-5311
STANDARD (LIFE INSURANCE)	Group number: 645816	<ul style="list-style-type: none"> • Contact Risk Management • File death claims through Central Payroll • Conversion forms on City INTRANET
COLONIAL LIFE (SECTION 125 PRE-TAX & SUPPLEMENTAL PREMIUMS)		
<ul style="list-style-type: none"> • Contact 	Chuck Mers 15 Bishop Dr, Suite 102 Westerville, OH 43081-0789 cmers@columbus.rr.com	614-882-9307 or 1-800-272-5025
<ul style="list-style-type: none"> • Health Plan Alternatives (Dependent Child Reimbursement account) 	Ms. Colleen Holcomb Hpa125@rrcol.com	614-890-8268
AFLAC		1-800-992-3522
OHIO DEFERRED COMP	www.ohio457.org	
RISK MANAGEMENT		
Main Number		645-8065
Fax Number		645-8696

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Section I. General Information

Note: Words or phrases that are capitalized are titles or have a special meaning. Those words or phrases with special meanings are defined in the Glossary, found at the end of this section, or within the text in which it is used.

Introduction

This Booklet describes the health care benefits you have under your Collective Bargaining Contract. It also tells you what payments are made for covered health care expenses. The City of Columbus shall provide negotiated benefits as stated your Collective Bargaining Contract. The City of Columbus employee benefits plan is not governed by the Employee Retirement Income Security Act of 1974 (ERISA). ("ERISA does not cover plans established or maintained by government entities, ..."ERISA, 29 USC -1001 et seq., 29 CFR Part 2509 et seq.)

The various Covered Services you are entitled to are called your "benefits." Your medical benefits are explained in general terms. This Booklet will provide the details you need to understand your health care benefits and is issued according to the terms of your Collective Bargaining Contract. In the event of a conflict between your Collective Bargaining Contract and this Booklet, the terms of your Collective Bargaining Contract will prevail. This Booklet does not give details on all the terms in your Collective Bargaining Contract.

This information is issued according to the terms of your Collective Bargaining Contract. It describes the health care benefits available to you as part of your Collective Bargaining Contract. The current benefits administration contract is between United Healthcare and the City of Columbus. United Healthcare agrees to provide the benefits described in this section. Employees are covered by the benefits administration contract who have:

- satisfied the Eligibility conditions,
- applied for coverage, and
- have been approved by the United Healthcare and/or the City of Columbus Human Resources.

This booklet is written in language to help you and your dependents understand your health care benefits. It may be confusing to you at times. If you have any questions, please call United Healthcare, the City of Columbus, Employee Benefits/Risk Management, or your division human resources personnel.

Amendments

Because of some state laws or the special needs of your Group, provisions called "amendments" or "updates" may be added to your booklet. "Amendments" or "updates" change provisions or benefits in your Booklet. **Please make sure to keep your Booklet up to date by inserting these "amendments" and/or "updates" as they are made available by your Department.**

Summary of Benefits

In general, the City offers the following benefits to all full-time employees (depending on eligibility requirements): medical insurance, prescription drug insurance, dental insurance, vision insurance, and life insurance. These benefits are negotiated benefits and are contained in each of the collective bargaining contracts.

Eligibility

This section describes how to apply for health care coverage, how and when you become eligible for coverage, who is considered a Dependent, and when your coverage begins. This section also explains when you should change your coverage and how you should apply for such change. To enroll, you must be a full-time employee and an enrollment application must be completed. You can enroll for either Individual or Family Coverage. You will receive an Identification Card which indicates the type of coverage you have. If you have Family Coverage, it is important for you to know which family members are eligible for benefits. Documentation showing proof of eligibility for each dependent is required at the time of enrollment. See the tables in this section for required documentation for each dependent.

Dependent Eligibility

A Dependent includes:

- The Employee's current legally married_spouse (HB 272)
 - On and after October 10, 1991, common law marriages are generally prohibited in Ohio. Common law marriage can only be terminated by death, annulment (R.C. 3105.31, divorce (R.C.3105.01, or dissolution (R.C. 3105.65)
- The Employee's or spouse's unmarried children who are allowed as a federal tax exemption includes:
 - Natural children where a legal relationship exists between a child and the child's natural or adoptive parents (R.C. 3111.01(A). The biological mother and child may be established through birth, and between the biological father and child by acknowledgement of paternity, or administrative determination of paternity (R.C. 3111.02(A).
 - Adopted children where a court granted legal guardianship.

- Grandchildren, nieces, nephews, brothers and sisters with proof of a court granted legal guardianship.
- Stepchildren and children who the Group has determined are covered under a Qualified Medical Child Support Order (Ohio Family Law, 27.5)
- Unmarried children who are related to the Employee or the Employee's spouse, or children for who either is the legal guardian. These children must be allowed as a federal tax exemption.

The age limit for eligible, unmarried children or qualifying dependents is up to the birthday of age 19; or up to the birthday of age 23 for a child who is a qualified dependent and who is allowed as a federal tax exemption. Annually, the City of Columbus may require dependency information to be updated by completion of a questionnaire, including eligibility documentation, and signature.

Eligibility will be continued past the age limit for unmarried children who can't work to support themselves due to mental retardation or a physical handicap if they are allowed as federal tax exemptions. The child's disability must have started before age 23 and must be medically certified. You must give us a Physician's written medical certification of such disability within 30 days of the date the child reaches the age limit when eligibility would otherwise end. The City will require proof of continued disability and dependency every three years or at the discretion of the City. No Dependents other than those stated are eligible for coverage.

Required Documentation for Enrollment of Dependents*	
Relationship to Employee	Required Documentation
Spouse	Official Marriage Certificate
Child by Birth	Birth Certificate
Child by Adoption	Official Court Documents & Birth Certificate
Child by Guardianship	Official Court Documents & Birth Certificate
Step-Child	Marriage Certificate, Birth Certificate & redacted (financial information blacked out) tax form
Grandchild, niece, nephew, brother, sister	Official Court Documents Showing Guardianship & Birth Certificate
Disabled Child (At Age 23)	Birth Certificate & Physician Medical Certification

*Documents listed are standard requirements and are subject to change upon notification.

When husband and/or wife are employed by the City of Columbus. you have these options:

- Both must carry single and/or family coverage if both are employees under Police.

- If one spouse is Non-Uniformed and the other one Police, both can carry single and/or family cover.
- The City of Columbus will co-ordinate benefits between the two plans.

Changes in Coverage

Open enrollment is during the month of February. Under normal circumstances you cannot change your coverage until open enrollment or at a special enrollment designated by Human Resources. You may, however, add dependents or change health care coverage from single to family or family to single during the year, only if you request the change **within 30 days** of one of the following events, referred to as a “qualifying event”:

- If you have Individual Coverage, you can change to Family Coverage if:
 - You marry,
 - Add a newborn child,
 - Your spouse loses health care coverage which is beyond their control by loss of employment. A natural child or qualified dependent would apply to this rule.
- If you have Family Coverage, you can change to Individual Coverage if:
 - There is a death of a spouse, divorce, legal separation (court documentation required), or annulment, or a
 - Dependent child no longer qualifies under plan. Examples: covered child who is no longer a tax exemption; child marries.
- If you notify the City of Columbus **within 30 days** of the event, coverage will begin or end on:
 - The date of birth for newborns;
 - The first of the month following the date of marriage unless the marriage was the first of the month, in which case, you are effective on the first of the month.
 - Termination date for ex-spouse, as well as any natural children of the terminating spouse from a prior marriage is the exact date of divorce stamped on the divorce decree, dissolution or annulment.
 - The date that the employee’s spouse loses health insurance by loss of employment.
 - Family Coverage should be changed to Individual Coverage when only the Employee is eligible for coverage, for example, divorce or death of a spouse, a covered dependent child loses eligibility, etc. If you fail to enroll family members within 30 days, you will have to wait until open enrollment. Open enrollment is an enrollment period which is offered once each Calendar Year for persons who did not apply for medical benefits within 30 days of their eligibility date.

Required Documentation for Enrollment Due to Qualifying Event	
Qualifying Event	Required Documentation*
Marriage	Official Marriage Certificate (for Spouse) & Birth Certificates & redacted (financial information blacked out) tax form (for dependent children, including step-children)
Spouse Loses Healthcare due to Involuntary Loss of Employment	Letter from Employer or Medical Plan
Birth of Child	Birth Certificate
Adoption of Child	Official Court Documents & Birth Certificate

Required Documentation for Termination Due to Qualifying Event	
Qualifying Event	Required Documentation*
Divorce	Divorce Decree
Death of Dependent	Death Certificate
Marriage of Dependent Child	Marriage Certificate

*Documents listed are standard requirements and are subject to change upon notification.

When Your Coverage Begins

Your Identification Card indicates when your coverage begins. This is called the Effective Date. The Effective Date will be the first of the month following the date of hire, unless you are hired on the first day of the month. Dental and vision benefits are in effect following one year of continuous City service, either on the first of the month from your date of hire or, if you were hired on the first of the month, on your one year anniversary date.

Charges for claims incurred during an Inpatient admission which began prior to the Effective Date of your coverage will not be covered. See Collective Bargaining Agreements and ASO for Pre-existing conditions.

Amount of Benefit Payments

Refer to the Collective Bargaining Agreement, and/or the Schedule of Benefits for specific applicable Deductibles, Coinsurance and Out-of-Pockets maximum amounts as well as cost containment requirements and associated penalties. All covered services will be payable on the basis of Medical Necessity and Reasonable Charges.

Amount of Benefit Payments

All eligible medical/surgical and physician, professional, other provider services are paid on the Reasonable Charge basis. All Covered Services are subject to the Deductible, Coinsurance and Out-of-Pocket maximums as identified in the Collective Bargaining Agreement. Covered Services must be Medically

Necessary not Experimental and/or Investigative unless otherwise specified. Refer to the exclusion section for services or items not covered.

Deductible Amounts

Before eligible expenses are paid, you must first satisfy the cash Deductible amount during each Benefit Year (January 1st through December 31st). Deductible amounts are listed in your Collective Bargaining Agreements and the Administrative Salary Ordinance. Under Family Coverage a specific cash Deductible amount is required. One eligible person under Family coverage will satisfy no more than the Individual Deductible. However, when two Individual Deductibles have been satisfied, no further Deductibles will be applied for the entire family during the Benefit Year. Your Benefit Year begins on January 1.

Deductible Carryover

Any eligible expenses incurred during the last three (3) months of a Benefit Year (January through December) and applied toward a Covered Person's Deductible for that year will be credited toward the cash Deductible for the next Benefit Year. The Benefit year is January 1 though December 31st.

Office Co-Pays

In-network office co-pays shall apply to only those Collective Bargaining Agreements where it is stated. All other services are subject to deductible and co-insurances.

Common Accident Provision

If you have Family Coverage and two or more members of your family are injured in the same accident, only one cash Deductible will be applied during the Benefit Year against all Reasonable Charges incurred as a result of the accident.

How to Apply For Benefits

This section provides information on filing claims, which charges require a claim form, and who will usually receive payment.

Questions About Your Benefits

Answers to many health care benefit questions are referenced in this section. The City of Columbus has also established a Dedicated Customer Service and Claims Unit within United Healthcare which services exclusively City of Columbus employees who need health benefit information further explained or clarified. Please refer to the front page of your benefit booklet for contact information.

It is your responsibility to determine if services rendered are covered under the Contract. If you contact the Dedicated Customer Service and Claims

Unit, be sure to keep records of such things as: the date of contact; the name of the insurance company representative; and the response you were given.

Filing and Payment of the Claim

Hospital or Facility Other Provider Claims

Charges for Covered Services while an Inpatient or an Outpatient are paid directly to the Contracting Hospital or Other Facility Provider. When you are admitted for Inpatient or Outpatient care, the Provider's admitting personnel will need to refer to your Identification Card. The Provider will file the claim.

If you receive covered services from a Hospital or Other Provider located outside of the network, the claims filing process works differently. You may be required to pay the bill and file your own claim. To file the claim, you should submit a copy of the paid bill, with your name, the patient's name, identification number and the patient's age to United Healthcare. When you file the claim, payment for Covered Services will be sent directly to you.

Out of State/Out of Country Non-Network Hospitals

For treatment in a Non-Network Hospital (in or out of the United States) you may be required to pay the bill. To receive payment under this program, submit a copy of the paid, itemized bill to United Healthcare. You should include your name, the patient's name, the identification number and the patient's age.

If the bill is in a foreign language, it should be translated into English. Payment for Covered Services will then be sent directly to you.

The City of Columbus is not liable for any Hospital or Other Provider Covered Services unless United Healthcare is notified within two years from the date the service was provided.

Physician and Professional Other Provider Claims

You should provide written notice of claims to the United Healthcare as soon as possible. Once United Healthcare has received notice, they will furnish you with a claim form for filing proof of service. Claim forms may also be available from your Employer or your Physician's office.

Your Physician may file your claim. You must complete the patient information section and sign the form. Your Physician will complete the remainder of the form, sign it, and send it to United Healthcare. You are responsible for paying applicable Deductible and Coinsurance payments.

If your Physician is a Non-Network provider, your benefits may not be the same. You might be required to file the claim and benefits will be paid to you. You are responsible for paying your Physician's bill, which may include charges in

excess of the reasonable level and any plan penalty specified in your labor agreement or administrative salary ordinance.

If you ask United Healthcare for a claim form and you do not receive it within 15 days, you may provide proof of service without a claim form. You must provide the following information:

- Name of the Employee and the Patient;
- Employee's social security number;
- Type of service provided;
- Dates on which services were provided;
- Places where services were provided;
- The Physician's diagnosis;
- The signature of the Physician who provided the service;
- Copies of the bills for Covered Services.

If the City of Columbus owes a benefit when the Employee has died or is a minor or is not legally competent, the City will pay the Participating Physician or a relative of the Employee. Any such payment made in good faith will discharge our obligation to the extent of the payment.

Your Rights for an Itemized Bill

Whenever you receive Covered Services, you have a right to request a copy of the Provider's itemized bill. Merely send a written request to the Provider. It is recommended that you exercise this right so that you will have a copy of the bill for your personal medical files.

Time of Payment

Covered services payable under this Contract will be paid immediately upon, or within 30 days after, receipt of written proof of services.

Explanation of Benefits (EOB)

After your claim has been processed, you will receive an Explanation of Benefits (EOB) identifying payment. You will be billed directly by the provider of service for any amount due.

Amounts Payable

This program will not pay more than the actual charge for Covered Services.

Payment of Benefits

You authorize the Claims Administrator to make payments directly to Providers for Covered Services provided under this plan. Payments may also be made directly to you. You cannot assign your right to receive payment to anyone else except as required by a "Qualified Medical Child Support Order" as defined by ERISA. Once a Provider performs a Covered Service, United Healthcare will not honor your request to withhold payment of the claims submitted. (OBRA, 1993)

Return of Payments

Any payment made in error by United Healthcare to the Employee, to the Group or to a Provider shall be returned to United Healthcare.

Physical Examinations

After you have filed a claim, United Healthcare has the right to require that you have one or more physical examinations. These examinations will help them determine what benefits are payable.

Provider Reimbursement

Benefits shown in the Booklet or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with United Healthcare.

Providers who have a reimbursement agreement with United Healthcare have agreed to accept either the Plan's Reasonable Charge allowance or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with United Healthcare will normally bill you for amount the Plan considers to exceed the Reasonable Charge in addition to any Deductibles, Coinsurance and Co-payments, if applicable.

Regardless of whether the Provider has a reimbursement agreement with United Healthcare, your payment obligations for Deductibles, Coinsurance and Co-payments are your responsibility.

The amount allowed represents the contract rate for a Network provider, or a Reasonable and Customary rate for a Non Network provider.

Appeals Procedures

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact United Healthcare in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to United Healthcare within 180 days after you receive the claim denial.

A qualified individual will review the claim in consultation with a health care professional with the appropriate expertise in the field who was not involved in the prior determination. United Healthcare (first level appeals) and the City of Columbus (second level appeals) may consult with medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon your request and free of charge, you have the right to reasonable access to all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by United Healthcare of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by United Healthcare of the decision within 15 days from receipt of the request for review of the first level appeal decision.
- Appeals of post-service claims, the first level appeal will be conducted and you will be notified by United Healthcare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by United Healthcare of the decision within 30 days from receipt of a request for reviews of the first level appeal decision.
- If you are not satisfied with the first level appeal decision of United Healthcare, you have the right to request a second level appeal from United Healthcare. Your second level appeal request must be submitted to us in writing within 60 days from receipt of the first level decision.

Urgent claim appeals that require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain do not need to be submitted in writing. You or your physician should call United Healthcare as soon as possible. United Healthcare will provide you with a written or electronic determination within 72 hours following receipt by United Healthcare of your request for review of the determination taking into account the seriousness of your condition.

HB4 Amendment

Effective May 1, 2000, Ohio law HB4 requires all health insurance carriers to have in place processes to receive and resolve complaints from Covered Persons. If you have exhausted the complaint appeal procedures, you, an authorized person, or provider with your written authorization, may ask the Ohio Department of Insurance (ODI) to review your complaint, or you may ask United Healthcare to arrange to have your claim reviewed by an Independent Review

Organization (IRO). United Healthcare is required to request ODI for IRO selection.

United Healthcare will select one of two IRO's randomly selected by the ODI for the claim review. The IRO will review the claim and report its findings to United Healthcare and the Covered Person within 30 days. If the seriousness of your condition requires an expedited review, United Healthcare shall provide you a written response to you no later than seven days after the receipt of the request. For more information, contact the plan or the ODI at the address and telephone number below:

Ohio Department of Insurance
Consumer Services Division
2100 Stella Court
Columbus, OH 43215-1526
(614) 644-2673 or 1-800-686-1526

You may ask the Ohio Department of Insurance (ODI) to review the complaint if your claim was denied as a not covered service and you have exhausted all appeal complaint procedures.

If your condition is not an urgent situation and your appeal was denied because the service or procedure was not medically necessary, and the service costs you \$500 or more, you, an authorized person, or provider may request, in writing, an external review through an IRO. However, your request must be submitted to the plan within 60 days after receiving the internal review denial letter from United Healthcare. United Healthcare will pay for the costs relating to this review and will comply with the decision. According to Ohio law, the IRO shall advise you, in writing, of its findings within 30 days after receiving the appeal request.

In accordance with Ohio Law, complaints must be resolved by United Healthcare within 60 days after receiving the written request to appeal.

You may request an IRO review in writing, by telephone or in person without exhausting the complaint appeal procedure if the adverse determination relates to an urgent situation. In this case, the IRO shall advise you, in writing, of its findings within 7 days after receiving your request.

Definitions for Adverse Determination, Authorized Person, and Independent Review as follows:

“Adverse Determination” a determination by the Plan or plan's designee that the health care services furnished or proposed to be furnished to a covered person is not medically necessary or medically appropriate.

“Authorized Person” a parent, guardian or any other person authorized to act on behalf of a covered person with respect to health care decisions. The provider or facility may request, in writing, a reconsideration of an Adverse Determination only with the consent of the covered person.

“Independent Review Organization” an organization certified by the State of Ohio to hear appeals of Adverse Determinations.

Liability

The City of Columbus does not choose a Provider for you. The City has no liability or responsibility for any acts, omissions, or conduct of those who provide Covered Services or supplies to you.

The City does not actually furnish any Covered Services. United Healthcare’s only obligation is to provide payment for Covered Services according to the terms of the Contract. United Healthcare provides administrative claims payments only and does not assume any financial risk or financial obligation with respect to claims.

Limits on Legal Action

No action in any court of law may be brought against the City of Columbus sooner than 60 days after a claim is filed or later than 3 years after the time limit for filing claims for the service in question.

General Provisions

This section describes how your coverage works, and includes some of the following information:

Coordination of Benefits and payment order with other plans, Subrogation, Medicare, Coverage Termination and Continuation, including COBRA and conversion options.

Coordination of Benefits

Coordination With Other Coverage

All benefits provided under this Booklet are subject to Coordination of Benefits. Coordination of Benefits (COB) is the procedure used when a Covered Person has health care benefits under more than one health care coverage. This Plan follows rules established by Ohio Revised Code 3902.13 to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, this Plan will follow Ohio Revised Code 3903.13 determines

which plan is primary and which is secondary. 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 its rules and procedures. If its 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.

This Plan will pay benefits without regard to benefits paid by the following kinds of coverage:

- Individual (not group) policies or contracts
- Medicaid
- Group hospital indemnity plans which pay less than \$100 per day
- School accident coverage
- Some supplemental sickness and accident policies
- Medicare

How This Plan Pays When Primary

When this Plan is primary, it will pay the full benefit allowed by this Plan as if you had no other coverage.

How This Plan Pays When Secondary

When this Plan is secondary, its payments will be based on the balance left after the primary plan has paid. It will pay no more than the balance. In no event will this coverage pay more than it would have paid if it had been primary.

This Plan will pay only for health care expenses that are Covered Services in this Booklet.

This Plan will pay only if you have followed all of our procedural requirements, including care obtained from or arranged by your primary care physician, pre-certification, etc.

This Plan will pay no more than the "allowable expenses" for the health care involved. If this Plan's allowable expense is lower than the primary plan's, then the primary plan's allowable expense will be used. The allowable expense may be less than the actual bill.

Which Plan Is Primary

To decide which plan is primary, consider both the coordination provisions of the other plan and which member of your family is the patient. The primary plan will be determined by the **first** of the following which applies: (ORC 3902.13)

1. Non-coordinating Plan

A plan that does not coordinate with other plans is always the primary plan.

2. Insured/Employee

The benefits of the plan that covers a person as an employee, member, insured, or subscriber, other than a dependent, is the primary plan. The plan that covers the person as a dependent is the secondary plan.

Medicare: The City will be primary over Medicare coverage for its active employees and/or their dependents that have Medicare coverage.

3. Children of Divorced or Separated Parents

a) If more than one plan covers a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:

- o The plan of the parent who is the residential parent and legal custodian of the child;
- o The plan of the spouse of the parent who is the residential parent and legal custodian of the child;
- o The plan of the parent who is no the residential parent and legal custodian of the child.

b) If the specific terms of the court decree state that one parent is responsible for the health care expenses of the child, the plan of that parent is the primary plan. A parent responsible for the health care pursuant to a court decree must notify the insurer or health insuring corporation of the terms of the decree.

4. Children and the Birthday Rule

When more than one plan covers the same child as a dependent of different parents who are not divorced or separated, the primary plan is the plan of the parent whose birthday falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year. If both parents have the same birthday, the benefits of the plan that covered the parent the longer is the primary plan. The plan that covered the parent the shorter time is the secondary plan.

If the other plan's provision for coordination of benefits does not include the "birthday rule" but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

5. Active Employment vs. Layoff or Retirement

The primary plan is the plan that covers a person as an employee who is neither laid off or retired, or that employee's dependent. The secondary plan is the plan that covers that person as a laid-off or retired employee, or that employee's dependent.

If both plans do not include this same rule, then it will be ignored. This rule does not supersede rule 2. Insured vs. dependent.

6. State or Federal Continuation Coverage

When the person's coverage is provided under a right of continuation under federal law (i.e., COBRA) or state law, any other plan covering that person will be primary to the plan covering the person under such continuation provision unless that other plan does not include this same rule.

7. Length of Time Covered by the Plan

If none of the other rules apply to determine the order of benefits, the primary plan is the plan that covered an employee, member, insured, or subscriber longer. The secondary plan is the plan that covered that person the shorter time.

8. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits (ORC 3902.13).

Right To Receive And Release Needed Information

Certain facts are needed to apply COB rules. United Healthcare has the right to decide which facts are needed. This plan may get needed facts from or give them to any other organization or person to do this. The Plan need not tell you or get your consent. Each person claiming benefits under this Plan must provide any facts needed to pay the claim.

HIPAA Privacy 45 CFR 164.506

(The Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations. Payment encompasses the various activities of health care providers to obtain payment for their services, to provide benefits under the plan and obtain reimbursement for the provision of health care. Health care operations are certain administrative, financial, legal, and quality improvement activities that are necessary to support the payments.)

Facility of Payment

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, this Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under this Plan and this Plan 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 reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by this Plan is more than should have been paid under this COB provision, this Plan may recover the excess from one or more of:

- The persons it has paid or for whom it have paid;
 - Another plan; or,
 - The provider of service.
- 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 this Plan has not paid a claim properly, you should first attempt to resolve the problem by contacting United Healthcare. Ask for the steps which were followed in the Claims Review. If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint. Website: ohioinsurance.gov/complaints/complaintmain.htm.

Subrogation

Subrogation and Right of Reimbursement

This provision applies when we pay benefits for personal injuries and you have a right to recover damages from another.

For more information about your rights contact Ohio Department of Insurance at www.ohioinsurance.gov/

Subrogation

- If United Healthcare pays benefits under this Plan, and you have a right to recover damages from another, the Plan is subrogated to that right. You or your legal representative must do whatever is necessary to enable United Healthcare to exercise the Plan's rights and do nothing to prejudice them.
- The Plan is subrogated to any right you may have to recover from another, his insurer, or under any "Uninsured Motorist", "Underinsured Motorist", "Medical Payment", "No-Fault" or other similar coverage provisions.

Reimbursement

If you recover damages from any part or through any coverage named above, you must hold in trust for us the proceeds of the recovery and must reimburse the Plan to the extent of payments made.

Your Duties

- Notify United Healthcare promptly of how, when, and where an accident or incident resulting in personal injury to you occurred and all information regarding parties involved.
- Cooperate with United Healthcare in the investigation, settlement and protection of United Healthcare's rights.
- Send the United Healthcare copies of any police report, notices or other papers received in connection with the accident or incident resulting in personal injury to you.

Medicare

The City will be primary over Medicare coverage for its active employees and/or their dependents who have Medicare coverage. The City plan will pay benefits first, Medicare will then be secondary.

The City of Columbus has elected to be the primary plan for Tax Equity and Fiscal Responsibility Act called TEFRA eligible employees. Please refer to TEFRA (P.L. 97-248).

Physician Recommendation

Covered Services are provided upon the authorization and recommendation of a Physician or surgeon, and only while you are being treated by the Physician or surgeon.

Notice

Any notice given by United Healthcare is sufficient if mailed to the Employee or the Group at the address on their records. Notice is considered as given as of the date of mailing. Notice by the City of Columbus is sufficient if in writing, and upon its receipt by United Healthcare.

Records

When you receive Covered Services, the records concerning the diagnosis and treatment of your condition will be available to United Healthcare for purposes of determining liability or for statistical analysis.

Rules and Regulations of Providers

Both the Covered Person and the Physician will conform to the rules and regulations of the Provider, including those governing admittance and discharge.

Terminations

In the event you are in the Hospital when your coverage ends, United Healthcare will provide benefits for Covered Services until you are discharged. However, services rendered by a Physician or Other Provider will not be covered once this coverage has ended.

Automatic Termination

Coverage is not transferable. If the Employee tries to transfer this coverage to a person who is not covered, coverage will automatically terminate.

Misrepresentation

If a Covered Person makes a fraudulent statement, relating to their application for coverage or a claim for benefits, this coverage will become null and void.

Termination Due to Loss of Eligibility

Coverage will terminate when you lose your eligibility. Under this Contract, coverage will terminate:

- For all Covered Persons, when the Employee loses employment with the Group. Coverage will continue until the end of the month of termination.
- For all Covered Persons when the Employee's classification becomes ineligible for coverage under the Group contract. Coverage will continue until the end of the month in which the employee became ineligible.
- For the spouse, in the event of an annulment, legal separation, divorce or dissolution. Coverage terminates on the exact date of these events.
- For all Dependents, in the event of the Employee's death. Coverage terminates the end of the month in which the employee died.
- For the Dependent children when they reach the limiting age, marry or otherwise lose eligibility as a Dependent, whichever occurs first.

Continuation Options

COBRA

For Employees: You have the right to choose continuation coverage for yourself and your dependents for up to 18 months any of the following events:

- Voluntary termination
- Hours of employment are reduced
- Your employment or health insurance ends for any reason other than your gross misconduct.

For Spouse: If you are the spouse of a City of Columbus employee, you have the right to choose continuation of coverage for yourself up to 36 months if you lose group health coverage for any of the following reasons:

- Death of employee
- Divorce or legal separation from employee

For Dependents: If you are a dependent child of a City of Columbus employee, you have the right to choose continuation of coverage for yourself for up to 36 months if you lose group health coverage for any of the following reasons:

- Death of employee
- Parents' divorce or legal separation
- Dependent child losing eligibility (such as reaching a limiting age, getting married, no longer a Federal Tax Exemption, etc)

Fulltime employees who terminate City employment, or reduce their hours to part-time, may participate in continuation of specific plan benefits at their own expense under the COBRA provision. For insurers with less than one year service, Medical and Drug coverage's only are available. Insurers with more than one year service are eligible for Medical, Dental, Drug and Vision. Current insurance claim administrators continue to manage these specific benefit plans.

A Notice to Elect continuation coverage will automatically be sent from the COBRA claim administrator, certified mail, to the eligible employee's address listed in City's payroll records. Fulltime employees on an approved leave of absence of three or more months will also receive a Notice after 90 days of the leave's effective date. Employees who accept part-time employment will need to contact Risk Management to request COBRA information.

A Notice to Elect continuation coverage will NOT automatically be sent to dependents. Risk Management, should be notified of dependents who become ineligible to participate in the City's plan. Qualifying events include legal separation, divorce, or dependent children who reach the limiting age of 19 or 23, or who marry. Contact Risk Management within one week of the qualifying event date.

Important Employee, spouse and dependent notifications required:

Under the federal law, the employee, spouse or other family member has the responsibility to notify the City of Columbus of a divorce, legal separation, or a child losing dependent status under the group health plan. This notice must be made within 30 days of the event or the date coverage ends in order to be eligible for COBRA continuation.

If this notification is not completed within the required 30-day notification period, right to continue coverage will be forfeited. Notification should be made by contacting Risk Management.

Once the election letter is received by the United Healthcare, a premium billing statement and confirmation letter will be sent. The first premium payment will provide coverage retroactive to the date when the City's plan terminated. All COBRA premium payments **must** be made timely. Failure to pay premiums by the due date will result in automatic cancellation of COBRA benefits.

Please contact your payroll division to update any mailing address information. The COBRA claim administrator's phone numbers are available on the "Important Phone Numbers" sheet found in the front of this Booklet.

Conversion

If you lose eligibility for one of the previously identified reasons, you will be eligible to re-enroll for conversion coverage within 30 days after termination. You may contact United Healthcare about conversion coverage. You may send a written request to United Healthcare for conversion coverage no later than thirty days after your active City plan or COBRA coverage have ended. Conversion coverage will be different from either the City's or COBRA coverage's. If you apply in time and pay the subscription fees, your conversion coverage will begin on the date the coverage has terminated.

Involuntary Termination Continuation Coverage Requirements

If the Employee's coverage ends due to an involuntary termination of employment, the Employee may be eligible to continue group coverage. If the Employee is eligible for continuation of group benefits, coverage for the Employee and eligible Dependents may continue for up to six months following the Employee's actual termination. There are specific requirements the Employee must meet to be eligible for this continuation of coverage, which are stated in Chapter 3923.122 of the Ohio Revised Codes. To determine if you are eligible, contact the City of Columbus, Employee Benefits Risk Management Section for information on continuation of group coverage before your last day of work

If the spouse is employed when this coverage terminates, he or she may apply for coverage through his or her employer's health care administrator program. Application for coverage through the employer's group benefit program must be made within thirty days after this coverage has ended

Extension of Benefits

Total Disability

If a Covered Person is Totally Disabled on the date of termination of coverage, the City of Columbus may furnish benefits for Covered Services which directly relate to the condition causing such Total Disability and for no other condition, disease or injury.

Benefits under this provision for Total Disability shall be provided:

- up to a maximum period of three consecutive months; or
- until the maximum amount of benefits has been paid; or
- until the Total Disability ends; or
- until the Covered Person becomes covered without limitation for that disabling condition under any other coverage, whichever occurs first.

GLOSSARY

This section defines terms which have special meanings. Whenever you see a word or phrase with a capital letter, it is a title or has a special meaning. The word or phrase is defined in this section or at the place in the text where it is used.

Alcoholism Treatment Facility--a Facility Other Provider which mainly provides detoxification and/or rehabilitation treatment for alcoholism.

Ambulance Transportation--Local transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- from your home, scene or accident or medical emergency to the Hospital or between Hospitals;
- between Hospital and Skilled Nursing Facility;
- from a Hospital or Skilled Nursing Facility to your home.

Trips must be to the closest facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest facility outside your

local area. Ambulance Service is limited to surface transportation, unless the closest facility that can provide services appropriate for your condition is accessible only by other than surface transportation. Unique situations may be subject to the United Healthcare's retrospective review.

Ambulatory Surgical Facility--an Facility Other Provider, with an organized staff of Physicians, which:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- does not provide Inpatient accommodations; and
- is not, other than incidentally, used as an office or clinic for the private practice of a Physician, or Professional Other Provider.

Basic Benefits--benefits which are payable under Hospital coverage, Physician (Surgical/Medical) coverage or comprehensive major medical coverage. This includes benefits which would have been payable had you enrolled for and/or chosen to collect from those coverage(s).

Benefit Year--a calendar year (January 1 through December 31).

Benefits After Termination--the benefits, if any, available when a person stops being a Covered Person.

Booklet--the term Booklet means this document.

Copay--A percentage or fixed charge for which you are responsible when receiving covered services.

Coinsurance--a percentage of the Reasonable Charge for which you are responsible per Covered Service in each calendar year.

Confinement--an Inpatient admission without discharge from one Hospital or Facility Other Provider with re-admission to a Hospital or Facility Other Provider within 90 days of the prior discharge. Confinements under the psychiatric and alcohol/substance abuse provisions are limited by negotiated language.

Contract Date--the date when coverage for the Group starts.

Covered Person--the Employee, and if Family Coverage is in force, the Dependents.

Covered Service--a service or supply shown in the Booklet and given by a Provider for which we will provide benefits. To be a Covered Service, services must be:

- authorized by a Physician;
- Medically Necessary, except as otherwise specified in this Booklet;
- consistent with the condition(s) for which you were admitted when an Inpatient; and,
- within the scope of the license of the Provider performing the service.
- A provider's service or supply for which the plan will pay. Not all prescribed or performed by a provider are necessarily a covered service.

Custodial Care--care provided for maintenance of the patient or which is designed to assist the patient in meeting the activities of daily living. Such care is not provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial Care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets and supervision over exercises or over self administration of oral medications not requiring constant attention of trained medical personnel.

Deductible--an amount of Covered Services, usually stated in dollars, for which you are responsible before we start to pay each Benefit Year.

Dependent--a Covered Person other than the Employee as shown in the Eligibility Section.

Diagnostic Service--a test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Physician or Professional Other Provider. These services are limited to the Diagnostic Services listed in the Benefit Section.

Dialysis Facility--a Facility Other Provider which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

Drug Abuse Treatment Facility--a Facility Other Provider which provides detoxification and rehabilitation treatment for drug abuse.

Effective Date--the date when your coverage begins.

Eligible Person--a person who satisfies the requirements of the Group Contract and is entitled to apply for coverage.

Emergency Medical Care--the initial treatment of a sudden and **acute medical condition** that is life threatening and requires prompt Medical Care. Examples of covered situations are heart attacks, kidney stones, strokes, etc.

Enrolled Employee--an Eligible Person who has made application and is enrolled for coverage. An Enrolled Employee is also referred to as an Employee.

Experimental/Investigative--any drug, device, equipment, facility, procedure, treatment, or supply (hereafter called service) which United Healthcare, in its discretion, may determine with regard to a particular illness, disease or condition:

- did not have governmental approval for marketing at the time when furnished for the purpose or manner rendered; or
- is not supported by Reliable Evidence which shows that the service:
 - is generally recognized as being safe and effective for treating the condition in question by those practicing the appropriate medical specialty;
 - has a definite positive effect on health outcomes;
 - over time leads to improvement in health outcomes under standard conditions of medical practice outside clinical investigatory settings (i.e., the beneficial effects outweigh any harmful effects); and
 - is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment means is not employable.

Reliable Evidence includes only:

1. published reports and articles in authoritative medical and scientific literature;
2. the written investigational or research protocols and/or the written informed consent used by the treating facility or of another facility which is studying the same service; and
3. compilations, conclusions and other information which we have available are drawn from (1) or (2) above.

United Healthcare has the authority and discretion to determine all questions in connection with whatever any service is Experimental/Investigative under this Booklet.

Other Providers include: (Each must be either contracting or approved by United Healthcare as satisfying the requirements for contracting.)

- Alcoholism Treatment Facility
- Ambulatory Surgical Facility
- Dialysis Facility
- Drug Abuse Treatment Facility
- Home Health Care Agency
- Outpatient Psychiatric Facility
- Pharmacy
- Psychiatric Hospital
- Rehabilitation Hospital
- Skilled Nursing Facility
- Durable Medical Equipment

United Healthcare may periodically add additional Other Providers to the list when such Providers provide services which are already Covered Services under this Booklet.

Family Coverage--coverage for the Employee and one or more Dependents.

Home Health Care Agency--an Other Provider which:

- provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
- is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Hospice --A facility or service which provides supportive care for terminally ill patients and families.

Hospital--an institution which means the specifications of Chapters 1739 of the Ohio Revised Code, except for the requirement that such institution be operated within the State of Ohio. Ohio Revised Code 1739

Identification Card--the card United Healthcare will give you. It contains your identification number and the Effective Date, and shows the type of coverage for which you enrolled.

Incurred--a charge will be considered Incurred on the date a Covered Person receives the service or supply for which the charge is made.

Individual Coverage--coverage for the Employee only.

Inpatient--a Covered Person who receives care as a registered bed patient in a Hospital or Other Provider where a room and board charge is made.

Medical Care--professional services given by a Physician or a Professional Other Provider to treat illness or injury.

Medical Emergency--a medical emergency exists when there is a sudden and unexpected onset of a serious medical condition. Symptoms must be so severe as to cause you to seek immediate medical attention regardless of the time. Failure to obtain immediate care would harm your health or jeopardize your life. (See also Emergency Medical Care)

Medically Necessary (or Medical Necessity)--a service or supply given by a Provider that is required to diagnose or treat your condition, illness or injury and which United Healthcare determines is:

- appropriate with regard to standards of good medical practice;
- not solely for the convenience of you or Provider;

- the most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or condition require that the services cannot be safely provided to you as an Outpatient.

Medicare--the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Illness--an emotional or mental disorder (except alcoholism or drug addiction) which, according to generally accepted medical standards, is susceptible to treatment.

Out-of-Pocket Limit--a specified dollar amount of Co-insurance expense incurred by a Covered Person for Covered Services in a Benefit Period. Such expense does not include any Deductible amount or charges in excess of the Reasonable Charge. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the your labor agreements for Out-of-Pocket Maximums)

Other Provider--the following persons or entities which are licensed, where required under applicable state laws, to render Covered Services:

- Other Provider
- Professional Other Providers

Outpatient--A Covered Person who receives services or supplies while not an Inpatient.

Outpatient Psychiatric Facility--A Facility Other Provider which mainly provides diagnostic and therapeutic services for the treatment of Mental Illness on an Outpatient basis. In Ohio, Outpatient Psychiatric Facilities are called Community Mental Health Facilities.

Payment Maximum--the maximum amount of payment for a Covered Service for the time period or other limit specified in this Booklet. Payments means the amount actually paid by the Plan for services received from a Provider which does not have a reimbursement agreement with United Healthcare or the amount for which you are given credit by a Provider as a result of United Healthcare's agreement with that Provider.

Pharmacy--a Facility Other Provider which is a licensed establishment where prescription drugs are dispensed by a pharmacist licensed under applicable state laws.

Physician--one of these professionals licensed under applicable state laws:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatrist or Surgical Chiropodist (D.P.M. or D.S.C.)

- Dental Surgeon (D.D.S.)
- Chiropractor (D.C.)
- Doctor of Optometry (O.D.)

Professional Other Provider includes:

- Physical Therapist
- Psychologist
- Registered Nurse Anesthetist (C.R.N.A.)
- Registered Nurse (R.N.)
- Licensed Practical Nurse (L.P.N.)
- Certified Nurse Midwife (C.N.M.)
- Licensed Occupational Therapist (O.T.)
- Licensed Speech Pathologist (S.P.)
- Laboratory (must be Medicare approved or, if applicable, PPO network labs)
- Professional Ambulance Service

Provider--a licensed Hospital, Physician, or Other Provider.

- *Medicare Approved Provider*--a Provider that is certified by the United States Department of Health and Human Services to receive payment under the Medicare Program.
- *Network Provider*—Any health care provider who has contracted with the health plan to provide services and abide by health plan policies and whose services are allowed by the plan.
- *Non-Network Provider*—A health care provider who has not contracted with the health care provider services. United Healthcare will allow these providers but at a reduced reimbursement rate.

The terms below apply to Hospital and Facility Other Providers only:

- *Contracting Provider*--a Hospital or Facility Other Provider that has an agreement with the health care administrator about payment for Covered Services.
- *Non-Contracting Provider*--a Hospital or a Facility Other Provider that does not have an agreement with United Healthcare.

Psychiatric Hospital--A Facility Other Provider which, for reimbursement to its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Psychologist--a licensed clinical psychologist. In states where there is no licensure law, the psychologist must be certified by the appropriate professional body.

Reasonable Charge--the amount of the charge that United Healthcare determines is reasonable for Covered Services you receive up to but not to exceed charges actually billed. Our determination considers:

- amounts charged by other Providers for the same or similar service;
- any unusual medical circumstances requiring additional time, skill or experience, and;
- other factors the United Healthcare determines are relevant.

The Reasonable Charge is reduced by any penalties for which a Provider is responsible as a result of its agreement with United Healthcare.

Rehabilitation Hospital--a Facility Other Provider which, for reimbursement to its patients, is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Substance Abuse--an emotional or mental disorder (related to alcoholism or drug addiction) which, according to generally accepted medical standards, is susceptible to treatment.

Skilled Nursing Facility--a Facility Other Provider which mainly provides Inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- minimal custodial, ambulatory, or part-time care; or
- treatment for Mental Illness, Substance Abuse, pulmonary tuberculosis.

Skilled Nursing Services--services which require the professional proficiency and scientific skills of an RN or LPN. Services must be performed on a regular basis under the general direction of a Physician in order to ensure the safety of the patient and achieve the medically desired result. Skilled Nursing Services do not include Custodial Care or services such as the following which could be performed by the average non-medical person with proper training:

- administration of oral medication, eye drops or ointments;
- non-infected wound care;
- monitoring vital signs;
- monitoring oxygen levels;
- treatment of minor skin problems;
- irrigation and other routine care of catheters;
- maintenance care of ostomies;
- routine care regarding braces and similar devices.

Surgery

- the performance of generally accepted operative and other invasive procedures;
- the correction of fractures and dislocations;
- usual and related pre-operative and post-operative care;
- other procedures as reasonably approved by us.

Therapy Services--Therapy Services and supplies used to promote recovery from illness or injury. These services are limited to the Therapy Services listed in the Benefits Section.

Totally Disabled (or Total Disability)--a condition resulting from disease or injury in which, as certified by a Physician:

- you are unable to perform the substantial duties of any occupation or business for which qualified and are not in fact engaged in any occupation for wage or profit; or you are substantially unable to engage in the normal activities of an individual of the same age.

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Section II: Cost Containment--Utilization Review

PPO Network physicians will be responsible for all utilization review service requirements.

The following utilization review provisions apply to all City employees and their dependents:

- A. Pre-Admission Certification.
If an employee is informed that a non-emergency inpatient admission is necessary, including psychiatric/substance abuse treatment, the inpatient admission must be pre-certified by the City's medical utilization review administrator. If no pre-certification is made or the inpatient admission is determined not to be medically necessary, a ten percent (10%) penalty will be applied to total charges in addition to the deductible, coinsurance and out of pocket maximum. In the event the care is determined to be medically unnecessary, the employee will be responsible for the cost of all medically unnecessary care.

- B. Assigned Length of Stay (Concurrent Review).
Once an elective admission has been pre-certified, a length of stay is assigned. If the hospital stay extends beyond the assigned length of stay, the employee will be responsible for all additional charges of medically unnecessary care, in addition to the deductible, coinsurance and out of pocket maximum. Medically necessary care will constitute justification for certification of a length of stay extension by the City's utilization review administrator.

- C. Continued Treatment and Technological Review.
Certain outpatient non-emergency therapy, outpatient continued treatment, and advanced technological treatments recommended by an employee's attending physician will require the City's medical utilization review administrator's approval. These treatments will include:
 - I. Therapy
 - A. Physical Therapy
 - B. Occupational Therapy

- II. Advanced Technological Procedures
 - A. Magnetic resonance imaging (MRI)
 - B. Lithotripsy
 - C. Ultrasound imaging during pregnancy
 - D. Angioplasty

- III. Treatment
 - A. Chiropractic
 - B. Podiatric

Once the employee's physician informs the employee that it is medically necessary for the employee to receive physical therapy, occupational therapy, chiropractic treatment or podiatric treatment on an ongoing basis, the employee must contact the City's medical utilization review administrator to obtain continued treatment authorization. Also, if the employee's physician instructs the employee to receive any of the listed advanced technological procedures, it is necessary for the employee to contact the City's utilization review administrator to obtain pre-treatment authorization.

In the event the employee does not obtain authorization for continued therapy, treatment, or technological review, the employee will be responsible for 10% of the total charges, in addition to the deductible, coinsurance and out of pocket maximum. In the event the care the employee receives is determined to be medically unnecessary, the employee will be responsible for the cost of all medically unnecessary care.

- D. **Mandatory Second Surgical Opinion.**
For all inpatient and outpatient non-emergency surgeries, a second surgical opinion may be required as directed by the utilization review administrator. This second opinion shall be covered at one hundred percent (100%) of reasonable charges. If the first two opinions conflict, a third opinion shall also be covered at one hundred percent (100%) of reasonable charges. If a second opinion is not obtained for the surgeries, a ten percent (10%) penalty of total charges shall be applied, in addition to the deductible, coinsurance and out of pocket maximum.

Based on medical information obtained prior to the surgery, the City's medical utilization review administrator may waive the mandatory second surgical opinion requirement in specific cases.

- E. **Medical Case Management.**
This program allows a consultant to review an employee's medical treatment plan to determine whether the covered person qualifies for alternate medical care. The determination of eligibility for a patient's medical case management will be primarily based upon medical necessity and appropriate medical care. Recommendations will be made to the family and health care providers. The utilization review administrator will recommend alternate medical treatment on a case-by-case basis. Alternate medical treatment benefits refer to expenses that are approved before they are incurred, which may not otherwise be payable as covered expenses under the medical plan.
- F. **Planned Discharge Program.**
In the event an employee is hospitalized and it is determined that hospitalization is no longer needed, this program allows the patient to receive care in the most medically appropriate setting.
- G. **Hospital Bill Review. (Non-uniformed and Uniformed Fire employees and their dependents)**
If an employee reviews his hospital bill and discovers overcharges by the provider, he will receive 50% of the reimbursed overcharges up to a maximum of \$250.00 per employee per confinement, upon verification of such overcharges by the third party administrator.
- H. **Emergency Admission. (Only Non-uniformed and Uniformed Fire employees and their dependents)**
All emergency admissions must be certified within 48 hours of the date of admission. Failure to do so will result in a 10% penalty of medically necessary care, and will not apply to deductible, coinsurance or maximum out-of-pocket limits. Medically unnecessary care is not covered and will be the employee's responsibility.
- I. **Hold Harmless. (Only Non-uniformed and Uniformed Fire employees and their dependents)**
In the event a dispute arises over payment for services provided, the City shall hold harmless an employee or dependent who, prior to receiving such services, has:
1) complied with the requirements and certification of the cost containment program, and
2) verified benefit plan coverage through the third party administrator.

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FOP**

Section III (a): Schedule of Medical Benefits

The following Schedule of Benefits is a summary of Uniformed Police's bargained benefits as of Contract dated December 9, 2005. Benefit details are described in the text preceding this Schedule.

Additionally, you may contact the City's Claims Administrator for clarification of the benefit summary. All Covered Services must be Medically Necessary, not Experimental/ Investigative.

Effective Dates of Coverage and Monthly Premiums

- Single or Family plans for medical and drug coverage's are in effect the first of the month following the hire date. The employee's life insurance policy is also effective on the first of the month from the hire date. If the employee's date of hire is the first of the month, coverage's are immediately in effect.
- Dental and vision plans are in effect the first of the month following the employee's completion of one year of continuous service.
- Open Enrollment month for insurance benefits is February.
- Employee's Insurance Monthly Premium. Employee's Insurance Monthly Premium shall be 9% of the negotiated insurance base. (Pre-tax program available. Contact Police Benefits Unit for information)

Wellness Benefit

- Covered well childcare visits for eligible dependents comply with House Bill 478. These specific preventive care benefits, which are subject to the plan's provisions, are:
 - Well baby coverage (birth to age 1) including exams, and routine diagnostic services are payable under the program up to a \$750 maximum payment, subject to the policy's limits; and,
 - Immunizations are payable separate from the routine exams and are not applied to the annual well baby or dependent coverage benefit.
 - Well dependent coverage (after age one and up) including exams, and routine diagnostic services are payable under the program up to a \$200 annual maximum payment, subject to the policy's limits.
- A routine mammogram benefit for all covered female employees and their

dependents is provided. A maximum benefit of \$125.00 will apply subject to the plan's provisions. The plan recognizes the following schedule for routine mammograms:

- one baseline exam for women ages 35-39 years
 - one exam every two years for women ages 40-49
 - one exam every year for women 50 years plus
- Provide coverage for routine prostate/colon rectal cancer tests for men 40-49 years, up to maximum of \$65.00, subject to 10% co-insurance. Men ages 50 and over, allow one sigmoidoscopy exam and/or PSA blood test up to a maximum of \$85.00, subject to 10% co-insurance.
 - Uniformed Police employees are eligible for a physical examination benefit on the first of the month following completion of one year of continuous City service. One annual, routine physical examination per Covered Person is provided, subject to Medical/Surgical PPO and NON-PPO Network coinsurance percentages. Medically Necessary stress test and its interpretation are subject to a maximum of 80% of \$250 Reasonable Charges. Dependent's annual physical examination benefit is limited to 90% of \$200 reasonable charges.

Basic Hospitalization/Medical-Surgical/Supplemental Benefits

The Uniformed Police policy covers services under the hospitalization, medical/surgical or supplemental benefits sections. Basic Hospitalization and the Supplemental portions of the Uniformed Police plan require separate Deductibles. Once the respective section's Deductible is satisfied, the policyholder and the City of Columbus share the costs of Covered Services at the applicable coinsurance percentages. Medical/Surgical services are not subject to a Deductible, however, coinsurance percentages apply which the policyholder and the City of Columbus share.

For payment of 100% of Reasonable Charges for all Covered Services, the total maximum out-of-pocket obligations for both Basic Hospitalization and the Medical/Surgical and Supplemental portions must be satisfied in a calendar year. However, under either the Basic Hospitalization or the Medical/Surgical and Supplemental categories, 100% of the Reasonable Charges will be paid if either portion's maximum out-of-pocket obligation is met. Applicable Covered Services are subject, in order, to Deductible, Coinsurance, and Maximum out-of-pocket limits, unless otherwise noted.

All Covered Services or dollar limits are payable on the basis of Reasonable Charge, whether or not it is specifically stated.

- Deductibles Basic Hospitalization \$200
 Supplemental Services \$200
 Medical/Surgical \$-0-

- Coinsurance
 - I. Basic Hospitalization PPO Network Providers**
10% of \$2,000 Reasonable charges or \$200)

 - Basic Hospitalization NON-PPO Providers
30%* of Reasonable charges plus applicable balance billing
*(20% penalty does not apply to either coinsurance or maximum out-of-pocket limits)

 - II. Medical/Surgical PPO Network Providers** 10% of Reasonable Charges
Out-Patient Services are considered under the Medical/Surgical section of this contract.
Medical/Surgical NON-PPO Providers
30%* of Reasonable Charges plus applicable balance billing
*(20% penalty does not apply to either coinsurance or maximum out-of-pocket limits)
Psychiatric and substance abuse outpatient services are subject to 50% coinsurance.

 - III. Supplemental** coinsurance 90/10% PPO Providers
70/30%* NON-PPO Providers
*(20% penalty does not apply to either coinsurance or maximum out-of-pocket limits)

- PPO Maximum Out of Pocket (Deductible and/or Coinsurance Totals)
Basic Hospitalization \$400
Medical/Surgical and Supplemental Services \$400

Hospital and Facility Other Provider

Inpatient Benefits

These benefits are available for room, board and ancillary services. All In-patient admissions must obtain pre-authorization from United Healthcare prior to admission.

If you are an Inpatient in a semi-private room, charges for your room, board (including special diets) and general nursing care are covered in accordance with your respective benefit plan. If you are in a private room, your daily room allowance is equal to the Facility's average semi-private room charge. You are responsible for the difference in room charges.

Ancillary Charges

Inpatient charges are subject to your plan's Amount of Benefit Payments. The following services are covered benefits:

- Operating and recovery room
- Drugs and medicines
- Oxygen and the use of equipment for the administration of oxygen
- Laboratory examinations
- Pathological tissue examinations
- Dressings and casts
- Thyroid function studies
- Blood transfusions excluding the cost of blood and blood plasma
- X-rays and radioactive studies (uptakes and scans)
- Electrocardiograms
- Electroencephalograms
- Physical therapy
- Inhalation therapy
- Intensive care and coronary care units
- Heart-lung equipment
- Kidney dialysis
- Anesthesia equipment and supplies
- Radioactive materials
- Radiation therapy
 - Intravenous chemotherapy for cancer treatment

Outpatient Hospital Benefits

Refer to Collective Bargaining Agreement, and/or Schedule of Benefits for applicable Deductibles, Coinsurance and Out-of-Pocket maximums, as well as cost containment requirements and associated penalties. Benefits for the following services are provided for Outpatient care:

- Initial treatment for accidental injury or accidental poisoning within 72 hours after the accident.
- Outpatient surgery requiring the use of the operating or emergency room. If your Physician believes your surgical procedure can be performed without keeping you in the Hospital overnight, you can go to the Hospital in the morning and, following Surgery, return home the same day. Benefits are provided for Covered Services in the operating room and recovery rooms.
- Diagnostic X-ray, electrocardiograms and electroencephalograms when directed toward a definite disease or injury.
- Kidney dialysis when received in an approved Provider.
- Intravenous chemotherapy for cancer treatment.
- Radiation therapy.

- Pre-admission Testing (PAT). Your Physician may determine that you need Inpatient care. Often the early part of a Hospital stay is used primarily for testing before treatment or Surgery begins. Under the PAT program, your Physician can order certain tests to be done as an Outpatient before you are admitted. Any test that would have been covered as an Inpatient will be paid for as part of your total bill. (Note: PAT is not the same as Outpatient diagnostic care. Your Physician must have scheduled an Inpatient admission in order for your tests to be covered under the PAT program.)
- Post Discharge Testing PDT. As with the PAT benefit, tests or treatments that would have been covered as an Inpatient will be paid for as part of your total bill. (Note: To be eligible for payment, PDT services must be completed within ten days following the time of patient discharge.)

Inpatient Psychiatric, Alcoholism and Substance Abuse Benefit

- Inpatient psychiatric admissions are limited to an annual maximum of 60 days per covered individual per calendar year.
- Inpatient alcohol or substance abuse admission is limited to a maximum of 35 days per year per covered individual.

Outpatient Psychiatric, Alcoholism & Substance Abuse Benefits

- In accordance with the Mental Health Parity Act, outpatient psychiatric treatments are limited to medically necessary care at the reasonable charge limit payable at the 50% level, per eligible individual. Services include but are not limited to:
 - Individual, group and family psychotherapy (counseling); electroshock therapy; psychological testing and psychiatric consultations.
 - Individual, group or family counseling under the supervision of a Physician or Psychologist; Rehabilitation or rehabilitation and detoxification of alcoholism or substance abuse; Physician or Psychologist must re-certify your need for continued care every 3 months.

The following therapies will not be covered: developmental or perceptual, primal, biofeedback, marriage counseling, orthomolecular testing, cathectathon, marathon and collaborative.

Hospital Benefits For Specialized Care

Benefits are provided for an Inpatient admission for any of the following reasons; however, some services may be limited:

- Maternity services (including normal delivery, Cesarean section delivery, abortion and complications of pregnancy). Under Individual Coverage, the Employee is covered. Under Family Coverage, the Employee and/or eligible female dependents are covered. Benefits are provided only for Inpatient admissions on or after the Effective Date of coverage and while your coverage remains in effect.

Under the HIPAA Act of 1996, maternity services are not considered pre-existing condition.

- There are no benefits for admissions after the date your group coverage ends, unless you are enrolled in COBRA, conversion coverage, or qualify for benefits under the Extension of Benefit provision.
- Nervous and mental care, tuberculosis, alcoholism and drug addiction.
- Diagnostic services when directed toward a definite disease or injury.
- Dental procedures, if a Hospital Confinement is necessary to safeguard the patient's life or health when they have a medical condition not related to the dental condition.

Non-Network Provider Benefits

If you are admitted or using a Non-Network Facility or Provider, services are reviewed based on benefits available but are payable at the Non Network rates. However, if your benefit plan requires PPO participation, you will receive a reduced benefit for the receipt of services from a Non-Network Provider.

Skilled Nursing Facility Benefits

If your Physician believes skilled nursing care is appropriate, a patient can recover in a Skilled Nursing Facility rather than the Hospital. The services must be for the same condition for which the patient was hospitalized, and the patient would have had to stay in the Hospital to receive the services. The patient must have unused Hospital days under their coverage. Two days in the Skilled Nursing Facility will count as one Hospital day under this coverage. This coverage does not apply to custodial care.

Hospice

Hospice benefits are provided under all benefit plans, with a contractual maximum of 60 days for all Non-uniformed groups' and Firefighter's plans.

Coordinated Home Health Care Benefits

You may be able to recover at home rather than in the Hospital if your Physician believes home care is appropriate. The home care program requires that the services be prescribed by your Physician to treat the condition for which you were hospitalized and specifies that you would have had to remain in the Hospital to receive those services.

Miscellaneous Benefits

In-Hospital Medical Benefits

Physician's visits to you while you are an Inpatient in the Hospital for a medical condition are covered. This benefit does not include any visits made in connection with dental work, dental surgery, surgery or maternity care.

Maternity Benefits

Obstetrical care, including pre- and post-natal care is covered up to the Reasonable Charge. The Employee is covered under the Single plan; under Family Coverage, the Employee and/or eligible Dependents are covered.

Obstetrical Services for all females eligible under Police coverage include Maternity Care such as Prenatal and Postnatal services; Laboratory examinations; Anesthesia in connection with the delivery. Voluntary abortions and sterilization procedures are covered under the plan. Voluntary sterilization benefits are provided under the "Supplemental Benefits" portion of the plan.

Radiation Therapy Benefits

This program will pay the professional charges for X-ray, radium, radon or radioactive isotope treatments. Payment is subject to the Reasonable Charge for this benefit. We will not pay for the rental of radioactive materials.

Emergency Benefits

If you are treated in the Outpatient department of a Hospital for an accidental injury or medical emergency, services are subject to Reasonable Charges and the provisions of the employee's plan. To receive services under this benefit, treatment should be received within 72 hours of the accident or onset of the sickness.

Laboratory Benefits

This program pays for network laboratory charges including vaginal Pap smears for PPO plans.

Additional Services

These expenses may be incurred in or out of the Hospital for Medically Necessary care and treatment recommended by a qualified Provider. Covered services may include:

- Physician's services for a surgical procedure and other medical care and treatment, except as limited for Outpatient care of a psychiatric condition, alcoholism or substance abuse.
- Nursing care by a trained nurse who is not a member of the Employee's immediate family and does not reside in the Employee's home. The attending Physician must certify that nursing care is necessary.
- Emergency surface transportation by professional ambulance for the first trip to and from the Hospital or Skilled Nursing Facility for any one injury, sickness or pregnancy, childbirth or related medical condition. (See Ambulance Transportation definition for other Medically Necessary ambulance services which may qualify.)
- X-ray and laboratory examinations for diagnosis or treatment.
- Speech, physical and occupational therapies, as permitted under ORC 3323.01 (Education of Handicapped Children). Refer to Utilization Review requirements.
- Voluntary sterilization for all Covered Persons.

- Chiropractic and Podiatry services. Refer to Utilization Review requirements.

Medical/Surgical Benefits

Surgery Benefits

Your program will recognize the Reasonable Charges for Medically Necessary surgical expenses and post-operative expenses incurred as the result of Surgery. If two or more surgical procedures are performed through the same incision the program pays Reasonable Charges for the major procedure, and the secondary procedure is payable at 50% of the Reasonable Charge.

- Diagnostic and Therapy services recognized under the Medical/Surgical portion of the plan include: X-ray examinations, radioisotope studies/scans; Diagnostic medical exams, EEG, EKG; Pathological and laboratory exams including vaginal PAP smears; Radiation Therapy; Inpatient physical therapy and hydrotherapy (This is a type of therapy which uses physical means such as massage, hydrotherapy, heat or a similar method to treat a disease or injury.); Chemotherapy (IV); and Hemodialysis.
- Pre-certification of required services will be done by the Network Provider. If a Non-Network Provider is used, the employee is responsible to pre-certify specific services. Failure to do so results in 10% penalty of Medically Necessary care and penalty will not apply to maximum out-of-pocket provisions. Medically Unnecessary care is not covered. (See Cost Containment Section for all utilization review requirements.)
- Surgical Services for Pre- and Post-Operative Services include: Operative and cutting procedures, suturing and removal of sutures; Treatment of broken bones and burns and removal of casts. Human organ transplants; Tissue transplants; Repair of jaw or natural teeth within six months of accident causing damage. Refer to the Cost Containment Sections for more details of this benefit.
- Anesthesia services are a Medical/Surgical benefit. These covered services include anesthesia administered by a Physician or surgeon; administered only in a Hospital by a registered nurse under the Physician's or surgeon's direction. (The nurse may not be an Employee of the Hospital); local anesthesia.
- Initial Examination for an accidental injury or accidental poisoning within 72 hours of the accident is an emergency care service. Medical emergency services are subject to Medical/Surgical coinsurance requirements.
- A FAIR FEE SUPPORT program is available which provides assistance in the

resolution of disputes over Reasonable fee exception situations, which represent unexpected expense to Covered Persons.

Cosmetic Surgery

The cosmetic surgery benefit includes coverage only when it is necessary to correct a defect which results from illness or injury, or a congenital defect that interferes with a person's daily function.

Anesthesia Benefits

This program will pay the Reasonable Charges for anesthesia services when administered by or under the direction of a Physician other than:

- the surgeon performing the surgery
- the assistant surgeon
- any employee (e.g. intern or resident) of the Hospital

Supplemental Benefits

Medical Supplies and Equipment

- Blood transfusions, in excess of the first 2 pints of blood or blood plasma in each calendar year for each Covered Person when not available to you without charge from voluntary donors, blood banks or similar sources. Blood transfusions include the cost of blood plasma expanders, blood and blood plasma.
- Major surgical and burn dressings to include colostomy bags. Routine bandages or dressings are excluded.
- Rental of iron lungs or other durable equipment for temporary therapy.
- Orthopedic braces (except corrective shoes), crutches and prosthetic appliances such as artificial limbs and eyes, to correct conditions arising out of an illness or injury occurring while your coverage is in force. This includes their replacement, repair, or adjustment.
- Hypodermic syringes and needles, not used for insulin.
- Prescriptions dispensed during an inpatient admission.
- Initial charge for surgical supplies including bandages, dressings, and appliances to replace physical organs or parts or to aid in their function

Therapy

- Services of a physical therapist or physiotherapist for Outpatient physical therapy.
- Occupational therapy to restore functional activities and coordination, and prevent deformities of the upper extremities through exercise, muscle strengthening, retraining and education.
- Speech therapy to diagnose or treat speech and hearing disorders, which result

from an accident or illness.

Nursing Services

Services of a registered nurse (RN) or a licensed practical nurse (LPN). This program will not cover nursing services:

- when your condition does not require nursing care.
- when the services are mostly custodial or non-medical.
- when the nurse is a relative or member of your household. This includes spouse, parent, child, brother or sister, by blood, marriage or adoption.

Drug Deductible

Effective with prescriptions dispensed on or after August 1, 2004, prescription drug deductible/co-payment charges are not payable under the supplemental benefits.

Miscellaneous Services

- Ambulance service used locally to and from the Hospital for Inpatients and Outpatients receiving accident care.
- Covered Services as specified under "Supplemental Benefits" when rendered in a Skilled Nursing Facility.
- Rehabilitation Services when offered by a Covered Provider.

Claims Administrator: United Healthcare of Ohio
1-800-681-3849

Written appeals sent to: Chairman, Appeals Committee
United Healthcare of Ohio
P.O. Box 740816
Atlanta, GA 30374-0816

Exclusions

This lists items which are not covered. You should read this section carefully so that you do not expect benefit payment for services not covered by the Contract. If you have any questions, call United Healthcare. No payment shall be made under any health benefit of the coverage in any event for:

- Expenses that are reimbursed through any public.
- Charges incurred while a Covered Person is confined in a Hospital operated by the United States of America or any agency thereof (e.g. veterans' military or other federal Hospital), or program, including Workers' Compensation charges which you would not be required to pay if there were no insurance.
- Charges on account of a Dependent for any medical expenses for which he is entitled to benefits as an Employee or former Employee of the City of Columbus.

- To the extent that they are provided as benefits by any governmental unit.
- For illnesses or injury that occurs as a result of any act of war.
- Charges as a result of war or international armed conflict.
- Services rendered in providing convalescent, chronic, or custodial care.
- Rest cures, mineral baths, massages, or other items of personal service such as, but not limited to, telephones, radio, and television.
- Blood and blood plasma.
- Homegoing (prescription) drugs and appliances, except as provided under Medical Supplies section.
- Ambulance services, except as provided under Additional Services or as stated in Supplemental Benefits.
- Services furnished during any Inpatient Confinement when the admission date was prior to the Effective Date of coverage.
- Charges for care and treatment of the teeth and gums except for accidental injury to natural teeth while covered and for cutting procedures in the oral cavity.
- Charges for eye exams for glasses.
- Charges made for eye refractions, eyeglasses, and hearing aids.
- Dental prosthetic appliances, except as required for accidental injury.
- Charges for services which are not Medically Necessary as deemed by United Healthcare or as defined in the Definitions section of your Booklet. Some examples are:
 - Services rendered for cosmetic or beautifying purposes unless made necessary by bodily injury resulting from an accident occurring while coverage is in effect.
 - Your travel, whether or not recommended by a Physician.
 - Admissions primarily for dieting or diet control unless deemed Medically Necessary by United Healthcare.
 - Psychoanalysis without an approved medical diagnosis; services rendered primarily for training or educational purposes; self-administered services; or services directed toward self-enhancement.
 - Biofeedback; marriage counseling; orthomolecular testing and developmental, perceptual, primal, cathectathon, marathon, collaborative or diversional therapies.
 - Food supplements in the treatment of obesity.
 - Dietary, nutritional and/or food supplements
 - Experimental and/or Investigative procedures.
 - Prescription Drug Deductible Charges
- Routine care of a newborn infant excepting: (a) care of a newborn infant weighing at birth 5lbs.8oz. or less; and (b) the initial examination of a newborn infant, as specified in the Schedule of Benefits.
- Examinations and procedures performed for screening surveys, or research; X-ray and fluoroscopic examinations made without film; and any procedure performed in connection with a physical examination ordered or required by an employer or

school as a (a) condition of employment; (b) condition of the continuance of employment; (c) condition of school admission; or (d) condition for remaining in school.

- More than 10 electroshock treatments during any one (1) period of continuous hospitalization under your Basic/Medical Surgical Benefits.
- Any services rendered in connection with (a) the treatment or diagnosis of corns, calluses, or bunions (except capsular or bone surgery therefore), flat feet, fallen arches or injuries to the arches, weak feet, chronic foot strain, or any other similar conditions relating to feet; (b) the treatment or removal of hypertrophy or hyperplasia of the skin or any subcutaneous tissue; (c) the palliative cutting, trimming or partial removal of toenails (unless matrix is removed); or (d) the fitting of shoes.
- Hypnotism used for anesthetic purposes.
- Desensitization treatment.
- Services in the nature of technical medical assistance or stand-by Physician services.
- Treatment programs which have no proven value or whose value is under investigation; research oriented treatments.

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Section III (b): Schedule of Prescription Drug Benefits

Network Pharmacy

- \$5.00 co-pay for generic drug for 30 day supply
- \$10.00 co-pay for brand
- \$25.00 co-pay for “dispense as written”, and a generic equivalent exists.
- \$5.00 co-pay applies to allergy serums under the direct reimbursement program.

Non-Network Pharmacy Retail

- \$15.00 per generic drug
- \$20.00 for brand. Non-network purchases are filed through the reimbursement program

Mail Order

- Limited to a 30 day minimum and a 90 day maximum supply
- Maintenance drugs must be obtained through the mail order program.

- \$10.00 co-pay for a generic drug
- \$20.00 co-pay for brand
- \$50.00 co-pay for “dispense as written” and a generic equivalent exists, written by the physician.

- Prenatal vitamins only and birth control pills as prescribed by a physician are covered drugs.

EXCLUSIONS

- *Experimental* drugs
- *Drugs* which may be dispensed without a prescription, such as aspirin, even though a doctor may have prescribed these.
- *Non-prescription* items.
- *Medications* which are covered under the terms of any other employer sponsored groups plan, or for which the individual is entitled to receive reimbursement under Workers' Compensation or any other Federal, State or Local Government program.
- *Immunization* Agents.
- *Administration* of drugs.

- *Any* prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the date of the physician's original order.
- *Medication* taken by, or administered to, the individual while a patient is in a licensed Hospital, extended care facility, nursing home or similar institution which operates, or allows to be operated, on its premises, a facility for dispensing drugs.
- *Medically unnecessary drugs* including prescription and prenatal vitamins and antiobesity drugs. Examples of other medically unnecessary excluded drugs are cosmetic, fertility drugs and nicotine patches without behavior modification classes.

City of Columbus Employee Benefits Booklet

Section III (b): Prescription Drug Insurance

The following prescription drug benefits are provided by the City to all employee groups. Refer to the following Schedule of Prescription Drug Insurance Benefits for your group's benefits.

Retail purchases, obtained at network pharmacies, require a specific deductible payment per each covered prescription.

The direct reimbursement program may be used by an employee awaiting a prescription card. Network purchases will be refunded based on the cost of the prescription less the applicable network (contracting pharmacy) deductible. This reimbursement program also refunds non-network (non-contracting) pharmacy purchases, however, a higher deductible deduction may apply.

Maintenance drugs, which are filled through the Provider's mail order service center, result in a lower per prescription deductible charge for a greater prescription quantity.

The Provider's name, mailing address, and a toll free number are included in the "Important Phone Number" section.

DEFINITION OF TERMS

ELIGIBILITY

Benefits are in effect on the first of the month following the hire date, unless the hire date is the first of the month.

PRESCRIPTION DRUG CARD

Each single policyholder will receive one prescription drug card for use at Network pharmacies for retail purchases. The employee may purchase eligible prescriptions for a specific deductible charge per prescription. An employee with family coverage initially will receive two cards for his/her and eligible dependents' use.

Each card includes the employee's name, unique Identification number, and a group number.

DEDUCTIBLE (also CO-PAYMENT)

The deductible is the amount the employee pays at the contracting pharmacy or for each mail order prescription for eligible prescriptions.

Deductibles are negotiated benefits and are identified in the Schedule of Benefits by Group.

NETWORK or CONTRACTING PHARMACY

A pharmacy, in a specific arrangement with the Provider, who can process the employee's benefit, applying the appropriate deductible, at the point-of-sale. The employee provides his/her identification card as proof of participation in the City's group plan.

NON-NETWORK or NON-CONTRACTING PHARMACY

A pharmacy that has no arrangement with the Provider to service the City's group plan. Refer to the Direct Reimbursement program for purchases obtained at non-contracting pharmacies.

COVERED DRUGS

Covered drugs are any prescription drugs or medicines, which may be lawfully dispensed by a licensed pharmacist on a Physician's prescription. *Also covered are prescriptions, which must be compounded by the pharmacist, allergy serums and insulin when written on a prescription.*

MAIL SERVICE PROGRAM

The mail service program is designed to provide convenience and savings to each participant. A specified days supply of maintenance medications are provided to the participant at a nominal cost per prescription. Mail service must be used to obtain maintenance drugs under all negotiated contracts. The negotiated deductibles and days supply are identified in the Schedule of Benefits.

DIRECT REIMBURSEMENT PROGRAM

Benefits are in effect on the first of the month following the hire date, unless the hire date is the first of the month. Employees may use their benefit plan as of the effective date of coverage. However, new hires' benefit card should be available within the month from the effective date of their benefits. For refund of eligible purchases under this drug plan program, Direct Reimbursement forms are available on the City's Intranet under Human Resources, Employee Benefits, and forms. The forms must be completed, with the identification of the drug(s) purchased and proof of purchase attached. Drug receipts up to 18 months from date of purchase may be filed for reimbursement.

Allergy medications purchases are refunded through the direct reimbursement program. Refund liability for allergy drugs is limited to 15 months from date of purchase.

MAINTENANCE DRUGS

Maintenance drugs are prescribed by a physician to treat a chronic condition such as diabetes, heart disease and hypertension. Maintenance drugs have a dispensing limit extending beyond 30 days. Some examples of maintenance drugs include blood pressure, thyroid, and heart medications

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Section III (c): Dental Insurance

This section of the Booklet describes the dental benefits you have under your group coverage effective January 1, 2008. It also explains what payments are made for covered dental expenses. The various Covered Services you are entitled to are called your "benefits." This section explains your dental benefits in general terms. It does not give details on all the terms in your Group Contract. In the event of a conflict between the Group Contract and this section, the terms of the Contract will prevail. The definitions in the Medical Benefits Section also apply to dental benefits.

This section is written in language to help you and your Dependents understand your dental benefits. While it may be confusing to you at times, you may contact Delta Dental or City of Columbus Risk Management at with your questions. Phone numbers for Delta Dental and Employee Benefits/Risk Management are listed in the "Important Phone Numbers" section.

Eligibility

Police and Fire dental benefits are in effect following one year of continuous City service, either on the first of the month from your date of hire or, if you were hired on the first of the month, on your one year anniversary date. No benefits will be provided for any charges incurred prior to the Effective Date of dental coverage.

How Payment Is Made

1. If the Dentist is a PPO Dentist and a Premier Dentist, Delta Dental will base payment on the lesser of:
 - a. The Submitted Amount;
 - b. The PPO Dentist Schedule; or
 - c. The Maximum Approved Fee.

Delta Dental will send payment to the PPO Dentist, and the Subscriber will be responsible for any difference between Delta Dental's payment and the PPO Dentist Schedule or the Maximum Approved Fee for Covered Services. The Subscriber will be responsible for the Dentist's Submitted Amount for any noncovered services.

2. If the Dentist is a PPO Dentist but is not a Premier Dentist, Delta Dental will base payment on the lesser of:
 - a. The Submitted Amount; or
 - b. The PPO Dentist Schedule.

Delta Dental will send payment to the PPO Dentist, and the Subscriber will be responsible for any difference between Delta Dental's payment and the PPO Dentist Schedule for Covered Services. The Subscriber will be responsible for the Dentist's Submitted Amount for any noncovered services.

3. If the Dentist is not a PPO Dentist but is a Premier Dentist, Delta Dental will base payment on the lesser of:
 - a. The Submitted Amount; or
 - b. The Maximum Approved Fee.

Delta Dental will send payment to the Premier Dentist, and the Subscriber will be responsible for any difference between Delta Dental's payment and the Maximum Approved Fee for Covered Services. The Subscriber will be responsible for the Dentist's Submitted Amount for any noncovered services.

4. If the Dentist does not participate in Delta Dental's PPO or Delta Dental Premier, Delta Dental will base payment on the lesser of:
 - a. The Submitted Amount; or
 - b. The Nonparticipating Dentist Fee.

Delta Dental will usually send payment to the Subscriber, who will be responsible for making payment to the Dentist. The Subscriber will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

5. For dental services rendered by an Out-of-Country Dentist, Delta Dental will base payment on the lesser of:
 - a. The Submitted Amount; or
 - b. The Out-of-Country Dentist Fee.

Delta Dental will usually send payment to the Subscriber, who will be responsible for making payment to the Dentist. The Subscriber will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Amount of Benefit Payments

Benefits are paid at 100% or 75% of your dentist's charge, as long as that charge is not higher than the Maximum Approved Fee for the services or supplies you received.

A fee meets the Maximum Approved Fee requirements if it is the lowest of:

- ◆ The Submitted Amount.

- ◆ The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service, irrespective of Dentist's contractual agreement with another dental benefits organization.
- ◆ The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstances.

Delta Dental may also approve a fee under unusual circumstances. Participating Dentists are not allowed to charge patients more than the Maximum Approved Fee for the Covered Service. In all cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for the Covered Service.

In some situations, there may be more than one way to treat a dental condition. When there is a choice of treatments which meet accepted standards of dental practice, Delta Dental will base payment on the least costly, even if you or your dentist choose a more costly way. For example, suppose you choose to have a bridge made rather than a removable partial denture. Delta Dental may choose to base payment to you on the usual cost of a partial denture, if this would provide an adequate and appropriate level of care. You and your dentist may decide to have the bridge made anyway, at which time you may apply the benefits this program has allowed toward the cost of the bridge.

This program will not in any case pay more than the actual fees charged for any dental treatment or dental fees that are over the Maximum Approved Fee.

How to Apply for Benefits

To use your Plan, follow these steps:

Please read this Summary Plan Description carefully so you are familiar with the benefits, payment mechanisms, and provisions of your Plan.

Make an appointment with your Dentist and tell him or her that you have dental benefits coverage with Delta Dental. If your Dentist is not familiar with your Plan or has questions about the Plan, have him or her contact Delta Dental by (a) writing Delta Dental, Attention: Customer Service, P.O. Box 30416, Lansing, Michigan, 48909-7916, or (b) calling the toll-free number, (800) 524-0149.

After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:

- a. The Subscriber's full name and address;
- b. The Subscriber's Member ID number;
- c. The name and date of birth of the person receiving dental care;
- d. The group's name and number.

Claims and completed information requests should be mailed to:

**Delta Dental
P.O. Box 9085
Farmington Hills, MI 48333-9085**

The completed claim form must be submitted to Delta Dental within 90 days after the services or supplies are provided to you. If you have a valid reason for submitting your claim after the time limit, your claim will be handled in the usual way--provided that you submit it as soon as possible. No claims should be submitted later than one year after the usual 90-day filing period ends.

Your bill must be submitted within the 90-day limit for filing claims.

NOTE: If your claim is for dental services for an injury resulting from an accident or the dental procedures listed in the Medical Section under Dental Surgery, you should first file a medical claim. After you receive payment from your medical coverage, file a dental claim and attach a copy of the medical payment voucher. This program will then consider any balance under your dental coverage.

Questions About Your Benefits or Appeals

You usually will be able to answer your health care benefit questions by referring to this section of your Booklet. Delta Dental and the City of Columbus have established a Dedicated Customer Service and Claims Unit.

It is your responsibility to determine if services rendered are covered under the Contract.

If you contact the Dedicated Unit, be sure to keep records of such things as:

- the date of contact;
- the name of the company representative; and
- the response you were given.

If you have questions, contact:

Delta Dental
P.O. Box 30416
Lansing, MI 48909-7916

1-800-524-0149

Website: www.deltadentaloh.com

Or, City of Columbus Employee Benefits/Risk Management.

General Provisions

This section describes how your coverage works, including:

- How and When coverage terminates;
- Extension of Benefits.

Riders, Endorsements, or Amendments

Because of some state laws or the special needs of your Group, provisions called "riders," "endorsements," or "amendments" may be added to your booklet. "Riders," "endorsements," or "amendments" change provisions or benefits in your Booklet.

Contract Maximum

The maximum amount this contract will pay for covered dental expenses for preventive, diagnostic and restorative, except orthodontics, for one person in one Benefit Year; (January through December) is \$1,500 for Uniformed Police.

The lifetime maximum payable for orthodontia services for any Covered child is \$1,850. The yearly maximum for all other Covered Services shall not apply to orthodontia.

Predetermination of Benefit

If your dentist plans a course of treatment which is expected to cost \$250 or more, you should have him or her submit the treatment program to Delta Dental on a claim form before starting work. Your dentist should include a description of the work to be done and an estimate of the charges. X-rays and other diagnostic aids should be included with the treatment program to help Delta Dental determine appropriate benefits. If your dentist submits these aids, you will know exactly what your benefits will be before the treatment begins.

Your Dental Benefits

For eligible employees and dependents, the following preventive and diagnostic dental services will be paid at 100% of the Maximum Approved Fee:

- Routine oral examinations - twice in any 12-month period. (365 days)
- Routine prophylaxis (cleaning of teeth) - twice in any 12-month period. (365 days)
- Topical application of fluoride - twice in any 12-month period.
- One set of full-mouth X-rays in any period of 36 consecutive months; including other necessary dental X-rays required with the diagnosis of a special condition.
- Bitewing X-rays accompanying the oral examination - twice in any 12-month period.
- Space maintainers that replace prematurely lost teeth for covered children under age 19.

- Emergency treatment for the temporary relief of severe pain, but which does not effect a definite cure.

The following restorative services will be paid at 75% of the Maximum Approved fee: Charge.

- Oral surgery.
- Fillings to restore diseased or accidentally broken teeth. Filling may be made of amalgam, silicate, synthetic porcelain or composite materials.
- Endodontics (treatment of the dental pulp), including pulpotomy, pulp capping, and root canal treatment.
- Apicoectomy (surgical removal of the apex or tip of tooth root).
- Management of acute infection and oral lesions (wounds or sores in the mouth).
- Repair or recementing of crowns, inlays, onlays, bridgework and dentures.
- Relining or rebasing dentures at least six months after their installation. This program will pay this benefit no more than once in any period of 36 months.
- Injectable medication and its administration provided in the dentist's office.
- Consultations required by the attending dentist.
- Inlays, onlays, or crown restorations for diseased or accidentally broken teeth. These restorations are covered only if regular fillings would not restore your teeth adequately and will be provided only once in any five-year period. Covered Persons under 17 years of age will receive stainless steel or prefabricated crowns only.
- Periodontal examinations and other periodontal treatments, including gingival curettage, gingivectomy, gingivoplasty and osseous surgery. These are all procedures used to treat the gums or the bony structures of the mouth which support the teeth.
- The initial installation of bridgework. Bridgework means a false tooth or false teeth at each end to existing teeth.
- The initial installation of partial or full removable dentures.
- Replacements for dentures or bridgework, or the addition of new false teeth to them. This program will pay this benefit only if one of the following conditions exist:
 - a) Your existing denture or bridgework cannot be repaired so that you can use it. Your denture or bridgework must be at least five years old before this program will pay for any part of the cost of replacing it.
 - b) Your existing denture is an immediate temporary denture which must be replaced with a permanent one, within one year.
 - c) You have had more teeth extracted, so that you must have teeth added to your denture or bridgework.
 - d) Prosthodontic: If a cast chrome or acrylic partial denture will restore the case, this plan shall allow the appropriate amount for such procedure toward a more complicated precision appliance that the employee and the

dentist may select. If in the construction of a denture, the employee and the dentist decide on "personalized" or "specialized techniques" as opposed to standard procedures, this plan shall allow the appropriate amount for the standard denture and the employee must bear the difference in cost.

- Extraction of teeth.
- General anesthesia or extraction of teeth in connection with other services covered at 75% of the Maximum Approved Fee.
- Sealant for dependents, under 19 years of age. Application limited to unrestored, non-decayed posterior permanent teeth (e.g.molars).

Orthodontia services are covered at 75% of the Maximum Approved Fee for FOP eligible children:

- Orthodontia is the treatment to correct the position or alignment of the teeth. Orthodontia benefits are provided for your covered children under age 19. Benefits will be paid for diagnostic orthodontic services and for orthodontic treatments.
- The lifetime maximum payable for orthodontia services for any Covered child is \$1,850. The yearly maximum for all other Covered Services shall not apply to orthodontia.

Limitations:

- The obligation of Delta Dental to make monthly or other periodic payments for an orthodontic treatment plan which began prior to the eligibility date of the Covered Person will begin with the first payment due following the Covered Person's eligibility date. The maximum amount payable for orthodontia will apply to this and subsequent payments.
- The obligation of Delta Dental to make monthly or other periodic payment for orthodontic services will end on the payment date next following the date the Covered Person loses eligibility; the Employee loses eligibility; upon termination for treatment for any reason prior to completion of the case; or on the termination date of the Contract, whichever occurs first.

Exclusions

This section lists items which are not covered. You should read this section carefully so that you do not expect benefit payment for services not covered by the Contract. If you have any questions, call your Claims Administrator.

No benefits are provided by the Group Contract for any of the following:

- Dental services or supplies which are provided before the Contract goes into effect or after it is terminated. (Except for services covered under Extension of Benefits.) In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before coverage goes into effect, even if

the prosthetic device or crown is installed after coverage goes into effect.

- Dental services or supplies which are provided or made available free of charge or are payable by some other agency. This program will not pay benefits for any service you could receive free or have paid for by some governmental agency, even if you do not choose to apply for or to accept this assistance. The list below includes some of the situations in which this program will not pay benefits for this reason:
 - a) If you can receive dental care as a military benefit. This is true if you receive dental services or supplies while you are in active military service; or if you receive them in a veterans' administration hospital.
 - b) If you can receive dental care as an occupational benefit. This is true if care would be provided or paid under a state or federal workers' compensation act; or if they would be provided or paid for under an occupational disease law or similar law.
 - c) If the services or supplies would be provided or paid for by any governmental agency.
- Dental services or supplies for a condition resulting from a riot, civil disobedience, nuclear explosion, nuclear accident, or an act of war.
- Dental services or supplies which are covered by any other contract. That is, if your hospital and physician coverage includes some oral surgery, you must have charges for those oral surgical procedures paid under that coverage. The following Dental services will be considered only as secondary coverage to the Medical plan. These services are to be submitted for benefit determinate under the medical plan first:
 - Removal of impacted teeth
 - Gingivectomy (including post-surgical visits), osseous or mucogingival surgery
 - Alveolectomy (edentulous and in addition of removal of teeth)
 - Removal of palatal torus
 - Incision of pericoronal gingival
 - Sialolithotomy; removal of salivary calculus
 - Closure of salivary fistula
 - Resection of benign tumor or soft tissue (2.5cm or larger)
 - Excision of cyst
- Dental services or supplies for which you have not been charged if you had not been covered by this dental insurance. For example:
 - a) If you would have been charged less if you had no insurance, payment will be based on the lower charge.
 - b) If the service would have been provided free by a clinic or health service which is operated by or for your employer, your union or a similar group,

this program will not pay any charges.

- Dental services and supplies to replace a lost or stolen denture.
- Charges for dental visits at home or in a Hospital, unless these visits are in connection with dental surgery or emergency care.
- Charges for certain specific kinds of services and supplies:
 - a) Appliances or restorations to increase the vertical dimension of the mouth or to restore the occlusion (bite); complete equilibration (treatment to equalize pressure in the bite) is one example of such a service.
 - b) Services primarily to stabilize the teeth in their supporting structures; examples include implantology and periodontal splinting (the cost of a complete or partial denture may be applied towards the cost of an implant).
 - c) Services and supplies which the American Dental Association considers experimental.
 - d) Services and supplies to correct a congenital malformation (one you were born with).
 - e) Services or supplies primarily to improve appearance; examples include capping teeth to cover stains, and shaping false teeth to make them look like the real teeth they replace.
 - f) Porcelain or other veneers of crowns and pontics placed on the molars; if veneers are used, payment will be the same as payment for a full cast gold crown or cast gold pontic.
 - g) A plaque control program, oral hygiene or dietary instruction.
 - h) A duplicate (spare) prosthetic device or appliance.
 - i) Local anesthesia or partial anesthesia (analgesia) when billed separate from dental service.
- Excess charges because:
 - a) You transferred from one dentist to another during a course of treatment;
 - b) You missed an appointment;
 - c) Services were rendered by more than one dentist; or
 - d) Services were repeated needlessly.
- Any services or supplies Delta Dental considers unnecessary.
- Non-dental services, such as filing our claim forms.
- Any services or supplies for repair or replacement of an orthodontic appliance, furnished in whole or in part, under this Booklet.
- Porcelain, porcelain and metal, or plastic and metal crowns for Covered Persons under age 17.
- Any services or supplies for which a benefit is not specifically provided under the Group Contract.

Passive PPO

Dental Care Plan – Voluntary Dental Preferred Provider Organization (PPO) A voluntary dental PPO shall be available to members that allows for the selection of a participating provider that will result in no balance billing over reasonable charges. All existing coinsurance levels and exclusions continue to apply.

Time of Payment

Indemnities payable under this Contract will be paid immediately upon, or within 30 days after, receipt of written proof of services.

Payment of Benefits

Payment will be sent to the Dentist for services rendered by a Dentist who participates in Delta Dental's programs. Payment for services rendered by a non-participating Dentist will usually be sent directly to the employee's home. You cannot, however, assign your right to receive payment to anyone else except as required by a "Qualified Medical Child Support Order" as defined by ERISA. Once a Provider performs a Covered Service, Delta Dental will not honor your request to withhold payment of the claims submitted.

Explanation of Benefits

After your claim has been processed, you will receive an Explanation of Benefits (EOB) telling what has been paid by Delta Dental. You will be billed directly for any amount due.

Amounts Payable

This program will not pay more than the actual charge for Covered Services.

Return of Payments

Any payment made in error by Delta Dental to the Employee, to the Group or to a dentist shall be returned to Delta Dental.

Delta Dental PPO (Point-of-Service)

Delta Dental's national preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from one of Delta Dental's PPO Dentists. This program has back-up coverage through Delta Dental Premier when treatment is received from a non-PPO Dentist.

Dental Examinations

After you have filed a claim, Delta Dental has the right to ask that you have one or more additional dental examinations. These exams will be at the program's expense and will help to determine what benefits will be paid, particularly when there are questions about services or supplies on your claim.

By accepting coverage under this Contract, you agree that Delta Dental may request any dental information or records related to your claims. You authorize any dentist or dental hygienist who provided services to release any necessary information and/or records to Delta Dental. You also agree that any other person or organization can release information related to your diagnosis, treatment or service.

Dental Providers (Dentist)

To be covered under this Contract, services and supplies must be provided by a dentist or dental hygienist working within the scope of his or her license. A dentist is a person licensed to practice dentistry. A dental hygienist is a person who is licensed to practice dental hygiene and is working under the supervision and direction of a dentist. All services must be based on accepted standards of dental practice as determined by the American Dental Association. They must be billed by or for a dentist. The services must also be connected with the diagnosis and treatment of the Covered Person's condition and not be solely for the convenience of the Covered Person or dentist.

Delta Dental PPO Dentist (PPO Dentist) or Participating Dentist – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental PPO. PPO Dentists agree to accept Delta Dental's fee determination as payment in full for Covered Services.

Delta Dental Premier Dentist (Premier Dentist) or Participating Dentist – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental Premier. Delta Dental Premier Dentists agree to accept Delta Dental's fee determination as payment in full for Covered Services.

Wherever a term of this Certificate differs from your state Delta Dental and its agreement with a Participating Dentist, the agreement in that state with that Dentist will be controlling.

Nonparticipating Dentist – a Dentist who has not signed an agreement with Delta Dental to participate in Delta Dental PPO or Delta Dental Premier.

Out-of-Country Dentist – A Dentist whose office is located outside of the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

Claims Review

If you have any questions about your benefits, a claim payment, or a claim denial, you should contact us by telephone, in writing, or in person.

Appeal Rights

Although you can contact us on any issue, you only have the right to appeal a claim denial. If you are not satisfied with the answer to your prior inquiry and wish to appeal a

claim denial, you should send your request in writing. Your written appeal should outline the problem and your previous efforts to resolve the matter, and should request another review. The appeal should be addressed to the Appeals Committee as follows:

Dental Director
Delta Dental
P.O Box 30416
Lansing, Michigan 48909-7916
Phone: 1-800-524-0149

You will receive a written answer no later than 60 days after your notice of appeal and all other necessary information is received. You will be notified if it is necessary to have your appeal reviewed by a medical specialist or medical review committee. Then, another 60 days are available to resolve your appeal. Even so, you will receive final notice of the decision no later than 120 days from the date your notice of appeal and all other necessary information is received.

Liability

The City of Columbus does not select a dentist for you. The City is not responsible or liable for any acts, omissions, or conduct of a dentist or dental hygienist. Delta Dental's only obligation is to make payments to the Employee according to contract terms of the Group Contract.

Limit On Legal Action

No action in any court of law may be brought against us sooner than 60 days after your claim was filed or later than three years after the service in question was received.

General Provisions

Termination of Group Contract

The Group Contract may be terminated by the City of Columbus or Delta Dental at any time by giving written notice 60 days prior to the termination date. Your coverage automatically ends upon termination of the group contract.

Automatic Termination

Coverage is not transferable. If the Employee tries to transfer this coverage to a person who is not covered, coverage will automatically terminate.

Misrepresentation

If a Covered Person makes a fraudulent statement, relating to their application for coverage or a claim for benefits, this coverage will become null and void.

Termination Due to Loss of Eligibility

Coverage will terminate when you lose your eligibility. Under this Contract,

coverage will terminate:

- For all Covered Persons, when the Employee loses employment with the Group. Coverage will continue until the end of the month of termination.
- For all Covered Persons when the Employee's classification becomes ineligible for coverage under the Group Contract. Coverage will continue until the end of the month in which the Employee became ineligible.
- For the spouse, in the event of an annulment, legal separation, divorce or dissolution.
- For all Dependents, in the event of the Employee's death.
- For the Dependent children when they reach the limiting age, marry or otherwise lose eligibility as a Dependent, whichever occurs first.

Extension of Benefits

Benefits will be extended for crowns and prosthodontic services that have been submitted on a claim form for "Predetermination" and have been approved by Delta Dental prior to the date of termination of these services. The services must be completed within 60 days of the date of approval by Delta Dental and while the dental program is still in effect. Benefits will also be extended for Prosthodontic Single Procedures which were begun while the employee was eligible. The Procedures must be completed before the last day of the month in which eligibility terminated irrespective of predetermination of benefits.

"Single Procedure" means crowns or Prosthodontic dental procedures to which a separate procedure number has been assigned in the Procedure Code and Nomenclature list established by the American Dental Association.

Definitions

This section defines terms which have special meanings. If a word or phrase has a special meaning or it is a title, it starts with a capital letter. The word or phrase is defined in this section or at the place in the text where it is used.

Benefit period - a 12-month period of time listed in the Schedule of Benefits.

Certificate - the term Certificate means this document.

Certificate holder - an Eligible Person who has enrolled for coverage, usually the employee.

Contract - the agreement (including the Group Application and any riders) between your Group and the City of Columbus, referred to as the Master Contract or Group Contract.

Contract date - the date when coverage for the Group starts.

Co-insurance - a percentage of the Reasonable Charge for which you are responsible per Covered Service after you meet an applicable Deductible in each Benefit Period.

Covered person - the Certificate Holder, and if Family Coverage is in force, the Dependents.

Covered service - a service or supply shown in the Certificate and given by a Provider for which we will provide benefits. Covered Services may be subject to a Co-payment. To be a Covered Service, services must be:

- authorized by a Physician;
- Medically Necessary, except as otherwise specified in this Certificate;
- consistent with the condition(s) for which you were admitted when an Inpatient; and,
- within the scope of the license of the Provider performing the service.

Deductible - if applicable, is an amount of Covered Services, stated in dollars, for which you are responsible before we start to pay each Benefit Period.

Dental hygienist - a person who is licensed to practice dental hygiene and is working under the supervision and direction of a Dentist.

Dentist - a person who is licensed to practice dentistry.

Dependent - a Covered Person other than the Certificate Holder as defined in the Medical Section, under Eligibility.

Effective date - the date when your coverage begins under this Certificate.

Eligible person - a person who satisfies the requirements of the Group Contract and is entitled to apply to be a Certificate Holder.

Experimental/Investigative - any drug, device, equipment, facility, procedure, treatment, or supply (hereafter called service) which we, in our discretion, may determine with regard to a particular illness, disease or condition:

- did not have governmental approval for marketing at the time when furnished for the purpose or manner rendered; or
- is not supported by Reliable Evidence which shows that the service:
 - is generally recognized as being safe and effective for treating the condition in question by those practicing the appropriate medical specialty;
 - has a definite positive effect on health outcomes;
 - over time leads to improvement in health outcomes under standard conditions of medical practice outside clinical investigatory settings (i.e.,

- the beneficial effects outweigh any harmful effect); and
- is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment means is not employable.

Reliable Evidence includes only:

1. published reports and articles in authoritative medical and scientific literature;
2. the written investigational or research protocols and/or the written informed consent used by the treating facility or of another facility which is studying the same service; and
3. compilations, conclusions and other information which we have available which are drawn from (1) or (2) above.

The City of Columbus has the authority and discretion to determine all questions in connection with whether any service is Experimental/Investigative under this Certificate.

Family coverage - coverage for the Certificate Holder and one or more Dependents.

Identification card - the card we will give you. It contains your identification number.

Incurred - a charge will be considered incurred on the date a Covered Person receives the service or supply for which the charge is made.

Individual coverage - coverage for the Certificate Holder only.

Maximum Approved Fee -A system used by Delta Dental to determine the approved fee for a given procedure for a given Delta Dental Premier Dentist.

Medically necessary (or Medical Necessity) - a service or supply given by a Provider that is required to diagnose or treat your condition, illness or injury and which we determine is:

- appropriate with regard to standards of good dental practice;
- not solely for the convenience of you or a Provider;
- the most appropriate supply or level of service which can be safely provided to you.

Other Provider - the following persons or entities which are licensed, where required under applicable state laws, to render Covered Services:

- Professional Other Providers

Physician - one of these professionals licensed under applicable state laws:

- Doctor of Medicine (M.D.)
- Dental Surgeon (D.D.S.)

- Dentist (D.M.D.)

PPO Dentist Schedule

The maximum amount allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Plan.

Professional other providers - the following persons or entities which are licensed, where required under applicable state laws, to render Covered Services:

- Dental Hygienist

Provider - a licensed Physician or Professional Other Provider.

- Medicare Approved Provider - a Provider that is certified by the United States Department of Health and Human Services to receive payment under the Medicare Program.
- Participating Provider - a Physician or Professional Other Provider that has a written agreement with a Blue Shield Plan about payment for Covered Services.

Reasonable charge - the amount of the charge that we determine is reasonable for Covered Services you receive up to but not to exceed charges actually billed. Our determination considers:

- amounts charged by other Providers for the same or similar service;
- any unusual medical circumstances requiring additional time, skill or experience; and
- other factors we determine are relevant.

For a Hospital or Facility Other Provider which is either a Network Provider or a Contracting Provider, the Reasonable Charge is the actual amount billed.

The Reasonable Charge is reduced by any penalties for which a Provider is responsible as a result of its agreement with us.

**City of Columbus
Employee Benefits Booklet
FOP**

Section III (d): Schedule of Vision Benefits

Network Doctor Plan

Deductibles Eye Examination \$0
Lenses and Frames \$0
Deductibles do not apply toward contact lenses.

Retail Frame Allowance \$130.00

Non-Network Doctor Plan Reimbursement Schedule

Eye Examination, up to \$35.00
Frames, up to \$35.00
Lenses:
 Single Vision, up to \$35.00
 Bifocals, up to \$50.00
 Trifocal, up to \$60.00
 Lenticular, up to \$90.00

Contact lenses (pair), in place of all other plan benefits for the benefit period
 Necessary \$170.00
 Cosmetic (elective) \$ 90.00*

* Under the Police Plan, this Cosmetic contact lens maximum allowance is for spouse and dependents only. Uniformed Police employees have a \$150.00 maximum allowance.

Exclusions

No Benefits for professional services or materials connected with:

1. Orthoptics or vision training, subnormal vision aids, or non-prescription lenses;
2. Lenses and frames furnished under this program which are lost or broken. These will not be replaced unless you are eligible for frames or lenses at that time.
3. Medical or surgical treatment of the eyes.
4. Services or materials provided as a result of any Workers' Compensation Law or similar legislation.
5. Any eye examination required by an employer as a condition of employment; or any services or materials provided by any other vision care plan, or group benefit plan containing benefits for vision care.

6. Sunglasses, with or without prescription or correction (tinted glasses with a tint other than a #1 or #2 are considered sunglasses).

Extra Cost Items

This plan is designed to cover your visual needs rather than cosmetic materials. There will be extra cost involved if you select:

1. Blended lenses.
2. Oversize lenses.
3. A frame that costs more than the plan allowance.
4. Two pairs of glasses in place of bifocals.
5. Cosmetic contact lenses (in excess of the plan allowance).
6. Tinted or coated lenses (other than #1 or #2).

City of Columbus
Employee Benefits Booklet
FOP

Section III (d): Vision Insurance

This section of the Booklet describes the vision care benefits you have under your group coverage. The various covered services you are entitled to are called your benefits. If you have questions, please contact Vision Service Plan (VSP). Phone and address information are located in the "Important Phone Numbers" section of the Benefit Booklet. Benefits are provided in accordance with the Network or Non-Network network plan.

How to Use the Vision Insurance Benefits Section

This section identifies details you need to understand the vision benefits plan issued to you according to the terms of your negotiated contract.

Amount of Benefit Payment and Exclusions

A Schedule of Benefits lists each negotiated contract group's unique benefit payments and follows this general description section. Exclusions and Extra Cost Items, unique to each negotiated group, are also listed in the Schedule of Benefits.

Eligibility

Coverage for employees and their eligible dependents are in effect on the first of the month following one (1) year of continuous City service.

Eligible dependents include your spouse and unmarried children who have not attained their 23rd (twenty-third) birthday. Notification of any change in status must be reported to your payroll office within thirty days of the event. Failure to do so may result in a loss of benefits.

No vision benefits will be provided for any charges incurred prior to the effective date of coverage.

Your Vision Insurance Benefits

VSP has contracts with private eye care practitioners throughout the local area and the nation. Network Doctors will provide professional vision care for employees and their eligible dependents. This type of vision care program assures that only the finest quality professional care and materials are provided to you. Network Doctors will be responsible

for filing benefit paperwork for you.

Vision Examination

A complete analysis of the eyes and related structures to determine the presence of vision problems will be provided to insured once every 12 months.

Spectacle Lenses

Network eye care practitioners will order the proper lenses for you. Your eye care benefit program provides the finest quality lenses fabricated to exacting standards. The eye care benefit program allows for lenses once every 12 months.

Frames

The plan offers a wide selection of frames, however, if you select a frame which costs more than the amount allowed by your plan (or a frame that requires oversize lenses), there will be additional charges. You are eligible for frames once every 24 months.

Contact Lenses

(In place of all other plan benefits for the benefit period.)

Necessary-Once every 12 months.

Cosmetic-Once every 12 months.

Contact lenses are considered necessary when approved for one of the following conditions:

1. Following cataract surgery,
2. To correct extreme visual acuity problems not correctable with spectacle lenses to at least 20/70 in either eye,
3. To correct for significant anisometropia,
4. Keratoconus.

When contact lenses are received for reasons other than those listed, they are considered cosmetic in nature. See your Schedule of Benefits for the maximum allowance made toward their cost.

How to Use Your Benefits

Contact your VSP doctor and make an appointment or call VSP for a list of member doctors. The following options are available under your eye care benefit program:

Option 1

Call a VSP member doctor, identify yourself as a VSP patient, and make an appointment. The doctor's office will verify eligibility and plan coverage, and obtain authorization from VSP.

Once you have elected to see a doctor within VSP's network, schedule your eye examination appointment. The Network Doctor will take care of all paperwork and will receive payment from VSP. See the Schedule of Benefits following this section to determine if you are required to pay a deductible toward vision services or for excluded materials, cosmetic options or extra cost items.

Option 2

If you choose to see an optometrist, ophthalmologist, or dispensing optician who is not a part of VSP's network, you will pay the doctor(s) for non-network services. Obtain an itemized receipt, which must contain the following information:

1. Patient's name
2. Date services began
3. The service and materials you received
4. The type of lenses you received (single vision, bifocal, trifocal, etc.)
5. Member's social security number.

Mail the itemized receipt to VSP, at the address listed in the Table of Contents. Reimbursement will be sent directly to you for services and materials you received (deductible not applicable) according to the Non-Network Reimbursement Schedule identified at the end of this section.

Option 3

You may choose to see a Non-Network Doctor for an examination and have a network eye care doctor fill your prescription. You must pay the Non-Network Doctor for the examination. Obtain a receipt for this service and the prescription for your lenses. Mail the receipt for the examination to VSP. Reimbursement will be made according to the Schedule of Benefits at the end of this section.

You may contact a Network eye care provider to have your prescription filled. The network eye care doctor will fit you with your new glasses or contacts and will file the necessary paperwork with VSP. You will be responsible for any applicable deductibles or for payment of excluded services or extra cost charges.

**NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE OHIO LIFE
AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.**

**Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, Ohio 43220**

**Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43266-0566**

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. On the following page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all the provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certification was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insurance life, the association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different type of coverages. Within this overall \$300,000 limit, the association will not pay more than \$100,000 in cash surrender values, \$100,000 in health insurance benefits, \$100,000 in present value of annuities, or \$300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

GROUP LIFE INSURANCE POLICY

Policyholder:	City of Columbus
Policy Number:	645816-A
Effective Date:	February 1, 2008

The consideration for this Group Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

Subject to the **Policyholder Provisions** and the **Incontestability Provisions**, this Group Policy (a) is issued for the Initial Rate Guarantee Period shown in the **Coverage Features**, and (b) may be renewed for successive renewal periods by the payment of the premium set by us on each renewal date. The length of each renewal period will be set by us, but will not be less than 12 months.

For purposes of effective dates and ending dates under this Group Policy, all days begin and end at 12:00 midnight Standard Time at the Policyholder's address.

This policy includes an Accelerated Benefit. Death benefits will be reduced if an Accelerated Benefit is paid. The receipt of this benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. However, if you meet the definition of "terminally ill individual" according to the Internal Revenue Code Section 101, your Accelerated Benefit may be non-taxable. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

All provisions on this and the following pages are part of this Group Policy. "You" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company. Other defined terms appear with their initial letters capitalized. Section headings, and references to them, appear in boldface type.

STANDARD INSURANCE COMPANY

By



President



Corporate Secretary

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COVERAGE FEATURES

This section contains many of the features of your group life insurance. Other provisions, including exclusions and limitations, appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number:	645816-A
Type of Insurance Provided: Life Insurance:	Yes
Policyholder:	City of Columbus
Employer(s):	City of Columbus
Group Policy Effective Date:	February 1, 2008
Policy Issued in:	Ohio

BECOMING INSURED

To become insured for Life Insurance you must: (a) Be a Member; (b) Complete your Eligibility Waiting Period; and (c) Meet the requirements in **Life Insurance** and **Active Work Provisions**. The Active Work requirement does not apply on the Group Policy Effective Date to Members who were previously insured with the Prior Plan.

Definition of Member: You are a Member if you are:

1. An active employee of the Employer and regularly working at least 40 hours each week;
2. A Member who became disabled prior to February 1, 2005 whose coverage has been agreed to be extended by the Policyholder and us; or
3. An active military reservist as covered by City Ordinance.

You are not a Member if you are:

1. A temporary or seasonal employee.
2. A leased employee.
3. An independent contractor.
4. A full time member of the armed forces of any country.

Class Definition:

Class 1: Active AFSME (American Federation of State, County and Municipal Employees) and CMAGE/CWA (Columbus Municipal Association of Government Employees and Communication Workers of America) Members who are in positions covered by collective bargaining agreements including those covered as reservists

Class 2: Active MCP (Management Compensation Plan) Members including those covered as reservists

- Class 3: Active Uniformed Fire Members including those covered as reservists, other than active Fire Deputy Chiefs and Assistant Chiefs
- Class 4: Active Uniformed Police and Police Supervisors including those covered as reservists
- Class 5: Active Members of Ohio Labor Council (OLC) including those covered as reservists
- Class 6: Members who were permanently and totally disabled prior to February 1, 2005 on the list agreed upon by us and the Policyholder
- Class 7: Active Fire Deputy Chiefs and Assistant Chiefs including those covered as reservists
- Class 8: Active FOP MCP Members (Police Chief and Deputy Chiefs)

Eligibility Waiting Period: You are eligible on one of the following dates:

Class 6:
If you are a Member on the Group Policy Effective Date, you are eligible on that date.

For all other classes:
If you are a Member on the Group Policy Effective Date, you are eligible on that date.

If you become a Member after the Group Policy Effective Date, you are eligible on the first day of the calendar month following the date you become a Member.

PREMIUM CONTRIBUTIONS

Life Insurance: For city employees (except for uniformed employees), who are eligible for medical insurance but choose not to participate: Contributory

All other Members: Noncontributory

SCHEDULE OF INSURANCE

SCHEDULE OF LIFE INSURANCE

For you:

Life Insurance Benefit: **Class 1:** Active AFSME (American Federation of State, County and Municipal Employees) and CMAGE/CWA (Columbus Municipal Association of Government Employees and Communication Workers of America) Members who are in positions covered by collective bargaining agreements

1.5 times your Annual Earnings, rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. The minimum amount is \$27,000. The maximum amount is \$200,000.

Class 2: Active MCP (Management Compensation Plan) Members

1.5 times your Annual Earnings, rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. The minimum amount is \$18,000. The maximum amount is \$200,000.

Class 3: Active Uniformed Fire Members including those covered as reservists, other than active Fire Deputy Chiefs and Assistant Chiefs

\$100,000.

Class 4: Active Uniformed Police and Police Supervisors

\$100,000.

Class 5: Active Members of Ohio Labor Council (OLC)

1.5 times your Annual Earnings, rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. The minimum amount is \$18,000. The maximum amount is \$200,000.

Class 6: Members who were permanently and totally disabled prior to February 1, 2005 on the list agreed upon by us and the Policyholder

\$15,000.

Class 7: Active Fire Deputy Chiefs and Assistant Chiefs including those covered as reservists

The greater of:

a. 1 times your Annual Earnings, rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. or;

b. \$100,000.

Class 8: Active FOP MCP Members (Police Chief and Deputy Chiefs)

1 times your Annual Earnings, rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. The maximum amount is \$200,000.

Repatriation Benefit:

The expenses incurred to transport your body to a mortuary near your primary place of residence, but not to exceed \$5,000 or 10% of the Life Insurance Benefit, whichever is less.

REDUCTIONS IN INSURANCE

If you reach an age shown below, the amount of insurance will be the amount determined from the Schedule Of Insurance, multiplied by the appropriate percentage below:

Classes 1, 2 and 6

Life Insurance:

Age	Percentage
65 through 69	65%
70 or over	39%

Classes 3, 4, 5, 7 & 8

Your insurance will not be reduced due to age.

OTHER BENEFITS

Accelerated Benefit: Yes

OTHER PROVISIONS

Limits on Right To Convert if
Group Policy terminates
or is amended:

Minimum Time Insured:	5 years
Maximum Conversion Amount:	\$2,000

Leave of Absence Provision:

For activated military reservists:	Insurance is continued during a leave of absence scheduled to last 12 months or the end of the military activation, whichever is less.
For all other leaves:	Insurance is continued during a leave of absence scheduled to last 90 days or less.

Insurance Eligible For Portability:

For you:

Life Insurance:	Yes
Minimum combined amount:	\$10,000
Maximum combined amount:	\$300,000

Annual Earnings based on: Earnings in effect on your last full day of Active Work.

PREMIUM RATES AND RENEWALS

Premium Rates:

Life Insurance: \$.120 monthly per \$1,000 of Life Insurance

Premium Due Dates: February 1, 2008 and the first day of each calendar month thereafter.

Grace Period: 90 days

Initial Rate Guarantee Period: February 1, 2008 to February 1, 2011

Notice of Rate Change: 90 days

Minimum Participation:

Life Insurance:

Percentage: 100% of eligible Members

LIFE INSURANCE

A. Insuring Clause

If you die while insured for Life Insurance, we will pay benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

B. Amount Of Life Insurance

See the **Coverage Features** for the Life Insurance schedule.

C. Changes In Life Insurance

1. Increases

An increase in your Life Insurance becomes effective on the first day of the calendar month coinciding with or next following the date you apply or the date of change in your classification, age or Annual Earnings or a labor negotiated date of change.

2. Decreases

A decrease in your Life Insurance because of a change in your classification, age or Annual Earnings becomes effective on the first day of the calendar month coinciding with or next following the date of the change.

Any other decrease in your Life Insurance becomes effective on the first day of the calendar month coinciding with or next following the date the Policyholder or your Employer receives your written request for the decrease.

D. Repatriation Benefit

The amount of the Repatriation Benefit is shown in the **Coverage Features**.

We will pay a Repatriation Benefit if all of the following requirements are met.

1. A Life Insurance Benefit is payable because of your death.
2. You die more than 200 miles from your primary place of residence.
3. Expenses are incurred to transport your body to a mortuary near your primary place of residence.

E. When Life Insurance Becomes Effective

1. Subject to the Active Work Provisions, your Life Insurance becomes effective on the date you become eligible.
2. Takeover Provision

If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, your Eligibility Waiting Period is waived on the effective date of your Employer's coverage under the Group Policy.

F. When Life Insurance Ends

Life Insurance ends automatically on the earliest of:

1. The date the last period ends for which you made a premium contribution, if your insurance is Contributory;
2. The date the Group Policy terminates;
3. The end of the month following the date your employment terminates unless you are eligible for benefits as a Class 6 Member; and

4. The date you cease to be a Member. However, if you cease to be a Member because you are working less than the required minimum number of hours, your Life Insurance will be continued with premium payment during the following periods, unless it ends under 1 through 3 above.
 - a. While your Employer is paying you at least the same Annual Earnings paid to you immediately before you ceased to be a Member.
 - b. While your ability to work is limited because of Sickness, Injury, or Pregnancy.
 - c. During the first 90 days of:
 - (1) A temporary layoff; or
 - (2) A strike, lockout, or other general work stoppage caused by a labor dispute between your collective bargaining unit and your Employer.
 - d. During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.
 - e. During any other scheduled leave of absence approved by your Employer in advance and in writing and lasting not more than the period shown in the **Coverage Features**.

G. Reinstatement Of Life Insurance

If your Life Insurance ends, you may become insured again as a new Member. However, 1 through 4 below will apply.

1. If your Life Insurance ends because you cease to be a Member, and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
2. If your Life Insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again.
3. If you exercised your Right To Convert, you must provide Evidence Of Insurability to become insured again.
4. If your Life Insurance ends because you are on a federal or state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.

(REPAT) LI.LF.OT.2X

CONTINUITY OF COVERAGE

A. Waiver Of Active Work Requirement

If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, you can become insured on the effective date of your Employer's coverage without meeting the Active Work requirement. See **Active Work Provisions**.

B. Payment Of Benefit

The benefits payable before you meet the Active Work requirement will be:

1. The benefits which would have been payable under the terms of the Prior Plan if it had remained in force; reduced by
2. Any benefits payable under the Prior Plan.

LI.CC.OT.1

ACTIVE WORK PROVISIONS

If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of Active Work as an eligible Member.

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business. You will also meet the Active Work requirement if:

1. You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. You were Actively At Work on your last scheduled work day before the date of your absence; and
3. You were capable of Active Work on the day before the scheduled effective date of your insurance or increase in your insurance.

LI.AW.OT.2

PORTABILITY OF INSURANCE

A. Portability Of Insurance

If your insurance under the Group Policy ends because your employment with your Employer terminates, you may be eligible to buy portable group insurance coverage as shown in the **Coverage Features** for yourself without submitting Evidence Of Insurability. To be eligible you must satisfy the following requirements:

1. On the date your employment terminates, you must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience.

(If you are unable to meet this requirement, see the **Right To Convert** provision for other options that may be available to you under the Group Policy.)

2. On the date your employment terminates, you are under age 65.
3. On the date your employment terminates, you must have been continuously insured under the Group Policy for at least 12 consecutive months. In computing the 12 consecutive month period, we will include time insured under the Prior Plan.
4. You must apply in writing and pay the first premium directly to us at our Home Office within 31 days after the date your employment terminates. You must purchase portable group life insurance coverage for yourself in order to purchase any other insurance eligible for portability.

This portable group insurance will be provided under a master Group Life Portability Insurance Policy we have issued to the Standard Insurance Company Group Insurance Trust. If approved, the certificate you will receive will be governed under the terms of the Group Life Portability Insurance Policy and will contain provisions that differ from your Employer's coverage under the Group Policy.

B. Amount Of Portable Insurance

The minimum and maximum amounts that you are eligible to buy under the Group Life Portability Insurance Policy are shown in the **Coverage Features**. You may buy less than the maximum amounts in increments of \$1,000.

The combined amounts of insurance purchased under this **Portability Of Insurance** provision and the **Right To Convert** provision cannot exceed the amount in effect under the Group Policy on the day before your employment terminates.

C. When Portable Insurance Becomes Effective

Portable group insurance will become effective the day after your employment with your Employer terminates, if you apply within 31 days after the date your employment terminates.

If death occurs within 31 days after the date insurance ends under the Group Policy, life insurance benefits, if any, will be paid according to the terms of the Group Policy in effect on the date your employment terminates and not the terms of the Group Life Portability Insurance Policy.

LI.TP.OT.IX

ACCELERATED BENEFIT

A. Accelerated Benefit

If you give us satisfactory proof of having a Qualifying Medical Condition while you are insured under the Group Policy, you may have the right to receive during your lifetime a portion of your Insurance as an Accelerated Benefit. You must have at least \$10,000 of Insurance in effect to be eligible.

If your Insurance is scheduled to end within 24 months following the date you apply for the Accelerated Benefit, you will not be eligible for the Accelerated Benefit.

Qualifying Medical Condition means you are terminally ill as a result of an illness or physical condition which is reasonably expected to result in death within 12 months.

We may have you examined at our expense in connection with your claim for an Accelerated Benefit. Any such examination will be conducted by one or more Physicians of our choice.

B. Application For Accelerated Benefit

You must apply for an Accelerated Benefit. To apply you must give us satisfactory Proof Of Loss on our forms. Proof Of Loss must include a statement from a Physician that you have a Qualifying Medical Condition.

C. Amount Of Accelerated Benefit

You may receive an Accelerated Benefit of up to 75% of your Insurance. The maximum Accelerated Benefit is \$200,000. The minimum Accelerated Benefit is \$5,000 or 10% of your Insurance, whichever is greater.

If the amount of your Insurance is scheduled to reduce within 24 months following the date you apply for the Accelerated Benefit, your Accelerated Benefit will be based on the reduced amount.

The Accelerated Benefit will be paid to you once in your lifetime in a lump sum. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, we will not ask you for a refund.

D. Effect On Insurance And Other Benefits

For any purpose other than premium payment, the amount of your Insurance after payment of the Accelerated Benefit will be the greater of the amounts in (1) and (2) below; however, if you assign your rights under the Group Policy, the amount of your Insurance will be the amount in (2) below.

(1) 10% of the amount of your Insurance as if no Accelerated Benefit had been paid; or

(2) The amount of your Insurance as if no Accelerated Benefit had been paid; minus

The amount of the Accelerated Benefit; minus

An interest charge calculated as follows:

A times B times C divided by 365 = interest charge.

A = The amount of the Accelerated Benefit.

B = The monthly average of our variable policy loan interest rate.

C = The number of days from payment of the Accelerated Benefit to the earlier of (1) the date you die, and (2) the date you have a Right To Convert.

E. Exclusions

No Accelerated Benefit will be paid if:

1. All or part of your Insurance must be paid to your Child(ren), or your Spouse or former Spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
2. You are married and live in a community property state unless you give us a signed written consent from your Spouse.
3. You have made an assignment of all or part of your Insurance unless you give us a signed written consent from the assignee.
4. You have filed for bankruptcy, unless you give us written approval from the Bankruptcy Court for payment of the Accelerated Benefit.
5. You are required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement.
6. You have previously received an Accelerated Benefit under the Group Policy.

F. Definitions For Accelerated Benefit

Insurance means your Life Insurance Benefit under the Group Policy.

LI.AB.OT.IX

RIGHT TO CONVERT

A. Right To Convert

You may buy an individual policy of life insurance without Evidence Of Insurability if:

1. Your Insurance ends or is reduced due to a Qualifying Event; and
2. You apply in writing and pay us the first premium during the Conversion Period.

Except as limited under C. Limits On Right To Convert, the maximum amount you have a Right To Convert is the amount of your Insurance which ended.

B. Definitions For Right To Convert

1. Conversion Period means the 31-day period after the date of any Qualifying Event.
2. Insurance means all your insurance under the Group Policy.
3. Qualifying Event means termination or reduction of your Insurance for any reason except:
 - a. The Member's failure to make a required premium contribution.
 - b. Payment of an Accelerated Benefit.
4. You and your mean any person insured under the Group Policy.

C. Limits On Right To Convert

If your Insurance ends or is reduced because of termination or amendment of the Group Policy, 1 and 2 below will apply.

1. You may not convert Insurance which has been in effect for less than the Minimum Time Insured. See **Coverage Features**.
2. The maximum amount you have a Right To Convert is the lesser of:
 - a. The amount of your Insurance which ended, minus any other group life insurance for which you become eligible during the Conversion Period; and
 - b. The Maximum Conversion Amount. See **Coverage Features**.

D. The Individual Policy

You may select any form of individual life insurance policy we issue to persons of your age, except:

1. A term insurance policy;
2. A universal life policy;
3. A policy with disability, accidental death, or other additional benefits; or
4. A policy in an amount less than the minimum amount we issue for the form of life insurance you select.

The individual policy of life insurance will become effective on the day after the end of the Conversion Period. We will use our published rates for standard risks to determine the premium.

E. Death During The Conversion Period

If you die during the Conversion Period, we will pay a death benefit equal to the maximum amount you had a Right To Convert, whether or not you applied for an individual policy. The benefit will be paid according to the **Benefit Payment And Beneficiary Provisions**.

LI.RC.OT.1

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us.

B. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

We will require further Proof Of Loss at reasonable intervals, but not more often than once a year after you have been continuously Totally Disabled for two years.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the Member or Beneficiary lacks legal capacity.

C. Proof Of Loss

Proof Of Loss means written proof that a loss occurred:

1. For which the Group Policy provides benefits;

2. Which is not subject to any exclusions; and
3. Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be provided until we receive Proof Of Loss.

D. Investigation Of Claim

We may have you examined at our expense at reasonable intervals. Any such examination will be conducted by specialists of our choice.

We may have an autopsy performed at our expense, except where prohibited by law.

E. Time Of Payment

We will pay benefits within 60 days after Proof Of Loss is satisfied.

F. Notice Of Decision On Claim

We will evaluate a claim for benefits promptly after we receive it. With respect to all claims, within 90 days after we receive the claim we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 90 days.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension; (b) when we expect to decide the claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information we need to resolve those issues.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may decide the claim based on the information we have received.

If we deny any part of the claim, we will send the claimant a written notice of denial containing:

1. The reasons for our decision.
2. Reference to the parts of the Group Policy on which our decision is based.
3. A description of any additional information needed to support the claim.
4. Information concerning the claimant's right to a review of our decision.

G. Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial of any other claim.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. With respect to all claims, within 60 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 60 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension; (b) when we expect to decide the claim on review; and (c) any additional information we need to decide the claim.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

If we deny any part of the claim on review, the claimant will receive a written notice of denial containing:

1. The reasons for our decision.
2. Reference to the parts of the Group Policy on which our decision is based.
3. Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.

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ASSIGNMENT

You may make an absolute assignment of all your Life and AD&D Insurance, subject to 1 through 8 below.

1. All insurance under the Group Policy, including AD&D Insurance, is assignable. Dependents Life Insurance is not assignable.
2. You may not make a collateral assignment.
3. The assignment must be absolute and irrevocable. It must transfer all rights, including:
 - a. The right to change the Beneficiary;
 - b. The right to buy an individual life insurance policy on your life under **Right To Convert**; and
 - c. The right to receive accidental dismemberment benefits.
 - d. The right to apply for and receive an Accelerated Benefit.
4. The assignment will apply to all of your Life and AD&D Insurance in effect on the date of the assignment or becoming effective after that date.
5. The assignment may be to any person permitted by law.
6. The assignment will have no effect unless it is: made in writing, signed by you, and delivered to the Policyholder or Employer in your lifetime. Neither we, the Policyholder, nor the Employer are responsible for the validity, sufficiency or effect of the assignment.
7. All accidental dismemberment benefits will be paid to the assignee. All death benefits will be paid according to the beneficiary designation on file with the Policyholder or Employer, and the **Benefit Payment And Beneficiary Provisions**.
8. The assignment will not change the Beneficiary, unless the assignee later changes the Beneficiary. Any payment we make according to the beneficiary designation on file with the Policyholder or Employer, and the **Benefit Payment And Beneficiary Provisions** will fully discharge us to the extent of the payment.

You may not make an assignment which is contrary to the rules in 1 through 8 above.

(ALLOWED) LI.AS.OT.2

BENEFIT PAYMENT AND BENEFICIARY PROVISIONS

A. Payment Of Benefits

1. Except as provided in item 3 below, benefits payable because of your death will be paid to the Beneficiary you name. See B through E of this section.

2. Accelerated Benefits will be paid to you if you are living.
3. The Repatriation Benefit will be paid to the person who incurs the transportation expenses.

B. Naming A Beneficiary

Beneficiary means a person you name to receive death benefits. You may name one or more Beneficiaries.

If you name two or more Beneficiaries in a class:

1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

You may name or change Beneficiaries at any time without the consent of a Beneficiary.

You must name or change Beneficiaries in writing.

Your designation:

1. Must be dated and signed by you;
2. Must be delivered to the Policyholder or Employer during your lifetime;
3. Must relate to the insurance provided under the Group Policy; and
4. Will take effect on the date it is delivered to the Policyholder or Employer.

If we approve it, a designation, which meets the requirements of a Prior Plan will be accepted as your Beneficiary designation under the Group Policy.

C. Simultaneous Death Provision

If a Beneficiary or a person in one of the classes listed in item D. No Surviving Beneficiary dies on the same day you die, or within 15 days thereafter, benefits will be paid as if that Beneficiary or person had died before you, unless Proof Of Loss with respect to your death is delivered to us before the date of the Beneficiary's death.

D. No Surviving Beneficiary

If you do not name a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the following classes:

1. Your Spouse.
2. Your children.
3. Your parents.
4. Your brothers and sisters.
5. Your estate.

E. Methods Of Payment

Recipient means a person who is entitled to benefits under this **Benefit Payment and Beneficiary Provisions** section.

1. Lump Sum

If the amount payable to a Recipient is less than \$25,000, we will pay it in a lump sum.

2. Standard Secure Access Checking Account

If the amount payable to a Recipient is \$25,000, or more, we will deposit it into a Standard Secure Access checking account which:

- a. Bears interest;
- b. Is owned by the Recipient;
- c. Is subject to the terms and conditions of a confirmation certificate which will be given to the Recipient; and
- d. Is fully guaranteed by us.

3. Installments

Payment to a Recipient may be made in installments if:

- a. The amount payable is \$25,000 or more;
- b. The Recipient chooses; and
- c. We agree.

To the extent permitted by law, the amount payable to the Recipient will not be subject to any legal process or to the claims of any creditor or creditor's representative.

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ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
 - a. Eligibility for insurance;
 - b. Entitlement to benefits;
 - c. Amount of benefits payable;
 - d. Sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the Group Policy any decision we make in the exercise of our authority is conclusive and binding.

LI.AL.OT.1

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

LI.TL.OT.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain or to increase insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim unless:

1. The insurance would not have been approved if we had known the truth; and
2. We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

We will not use a misrepresentation to reduce or deny a claim after the insured's insurance has been in effect for two years during the lifetime of the insured.

B. Incontestability Of Group Policy

Any statement made by the Policyholder or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder or Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.

LI.IN.OT.2

CLERICAL ERROR, AGENCY, AND MISSTATEMENT

A. Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

1. Cause a person to become insured.
2. Invalidate insurance otherwise validly in force.
3. Continue insurance otherwise validly terminated.

B. Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent.

C. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of insurance based on the correct age; and
2. The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

LI.CE.OT.1

TERMINATION OR AMENDMENT OF THE GROUP POLICY

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium. The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving us written notice.

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. If the terms of the Certificate differ from the Group Policy, the terms stated in the Group Policy will govern. The Policyholder, your Employer, and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups thereof.

LI.TA.OT.1

DEFINITIONS

Annual Earnings means your annual rate of earnings from your Employer. Your Annual Earnings will be based on your earnings in effect on your last full day of Active Work unless a different date applies (see the **Coverage Features**). Annual Earnings includes:

1. Contributions you make through a salary reduction agreement with your Employer to:
 - a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), or 457 deferred compensation arrangement; or
 - b. An executive nonqualified deferred compensation arrangement.
2. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

Annual Earnings does not include:

1. Bonuses.
2. Commissions.
3. Overtime pay.
4. Shift differential pay.

5. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
6. Any other extra compensation.

Child means:

1. Your unmarried child from live birth through age 20 (through age 24 if a registered student in full time attendance at an accredited educational institution); or
2. Your unmarried child who meets either of the following requirements:
 - a. The child is insured under the Group Policy and, on and after the date on which insurance would otherwise end because of the Child's age, is continuously Disabled.
 - b. The child was insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy and was Disabled on that day, and is continuously Disabled thereafter.

Child includes any of the following, if they otherwise meet the definition of Child:

- i. Your adopted child; or
- ii. Your stepchild, if living in your home;

Your child is Disabled if your child is:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon you for support and maintenance, or institutionalized because of mental retardation or physical handicap.

You must give us proof your Child is Disabled on our forms within 31 days after a) the date on which insurance would otherwise end because of the Child's age or b) the effective date of your Employer's coverage under the Group Policy if your child is Disabled on that date. At reasonable intervals thereafter, we may require further proof, and have your Child examined at our expense.

Contributory means you pay all or part of the premium for insurance.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. See **Coverage Features**.

Evidence Of Insurability means an applicant must:

1. Complete and sign our medical history statement;
2. Sign our form authorizing us to obtain information about the applicant's health;
3. Undergo a physical examination, if required by us, which may include blood testing; and
4. Provide any additional information about the applicant's insurability that we may reasonably require.

Group Policy means the group life insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Injury means an injury to your body.

Life Insurance means life insurance under the Group Policy.

Noncontributory means the Policyholder or Employer pays the entire premium for insurance.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your spouse, or the brother, sister, parent or child of either you or your spouse.

Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan means your Employer's group life insurance plan in effect on the day before the effective date of your Employer's coverage under the Group Policy and which is replaced by the Group Policy.

Sickness means your sickness, illness, or disease.

Spouse means a person to whom you are legally married. However, for purposes of insurance under the Group Policy, Spouse does not include a person who is a full-time member of the armed forces of any country or a person from whom you are divorced or legally separated.

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POLICYHOLDER PROVISIONS

A. Premiums

The premium due on each Premium Due Date is the sum of the premiums for all persons then insured. Premium Rates are shown in the **Coverage Features**.

B. Contributions From Members

The Policyholder determines the amount, if any, of each Member's contribution toward the cost of insurance under the Group Policy.

C. Changes In Premium Rates

We may change Premium Rates when:

1. A change or clarification in law or governmental regulation affects the amount payable under the Group Policy. Any such change in Premium Rates will reflect only the change in our obligations; or
2. Factors material to underwriting the risk we assumed under the Group Policy, including, but not limited to, number of persons insured, age, Annual Earnings, gender and occupational classification, change by 25% or more; or
3. We and the Policyholder mutually agree to change Premium Rates.

Except as provided above, Premium Rates will not be changed during the Initial Rate Guarantee Period shown in the **Coverage Features**. Thereafter, except as provided above, we may change Premium Rates upon advance written notice to the Policyholder. The minimum advance notice is shown in the **Coverage Features** as Notice of Rate Change. Any such change in Premium Rates may be made effective on any Premium Due Date, but no such change will be made more than once in any contract year. Contract years are successive 12 month periods computed from the end of the Initial Rate Guarantee Period.

D. Payment Of Premiums

All premiums are due on the Premium Due Dates shown in the **Coverage Features**.

Each premium is payable on or before its Premium Due Date directly to us at our home office. The payment of each premium as it becomes due will maintain the Group Policy in force until the next Premium Due Date.

E. Grace Period And Termination For Nonpayment

If a premium is not paid on or before its Premium Due Date, it may be paid during the following Grace Period. The length of the Grace Period is shown in the **Coverage Features**. The Group Policy will remain in force during the Grace Period.

If the premium is not paid during the Grace Period, the Group Policy will terminate automatically at the end of the Grace Period.

The Policyholder is liable for premium for insurance under the Group Policy during the Grace Period. We may charge interest at the legal rate for any premium which is not paid during the Grace Period, beginning with the first day after the Grace Period.

F. Termination For Other Reasons

The Policyholder may terminate the Group Policy by giving us written notice. The effective date of termination will be the later of:

1. The date stated in the notice; and
2. The date we receive the notice.

We may terminate the Group Policy as follows:

1. On any Premium Due Date if the number of persons insured is less than the Minimum Participation Number or less than the Minimum Participation Percentage shown in the **Coverage Features**.
2. On any Premium Due Date if we determine that the Policyholder has failed to promptly furnish any necessary information requested by us, or has failed to perform any other obligations relating to the Group Policy.

The minimum advance notice of such termination by us is the same as the Notice of Rate Change stated in the **Coverage Features**.

G. Premium Adjustments

Premium adjustments involving a return of unearned premiums to the Policyholder will be limited to the 12 months just before the date we receive a request for premium adjustment.

H. Certificates

We will issue certificates to the Policyholder showing the coverage under the Group Policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the Certificate differ from the Group Policy, the terms stated in the Group Policy will govern.

I. Records And Reports

The Policyholder or Employer will furnish on our forms all information reasonably necessary to administer the Group Policy. We have the right at all reasonable times to inspect the payroll and other records of the Policyholder or Employer which relate to insurance under the Group Policy.

J. Agency And Release

Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of Standard Insurance Company. The Policyholder, Employer and such individuals have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy. The Policyholder and each Employer hereby release, hold harmless and indemnify Standard Insurance Company from any liability arising from or related to any negligence, error, omission, misrepresentation or dishonesty of any of them or their representatives, agency or employees.

K. Notice Of Suit And Indemnification

The Policyholder or Employer shall promptly give us written notice of any lawsuit or other legal proceedings arising under the Group Policy.

L. Entire Contract, Changes

The Group Policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the Group Policy when issued.

The Group Policy may be changed in whole or in part. No change in the Group Policy will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. No agent has authority to change the Group Policy or to waive any of its provisions.

M. Effect On Workers' Compensation, State Disability Insurance

The coverage provided under the Group Policy is not a substitute for coverage under a workers' compensation or state disability income benefit law and does not relieve the Employer of any obligation to provide such coverage.

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