

PROGRAM PROVISIONS FOR:

PRIME CARE ADVANTAGE

PRIME CARE CHOICE

OUT-OF-AREA PLAN

PRIME CARE CONNECT

PRESCRIPTION DRUG PROGRAM

HEALTH REIMBURSEMENT ACCOUNT

Faculty and Staff Health Plans Specific Plan Details Document

2019 Plan Year (January 1-December 31, 2019)



THE OHIO STATE UNIVERSITY
HUMAN RESOURCES



CONTACT INFORMATION

THE OHIO STATE UNIVERSITY

Office of Human Resources

Customer Service Center | 614-292-1050

1590 North High Street, Suite 300

Columbus, OH 43201-2190

800-678-6010

Fax: 614-292-6235

E-mail: hr@osu.edu

hr.osu.edu

Provides information regarding:

- Certification of state service requests
- Flexible Spending Accounts – Dependent Care and Health Care
- Health Insurance
 - Enrollment
 - Verification of coverage
- Life Insurance
 - Change of beneficiary
 - Enrollment
- Retirement Programs
 - ARP, OPERS, STRS
- Supplemental Retirement Accounts– 403(b) and 457(b) plans
- Tuition Assistance
 - For dependents
 - For faculty and staff
- Your Plan for Health, yp4h.osu.edu

Employee and Labor Relations

614-292-2800

Provides information regarding:

- Family/medical leave, sick leave, vacation leave, medical leave, personal leave, military leave, paid parental leave, organ donation leave, jury duty/court

Integrated Absence Management and Vocational Service

614-292-3439

800-678-6413

Fax: 614-688-8120

E-mail: id@hr.osu.edu

Available to provide consultation on:

- Department presentations
- Long-term and short-term disability
- OPERS/STRS disability retirement
- Unemployment compensation, 614-688-3578
- Transitional work
- Workers' compensation

YOUR PLAN FOR HEALTH

614-292-4700 or 800-678-6269

E-mail: yp4h@osu.edu or visit yp4h.osu.edu

- Biometric Health Screenings
- Educational Programming
- Personal Health & Well-Being Assessment (PHA)
- Incentive Programs
- Personal Health Coaching Program
- Care Coordination Program
- Ohio State 24/7 NurseLine

Ohio State Employee Assistance Program (EAP) 800-678-6265

• 24/7/365 live connection osuhealthplan.com/OhioStateEAP
Serves faculty, staff and their families

Other Important Contacts

Care Works of Ohio, Inc. 888-627-0058

- Workers' compensation claims assistance

CoreSource, Inc. 800-678-6269

- View medical claims mycoresource.com
- Print medical/prescription drug cards
- COBRA administration

Delta Dental Plan of Ohio 800-524-0149

- Customer and Claims Services
- View claims, find dentist, print ID cards toolkitonline.com

Express Scripts 866-727-5867

- Prescription drugs—retail/home delivery/claims . . express-scripts.com

Ohio State Travel Assistance

U.S. 866-807-6193

International 01-770-667-0247

Medical care coordination outside Ohio

Ohio State University Health Plan, Inc. 614-292-4700

. 800-678-6269

osuhealthplans@osumc.edu

- Prior authorization of required services and admissions, provider network and other medical services
- General benefit information and questions . . . osuhealthplan.com

TASC (Flexible Spending Account and HRA Administrator)

Customer Service 855-FLEX-OSU(353-9678)

Unum 866-245-3013

- Disability claims assistance

Vision Service Plan (VSP) 800-877-7195

- Vision providers and claims assistance vsp.com

TABLE OF CONTENTS

Introduction	3
Covered Person's Rights	4
Covered Person's Responsibilities	4
Discrimination is Against the Law	5
General Plan Provisions	7
Termination of Coverage	15
Covered Services	16
Exclusions or Limitations	23
The Ohio State University Health Plan, Inc	25
How Payment Is Determined	26
Medical Claims Processing	28
Hospitalization Review	32

Coverage Continuation	33
Prescription Drug Program	35
Medical Plans	
Prime Care Advantage	41
Prime Care Choice	46
Prime Care Connect	55
Out-of-Area Plan	60
Health Reimbursement Account	65
Definitions	68
Ohio State Travel Assistance	74
Appendix – Claim Determination and Appeal Procedures	75

INTRODUCTION

This Faculty and Staff Health Plans Specific Plan Details Document describes and establishes the important provisions of the medical and prescription drug benefits provided to faculty and staff and their eligible dependents by The Ohio State University and its designated affiliates.

ABOUT THIS DOCUMENT

- You are strongly urged to read this booklet in its entirety. This booklet dictates how medical claims are processed or considered as covered services under the OSU plans.
- This booklet is broken down into a number of related sections and is best used by familiarizing yourself with the following:
 - **The inside front cover** – contact information for the services discussed in this booklet, as well as other employee benefit programs maintained by Ohio State.
 - **The table of contents** – the easiest way to navigate this booklet.
 - **The definitions section** – contains a list of several important terms used throughout this booklet
- This booklet also describes your rights and responsibilities as a covered person through enrollment in a university-sponsored medical plan. It is very important that you have a good understanding of the covered services available to you and of the items that are excluded or limited by your medical plan.

Note: This Faculty and Staff Health Plans Specific Plan Details Document is also available online at hr.osu.edu/benefits/medical, where it may be updated periodically as needed. If the information provided in the printed version of this document differs from the online version, the online version will govern.

ALTERATION OF BOOKLET

Only the university has the authority to change the coverage and/or terms under the medical plans.

TERMS USED IN THIS BOOKLET

The following terms are used interchangeably throughout this booklet:

- The Ohio State University Faculty and Staff Health Plans Specific Plan Details Document also called Faculty and Staff Health Plans Specific Plan Details Document, the booklet, or document.
- The Ohio State University Faculty and Staff Health Plans also called the medical plans, Ohio State plans, university-sponsored medical plans and university medical plans.
- Faculty and staff also called you, employee or member.
- The Ohio State University also called Ohio State, the university, the employer and the plan sponsor.
- Office of Human Resources also called OHR.
- The Internal Revenue Code of 1986, as amended, also called the Code.
- Other important terms are defined in the “Definitions” section.

COORDINATION OF BENEFITS (COB)

If you or your family members are covered by more than one medical plan, you may not be able to collect benefits from both plans. Each plan may require the covered person to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read the rules very carefully, including the “Coordination of Benefits” section of this Faculty and Staff Health Plans Specific Plan Details Document, and compare these rules with the rules of any other plan that covers you or your family. Pharmacy benefits are not coordinated.

OPERATION AND ADMINISTRATION OF THE OHIO STATE PLANS

- The Ohio State University is the Plan Sponsor.
- The benefits provided under the Ohio State plans are paid for directly by Ohio State, which means that the Ohio State plans are considered to be self-funded. Covered employees pay all or part of the cost of providing benefits under the Ohio State plans through payroll deductions (i.e., employee contributions) and, if applicable, the employing departments provide the balance.
- CoreSource is the university’s third party administrator and COBRA administrator. Express Scripts is the university’s pharmacy benefit manager. See page 2 for contact information.
- The Senior Vice President for Talent, Culture and Human Resources (or any successor) or his or her delegates may change, suspend, withdraw, amend, modify or terminate the Ohio State plans, including this Faculty and Staff Health Plans Specific Plan Details Document, or any of its provisions at any time and for any reason in their sole discretion.
- The Plan Administrator (defined in the “Definitions” section) has the discretionary authority to interpret the Ohio State plans in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Ohio State plans. Benefits under the Ohio State plans shall be paid only if the Plan Administrator decides in its discretion that a covered person is entitled to them. If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, a reference in this Faculty and Staff Health Plans Specific Plan Details Document to the Plan Administrator shall be deemed to include a reference to such delegate.

CONTINUED ON PAGE 4

INTRODUCTION

FOR MORE INFORMATION (SEE PAGE 2 FOR CONTACT INFORMATION)

If you have questions when using your medical benefits, refer to the following for assistance:

- Office of Human Resources (OHR) Customer Service Center, hr@osu.edu – General benefits information, enrollment, eligibility, Publications, Ohio State Travel Assistance
- OHR website, hr.osu.edu – Links to provider network listings for dental, medical, pharmacy and vision plans
- OSU Health Plan, osuhealthplan.com – Assistance with prior authorization of hospital admissions and medical services, provider listings, general benefits information, case management and scheduling of YP4H programming and services
- Third Party Administrator – CoreSource, mycoresource.com – Medical claims processing, ID cards for medical plans and prescription drug program and COBRA administration
- Pharmacy Benefit Manager – Express Scripts, express-scripts.com – Prescription drug claims processing, prior authorization for certain medications.

COVERED PERSON'S RIGHTS

The university is committed to offering quality medical care for its employees and their eligible dependents. As a person covered by one of The Ohio State University's medical plans, you have certain rights that help ensure you and your family members receive quality medical care.

AS A COVERED PERSON UNDER OF AN OHIO STATE MEDICAL PLAN, YOU HAVE THE RIGHT TO THE FOLLOWING:

- Receive and have access to information about the functions of OSU Health Plan, participating medical care providers, rules and regulations of your medical plan and your rights and responsibilities.
- Fair and respectful consideration and treatment by staff at OSU Health Plan, OHR, CoreSource, Express Scripts, medical care providers and customer service.
- Confidentiality and privacy regarding your medical care matters.
- Receive an explanation of all benefits to which you are entitled under your medical plan.
- Receive quality medical care through your medical plan network in a timely manner and in the most appropriate setting possible.
- Participate with your providers in decision-making about your medical care needs and how best to meet those needs within the requirements of your medical plan.
- Have access to complete and understandable information about your health conditions and the treatments rendered by your medical care providers.
- Refuse treatment and be informed by your medical care provider or OSU Health Plan of the consequences of such action.
- Be informed of health and wellness, maintenance and preventive programs to help promote and maintain a healthy lifestyle.
- Express concerns and complaints about provider services and administration.
- File a formal appeal, as outlined in the Medical Claims Processing – Appeal Procedure and Prescription Drug – Appeal Procedure sections of this booklet.

COVERED PERSON'S RESPONSIBILITIES

For the Ohio State medical plans to work effectively there are certain procedures which you, as a covered person, must follow. As a person covered by an Ohio State medical plan, you have certain responsibilities that will help ensure that you and your family members receive quality care. You are expected to be an active participant in your medical care.

AS A COVERED PERSON UNDER AN OHIO STATE MEDICAL PLAN, YOU HAVE THE RESPONSIBILITY TO:

- Choose a primary care provider who is available to accept new patients and to coordinate medical services if advised by your plan.
- Learn about your coverage options, limitations and exclusions by reviewing the resources available to you.
- Know the rules regarding use of network providers, coverage and prior authorization according to your medical plan.
- Know how to get information from customer service and/or the Plan Administrator available at osuhealthplan.com.
- Report to OSU Health Plan suspected wrong doing related to medical service and fraud.
- Be a responsible consumer of available health care resources.
- Provide complete, honest and factual information about your medical care status that is needed by providers in order to address your medical care needs.
- Follow a consensual treatment plan as discussed with and recommended by your medical care providers.
- Listen to and understand the potential consequences that may result should you refuse such treatment.
- Understand your medical and prescription drug benefits, as described in this booklet.
- Understand and meet your financial obligations for copays, annual deductibles, coinsurance and non-covered health-related services, as indicated in this booklet.
- Provide, when requested, complete and factual information to CoreSource and Express Scripts about any other medical coverage or insurance benefits that you may have.
- Provide, when requested, complete and factual information related to dependency verification.
- Treat other covered persons, providers and administrative staff with respect and consideration.

CONTINUED ON PAGE 5

COVERED PERSON'S RESPONSIBILITIES

UPDATING YOUR INFORMATION:

- Inform your departmental human resource contact of any address or name changes or make the change online at eprofile.osu.edu
- Inform the OHR Customer Service Center of any changes you may have in your family status (for example, marriage, divorce, birth or adoption of a child, dependent child reaching the limiting age, death of a spouse or dependent child) by using eBenefits online at eprofile.osu.edu or by submitting a completed Health Election Form, available at hr.osu.edu/policies-forms, to OHR **within 31 days** of the status change.

WHEN RECEIVING COVERED MEDICAL OR PRESCRIPTION DRUG SERVICES:

- Present your medical/prescription drug ID card before receiving medical or prescription drug services.
- At the time of service you should pay any copay amounts that may apply.
- Notify OSU Health Plan if you are admitted to a hospital, generally within one business day.
- Claims should be filed as instructed on your medical/prescription drug ID card.
- At the time of your provider visit, you should discuss the medical and financial advantages of generic drugs with your provider.

DISCRIMINATION IS AGAINST THE LAW

The Ohio State University complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Ohio State University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Ohio State University:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact The Ohio State University's affirmative action and EEO coordinator.

If you believe that The Ohio State University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Affirmative Action and EEO Coordinator
1590 N. High St., Suite 300
Columbus, OH 43201-2190
Phone: 614-292-2800
Fax: 614-292-6199
Email: aa-eeo@osu.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the affirmative action and EEO coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HMI Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Continued on the following page.

CONTINUED ON PAGE 6

DISCRIMINATION IS AGAINST THE LAW

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-264-1552, Access Code# 80014189.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-264-1552, Código de acceso # 80014189.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-264-1552，访问代码 # 80014189

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-264-1552, Zugangscode # 80014189.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 008 462 2551 رمز الدخول 98141008

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-264-1552, Toegangscodes # 80014189.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-264-1552, Код доступа # 80014189.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-264-1552, Code d'accès # 80014189.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-264-1552, mã số truy cập # 80014189.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-264-1552, Access Code# 80014189.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-264-1552, 액세스 코드 # 80014189, 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-264-1552, Codice d'accesso # 80014189.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-264-1552，访问代码 # 80014189，まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-264-1552, Toegangscodes # 80014189.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-264-1552, Код доступу# 80014189.

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-264-1552, Cod de acces # 80014189.

GENERAL PLAN PROVISIONS

The following terms and conditions apply to all university medical plans.

ELIGIBILITY

- **Employee holds a Qualifying Appointment.** An eligible employee is any faculty or staff member who holds a qualifying appointment, as determined by The Ohio State University. Details are available at hr.osu.edu/benefits/eligibility.
- **Employee does not hold a Qualifying Appointment.** In addition, an eligible employee is any employee who does not hold a qualifying appointment but is a “full-time employee.” In general, a full-time employee is an individual who is employed, on average, for at least 30 hours of service per week. The university uses a look-back measurement method to determine who is a full-time employee for purposes of coverage under the medical plans. The look-back measurement method is based on Internal Revenue Service regulations under the Patient Protection and Affordable Care Act (PPACA). The look-back measurement method applies to all university employees.

The look-back measurement method involves three different periods:

- A measurement period for counting an employee’s hours of service. If you are an ongoing employee, this measurement period (which is also called the “standard measurement period”) ran from October 5, 2017 through October 4, 2018 and determined your medical plan eligibility for the 2019 plan year. If you are a new employee who is a variable hour employee, this measurement period will follow your employment with the university and will last for 11 months.
- A stability period is a period that follows a measurement period. An employee’s hours of service during the measurement period will determine whether the employee is a full-time employee who is eligible for coverage during the stability period. As a general rule, the employee’s status as a full-time employee or not a full-time employee is “locked in” for the stability period, regardless of how many hours the employee works during the stability period, while the employee remains employed. The stability period will last for 12 months.
- An administrative period is a short period between the measurement period and the stability period when the university performs administrative tasks, such as determining eligibility for coverage.

Note that special rules apply when employees are rehired by the university or return from an unpaid leave of absence. The rules for the look-back measurement method are very complex. This is just a general overview of how the rules work. More complex rules may apply to an employee’s situation. The university intends to follow Internal Revenue Service regulations and any future guidance issued by the Internal Revenue Service when administering the look-back measurement method.

- If you are an eligible employee, you may cover yourself and those persons who qualify as your eligible dependents. Dependents can only be enrolled if you are enrolled in coverage. You may not be covered as both a spouse and dependent by any medical coverage provided by the university.
- Coverage is not automatic. To cover yourself and your eligible dependents, you must enroll. To enroll in a medical plan, use eBenefits online at eprofile.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms. The university-sponsored medical plans will not cover a person as both a covered employee and dependent or as a dependent of more than one covered employee.
- **The university has the ability to rescind (i.e., retroactively terminate) coverage if such coverage was gained due to an individual (or person seeking coverage on behalf of the individual) performing an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact.**

ENROLLMENT

To enroll in a medical plan, use eBenefits online at eprofile.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms. You must enroll in the desired medical plan:

- Within 31 days of appointment in an eligible position as reflected in the university’s human resource system (PeopleSoft).
- Within 31 days of loss of other eligible coverage.
- During the annual open enrollment period.
- In connection with a qualifying status change as described in “Change in Coverage Due to Qualifying Status Change” below.
- In connection with an event that provides special enrollment rights as described in “Special Enrollment Rights” below.
- In limited circumstances, you may be eligible to enroll in the medical plan on an after-tax basis as described in “Coverage Elections Outside an Enrollment Period” below.

SPECIAL ENROLLMENT RIGHTS

Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

- CHIPRA provides you and your dependents with special enrollment rights for medical plan coverage without having to wait for an open enrollment period if either of the following occurs:
 - You or your dependents are terminated from Medicaid or state Children’s Health Insurance Program (CHIP) coverage as a result of a loss of eligibility. If so, you must request this special enrollment within 60 days of the loss of coverage.
 - You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP. If so, you must request this special enrollment within 60 days of when eligibility is determined.
- To enroll in a university medical plan, you and your dependents must be benefits-eligible and you must use eBenefits online at eprofile.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms. Documentation of the above event is required.

CONTINUED ON PAGE 8

GENERAL PLAN PROVISIONS

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- HIPAA provides you and your eligible dependents with special enrollment rights for medical plan coverage without having to wait for an open enrollment period if either of the following occurs:
 - You acquire an eligible dependent after your employment begins as a result of marriage, birth, adoption, or placement for adoption.
 - You (or your eligible dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage under a university medical plan and you (or your eligible dependent) lose that other coverage because of loss of eligibility (other than for failure to pay premiums or termination for cause), termination of employer contributions or exhaustion of COBRA continuation coverage.
- If either of these events occurs, you must request this special enrollment within 31 days of the date of the event.
- To enroll in a university medical plan, you and your dependents must be benefits-eligible and you must use eBenefits online at eprofile.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms. Documentation of the above event is required.

EFFECTIVE DATE OF COVERAGE

The effective date for all eligible employees and their eligible dependents will be determined by the university. Coverage will be communicated to CoreSource and Express Scripts for the purposes of claims administration. Coverage will be effective on:

- Date of hire or transfer to an eligible appointment as reflected in the university's human resource system (PeopleSoft).
- Date of a qualifying status change
- January 1 of a new plan year, if the election is made during and as part of the annual open enrollment period
- First day of the employee's "stability period" as determined by the university. See "Eligibility" below.

ELIGIBLE DEPENDENTS

Spouse

An individual whose marriage to a covered employee is recognized by the Internal Revenue Service for federal income tax purposes.

Dependent child

Child of a covered employee who meets all of the following eligibility criteria:

1. Has not reached the age limit of 26 (e.g., 26th birthday); except in cases described more fully below, and
2. Fits into one of the following categories:
 - The employee's biological child;
 - The employee's adopted child or child placed with the employee for adoption;
 - The employee's step-child; or
 - The child for whom the employee has legal guardianship, or legal custody, and such child is the employee's tax dependent.

Dependent child coverage beyond the age limit due to disability

A dependent child may be eligible for continued coverage as a dependent child after attaining age 26 if:

- The child is and continues to be incapable of self-sustaining employment by reason of physical handicap or intellectual disability; and
- The child is the employee's dependent as defined in Section 105(b) of the Code; and
- The child was (1) covered by a university medical plan when he or she reached the limiting age and the employee makes application for continuation of coverage to the university within 31 days after the child's loss of coverage due to reaching the limiting age; or (2) covered as a dependent under the medical plan of his or her parent's employer immediately prior to a loss of coverage under such plan (documentation of prior coverage required) and the employee makes application for continuation of coverage to the university within 31 days after such loss of coverage occurs. In each case, the employee must provide satisfactory proof of the child's incapacity and dependence upon the employee; and
- The employee provides proof of the continuance of such incapacity and dependence upon request by the university.

Consult with a tax advisor with any questions regarding whether or not the child meets the Code requirements.

GENERAL PLAN PROVISIONS

The following terms and conditions apply to all university medical plans.

Grandfathered Sponsored Dependent (Affidavit of Sponsored Dependency required)

The grandfathered sponsored dependent of a covered employee who meets all of the following criteria:

1. The individual was enrolled in The Ohio State University Faculty and Staff Health Plans as a sponsored dependent as of December 31, 2016;
2. The individual remains continuously enrolled in The Ohio State University Faculty and Staff Health Plans on and after December 31, 2016;
3. The individual meets all of the following criteria:
 - a. The individual resides at the same principal place of abode as the employee and is a member of the employee's household for the entire tax year during which grandfathered sponsored dependent coverage is provided;
 - b. The individual shares a relationship with the employee as defined by one of the following:
 - Parent, step-parent, parent-in-law, or person who stood in loco parentis to the employee as a child
 - Grandparent or grandparent of the employee's spouse
 - Sibling or sibling-in-law
 - Aunt or uncle
 - Niece or nephew
 - Son or daughter-in-law
 - Grandchild or spouse of the employee's grandchild
 - Biological, adopted, step or foster child who is not otherwise eligible for coverage under the terms of the university medical plans
 - Opposite-sex domestic partner who is unmarried, is not related to the employee by blood to a degree of closeness which would prohibit marriage in the state in which they legally reside and who has been in a relationship with the employee for at least six (6) months and intends to remain so indefinitely
 - Dependent child of an opposite-sex domestic partner (described above);
 - c. The individual is dependent upon the employee for more than 50% of his or her support. The employee must be able to provide documentation of such support to OHR or to CoreSource for claims administration, if requested, to verify the dependent status of this individual.

Support includes:

 - i. Housing/shelter;
 - ii. Cost for his or her clothing, food, education, recreation and transportation expenses;
 - iii. Cost for his or her medical, dental and/or vision care; and
 - iv. Cost for a proportionate share of other expenses necessary to support the grandfathered sponsored dependent within the employee's household (such as food and utilities), but which cannot be directly attributed to that individual;
 - d. The individual is enrolled in Medicare if he or she is eligible for such coverage. The university's medical plan will be a secondary payer to Medicare, unless the individual is a family member (not a spouse) who is entitled to Medicare on account of disability; and
 - e. The individual is the employee's dependent under Section 152 of the Code, without regard to subsection (d) (1) (B) of Section 152.

Consult with a tax advisor with any questions regarding whether or not the individual meets the Internal Revenue Service qualifications.

Regardless of any other provision in this booklet to the contrary, a grandfathered sponsored dependent must remain enrolled in the medical plan for the entire plan year, unless the grandfathered sponsored dependent dies or the grandfathered sponsored dependent provides proof of obtaining other medical coverage.

BENEFIT PLAN YEAR

- January 1 to December 31

CHANGE IN COVERAGE DUE TO A QUALIFYING STATUS CHANGE

- You may enroll, make changes or disenroll in coverage during the plan year only if you experience a qualifying status change. The change in coverage must be consistent with and on account of the qualifying status change (e.g., you cover your spouse following your marriage). If you wish to change your elections due to a qualifying status change, the Office of Human Resources must receive such change within 31 days of the qualifying status change.

CONTINUED ON PAGE 10

GENERAL PLAN PROVISIONS

The following terms and conditions apply to all university medical plans.

Qualifying Status Change

- Qualifying status changes include:
 - Change in your legal marital status (marriage, death of a spouse (as defined in the Code), divorce, legal separation or annulment);
 - Termination of a grandfathered sponsored dependency;
 - Change in the number of your dependents (birth, death, adoption or placement for adoption);
 - Change in your employment status or the employment status of your spouse or dependent (termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence or change in work site) that results in the individual becoming eligible, or ceasing to be eligible, under any cafeteria plan or other employee welfare benefit plan of your employer or the employer of your spouse or dependent;
 - Event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstances;
 - Change in your place of residence or change in the place of residence of your spouse or dependent impacting eligibility;
 - Termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must submit an election change within 60 days);
 - You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP (you must submit an election change within 60 days); or
 - Entitlement to Medicare or Medicaid.
- In addition, you might be able to make a change under the following circumstances:
 - Judgment, decree or order requiring coverage of certain dependents (31-day time limit does not apply);
 - Certain leaves of absence;
 - Significant changes in cost of coverage, including a significant change in medical contributions due to a change in full-time equivalency;
 - Significant curtailment of coverage;
 - If you have a change in employment status during a stability period that is expected to reduce your average hours to less than 30 hours per week, you may drop health plan coverage, provided that you expect to enroll in other health coverage (for example, through a spouse or the purchase of health insurance);
 - Certain changes in or loss of coverage under another plan;
 - Certain additions or improvements to benefit package options; or
 - You enroll in health insurance purchased through the public Marketplace effective other than January 1 in connection with a Marketplace special enrollment event.

Note: Qualifying status change determinations are made by the university in accordance with the university's Flexible Benefits Plan and Internal Revenue Service rules. Documentation of the status change may be required. Refer to the Life Events section of the OHR website at hr.osu.edu/life-events to determine the type(s) of benefit election changes you may make as a result of specific qualifying status changes.

When a qualifying status change occurs:

- To make enrollment changes in medical coverage, use eBenefits online at eprofile.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms. Documentation may be required for some events.
 - The completed form must be submitted to the OHR Customer Service Center within 31 days of the qualifying status change unless otherwise noted above.
 - Changes in coverage and contributions will be effective as of the date of the qualifying status change.
 - If you do not submit enrollment changes to the university within 31 days (except as otherwise noted above), a change can only be made during the next open enrollment period or upon the occurrence of a future qualifying status change. The university determines the open enrollment period, which typically occurs two months prior to the end of the plan year.

Note: A newborn infant must be added within 31 days of the birth. Otherwise the newborn cannot be added until the next open enrollment period. If coverage is already in effect, you must add the newborn, even if you have family coverage.

The university must approve all qualifying status changes. The university determines the effective date for all enrollment changes and any contribution changes that may be required as a result of the qualifying status change.

Note: Your coverage level and premium contributions may be adjusted based on the qualifying status change.

Coverage elections for rehires

- If your employment with the university terminates and you are rehired into a benefits-eligible position within 30 days after that termination, you and your eligible dependents will be reinstated with the same elections that you had immediately before your termination and accumulations for plan features such as annual deductibles and out-of-pocket limits, as well as expenses you had accumulated towards the Ohio State plan's lifetime maximums, will continue to apply as if there was no loss of coverage. See the Health Reimbursement Account (HRA) section of this book for details related to your HRA.
- If your employment with the university terminates and you are rehired into a benefits-eligible position more than 30 days after that termination, you will be able to make new elections as to your coverage levels and coverage options under the Ohio State plan. If you re-enroll within the same plan year, plan features such as annual deductibles and out-of-pocket limits, as well as expenses you had accumulated towards the Ohio State plan's lifetime maximums, will continue to apply as if there was no loss of coverage. See the Health Reimbursement Account (HRA) section of this book for details related to your HRA.

CONTINUED ON PAGE 11

GENERAL PLAN PROVISIONS

COVERAGE ELECTIONS OUTSIDE AN ENROLLMENT PERIOD

Introduction

If you are in an eligible university faculty or staff appointment and an enrollment period, as described in “Enrollment” above (e.g., newly eligible, qualifying status change, annual open enrollment), is missed or if coverage under the medical plan is terminated by the university because an otherwise eligible covered employee did not take a required action to maintain eligibility (e.g., fully respond to Dependent Eligibility Verification (DEV), apply timely for continued coverage for a disabled child who has reached the limiting age), the covered employee may elect to participate in the medical plans described in this booklet on an after-tax basis by submitting a paper *After-Tax Medical Plan Election Form*, which is available by calling 614-292-1050. After-tax medical coverage elections and changes to those elections cannot be completed through eBenefits. COTC, OSUP, Graduate Associates and Post-Doctoral Fellows are not eligible for this coverage.

- Eligible employees, as described above, and any eligible dependents of covered employees, as described in the “Eligible Dependents” section of this booklet, may enroll in after-tax medical coverage. However, the following exceptions shall apply to disabled children who have reached the limiting age and dependents whose coverage has been terminated because the required documentation was not submitted for DEV:
 - **Disabled children who have reached the limiting age.** An *After-Tax Medical Plan Election Form* and an *Application for Continued Health Plan Eligibility for Over Age Dependents* available by calling 614-292-1050 must be submitted to OSU Health Plan for approval. OSU Health Plan will determine if the child was continuously disabled from the date that previous employer medical coverage ended through the date that after-tax medical coverage has been requested. OSU Health Plan will notify OHR of the approval or denial. If denied, OSU Health Plan will notify the employee of the denial in writing. If approved, OSU Health Plan will notify the employee of the approval and effective date in writing.
 - **DEV.** For dependents whose coverage has been terminated because the required documentation was not submitted for DEV, an *After-Tax Medical Plan Election* form must be submitted to OHR. In addition, all required documents must be submitted so dependent eligibility can be confirmed. Coverage will be effective on the date that the required documentation for DEV and the *After-Tax Medical Plan Election Form* have been received.
- If an employee has existing coverage under the medical plans and then applies for after-tax medical coverage for a dependent(s), the medical plan elected for after-tax medical coverage must be the same plan in which the employee is already enrolled.
- If an employee enrolls in after-tax medical coverage, the employee cannot terminate that coverage for the remainder of the plan year, provided that the employee and, if applicable, his or her dependents remain eligible to participate in the university’s medical plans. Exceptions to this requirement: (1) coverage for an eligible dependent may be terminated if the dependent dies; or (2) the termination meets the criteria described in the “After-Tax Medical Enrollment Changes During the Plan Year” section below.

After-Tax Medical Enrollment Changes During the Plan Year

- If, after enrolling in after-tax medical coverage, a covered employee or his or her dependent experiences a subsequent special enrollment event, as described in the “SPECIAL ENROLLMENT RIGHTS” section on page 7, the employee will have the right to enroll in pre-tax medical coverage and, if desired, be allowed to elect a different medical plan on a pre-tax basis. Any such enrollment changes must meet the requirements of a special enrollment event, including any deadlines to request special enrollment, and require a completed *After-Tax Medical Plan Election Form*, which is available by calling 614-292-1050. After-tax medical coverage cannot be dropped or changed through eBenefits.
- Regardless of any other provision in this booklet to the contrary, no other enrollment changes to after-tax medical coverage will be permitted during the plan year.

Effective Date of Coverage

- Coverage will be effective on the date that the *After-Tax Medical Plan Election Form* and all required documents are received by OHR or OSU Health Plan.
- However, there is an exception in limited circumstances if the late enrollment request is to add (1) a newborn child, (2) a newly adopted child, (3) a child placed for adoption or (4) a child for whom the employee has legal guardianship or legal custody and such child is the employee’s tax dependent. In that case, if the *After-Tax Medical Plan Election Form* is received by OHR within 90 days of the event (i.e., birth, adoption or placement), the after-tax medical coverage will be effective as of the date of such event. After-tax premium contributions will be deducted for the retroactive coverage and will be calculated beginning with the pay period in which coverage begins.

Contributions

- After-tax premium contributions will be charged beginning with the pay period in which coverage is effective.
- If the employee has existing pre-tax medical coverage, that premium will continue to be deducted on a pre-tax basis in addition to the after-tax premium contributions.
- The current contribution rates are available by calling 614-292-1050.

CONTINUED ON PAGE 12

GENERAL PLAN PROVISIONS

Annual Termination of After-Tax Coverage

- Except in the case of disabled children who have reached the limiting age, after-tax medical coverage will terminate at the end of the plan year. If an eligible employee desires to maintain medical coverage for himself or herself and/or his or her eligible dependents, the employee must enroll in pre-tax medical coverage for the next plan year during the annual open enrollment period.
- Disabled children who have reached the limiting age and who are enrolled in after-tax medical coverage will remain enrolled in the after-tax medical coverage unless such coverage is waived by the covered employee for the next plan year during the annual open enrollment period. Those children are not eligible to enroll in pre-tax medical coverage during the annual open enrollment period.

CONTINUED ON PAGE 13

GENERAL PLAN PROVISIONS

The following terms and conditions apply to all university medical plans.

MEDICAL/PRESCRIPTION DRUG ID CARD

You will receive a medical/prescription drug ID card shortly after your effective date of coverage. Check your card(s) to make sure that the information is correct. If the information is incorrect, contact the OHR Customer Service Center by calling 614-292-1050. If your card is lost, stolen, or you need additional cards, contact CoreSource to issue new card(s). Contact information for CoreSource is available on page 2 of this booklet.

MEDICAL CARE OUTSIDE OHIO OR INTERNATIONALLY

- If you are enrolled in one of the university's medical plans, you are covered for emergency care, outside Ohio and internationally. To determine your coverage level, carefully read the Schedule of Benefits available for your medical plan or contact OSU Health Plan for assistance.
- When paying for international medical services, request that the doctor or hospital complete a description of services provided translated into English. This is required for your medical insurance reimbursement when you return home. Refer to the Ohio State Travel Assistance section of this booklet for details.

CASE MANAGEMENT

- In order to provide a comprehensive approach to the management of specialized medical care, OSU Health Plan provides and when necessary requires, case management services. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates resources to promote quality cost-effective outcomes. To accomplish this, input is obtained from providers, patients, family members (with patient's authorization), medical consultants and other sources. Patients are informed of approved settings for medical treatment options.
- On an exception basis, subject to OSU Health Plan's case management process, medical benefits may be provided for settings and/or procedures not expressly provided for, but not prohibited by law, rule, or general policy. All requests for case management will be individually reviewed by OSU Health Plan.
- OSU Health Plan has the right to deny consideration of benefits under case management if the use of such services is not clinically or medically necessary. This is inclusive of all services, those normally reviewed by case management, special requests for case management and any appeals to OSU Health Plan.

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

Federal HIPAA regulations restrict how the university and the Ohio State plans may use medical information about you and your family.

Permitted Uses and Disclosures

- The Ohio State plans may use or disclose PHI to the university, provided that the university does not use or disclose that information except for the following purposes:
 - To perform health plan administrative functions,
 - To obtain premium bids for group health insurance, or
 - To modify, amend or terminate the plans.
- The Ohio State plans may also disclose PHI to the university pursuant to your written authorization.
- All uses and disclosures of PHI must be consistent with HIPAA.

Conditions of Disclosure

- The Ohio State plans may disclose PHI to the university only upon receipt of a certification from the university, as plan sponsor of the OSU plans, that the plan documents have been amended to incorporate the provisions set forth below and that the university, in its capacity as plan sponsor, agrees to such provisions.
- The university, as plan sponsor of the Ohio State plans, agrees to:
 - Not use or further disclose PHI other than as permitted or required by plan documents or as required by law.
 - Ensure that any agents or subcontractors to whom it provides PHI received from the Ohio State plans agrees to the same restrictions and conditions that apply to the university with respect to such PHI and that they agree to implement reasonable and appropriate security measures to protect the information .
 - Not use or disclose the PHI received from the Ohio State plans for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the university (except to the extent that such other benefit or employee benefit plans is part of the organized health care arrangement of which the Ohio State plans are a part).
 - Report to the Ohio State plans any use or disclosure of the information that is inconsistent with the uses or disclosures provided.
 - Report to Ohio State plans any security incident of which it becomes aware.
 - Make a covered person's PHI available to them if they request access, in accordance with federal HIPAA regulations.
 - Incorporate any approved amendments to a covered person's PHI requested by the covered person, in accordance with federal HIPAA regulations.
 - Make available an accounting of disclosures of a covered person's PHI when requested by the covered person, in accordance with federal HIPAA regulations.
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Ohio State plans available to the Secretary of Health and Human Services for purposes of determining compliance of the plans with the law.

CONTINUED ON PAGE 14

GENERAL PLAN PROVISIONS

- If feasible, return or destroy all PHI received from the Ohio State plans that the university still maintains in any form and retain no copies of information when no longer needed for the purpose for which the disclosure was made. If such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
- Ensure adequate separation between the Ohio State plans and the university as required by federal law. **The following terms and conditions apply to all university medical plans.**

Permitted Uses and Disclosures of Aggregate Health Information

- The Ohio State plans may disclose Aggregate Health Information (see the “Definitions” section) to the university, provided that the Aggregate Health Information is only used by the university for the purpose of:
 - Obtaining premium bids for providing health insurance coverage; or
 - Modifying, amending, or terminating the Ohio State plans.

Permitted Uses Enrollment and Disenrollment Information

The Ohio State plans may disclose enrollment and disenrollment information and information on whether individuals are participating in the Ohio State plans to the university, provided such enrollment and disenrollment is only used by the university for the purpose of performing its administrative functions. Enrollment information held by the university in its capacity as an employer is not PHI.

Security of PHI

The university will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Ohio State plans.

Adequate Separation Between Plan and Plan Sponsor

- Those employees or other persons under the control of the university involved in performing plan administration functions for, or on behalf of, the Ohio State plans may be given access to and use PHI. Without limiting the generality of the foregoing, such persons include, without limitation:
 - Ohio State University Wexner Medical Center: employees in Payroll who perform administrative functions for the Medical Plans.
 - OHR Benefits Services: all employees in Benefits Services who perform administrative functions for the Ohio State plans and employees who review and/or make determinations regarding claims or complaints.
 - Payroll Services: employees in Payroll Services who perform administrative functions for the Ohio State plans.
 - Office of the Chief Information Officer (OCIO): employees who perform administrative functions for the Ohio State plans.
 - Office of Legal Affairs: employees who perform administrative functions for the Ohio State plans.
 - Others: any other employee of the university performing plan administration functions for the Ohio State plans who is designated in writing by the Privacy Official of the plans as being entitled to access to PHI.
- The employees or other persons described above shall have access to PHI only to the minimum extent necessary to perform plan administrative functions, unless an individual authorization exists. In the event that any such employees do not comply with these provisions, the employee shall be subject to disciplinary action by the university for non-compliance pursuant to the discipline procedures established by the university.
- The separation provided for above will be supported by reasonable and appropriate security measures.

TERMINATION OF COVERAGE

TERMINATION OF COVERAGE

- Coverage will terminate for the following covered person(s) when the following events occur:
 - For the covered employee and his/her dependents, when the employee terminates from the university. Coverage will cease on the last day of the pay period within which the employee's termination date occurs as reflected in the university's human resource system (PeopleSoft).
 - For the covered employee and his/her dependents, on the last day of the employee's stability period if the employee is considered a full-time employee during that stability period, provided that the employee is not eligible for coverage in the next applicable stability period. Refer to "Eligibility" above.
 - For the covered employee and his/her dependents, when the employee transfers to an ineligible appointment as reflected in the university's human resource system (PeopleSoft) during a stability period if the employee is not considered a full-time employee during that stability period. Coverage will cease on the last day of the pay period within which the employment status change occurs.
 - For the covered employee and his/her dependents, if the employee fails to pay the employee contributions in full. In that case, the elected benefits will be terminated for lack of payment.
 - For the spouse of the covered employee, upon decree of divorce, dissolution, or legal separation. Coverage will cease on the event date. If timely notice is provided, premiums will be changed effective as of the pay period following the event date.
 - For a dependent child reaching age 26 (other than an eligible disabled child), at the end of the month in which the child reaches age 26.
 - For any other dependent, when the dependent no longer qualifies as a dependent. Coverage will cease on the event date. If appropriate, and if timely notice is provided, premiums will be changed effective as of the pay period following the event date.
 - The covered employee is responsible for notifying the university within 31 days of the date of any status change involving the eligibility of a covered dependent. The university may recover from the employee all damages sustained from losses (including paid claims and premium costs) and reasonable attorneys' fees incurred to recover such damages that are brought about as a result of the employee's failure to notify the university of status changes which affect dependent eligibility.
- Coverage may be rescinded (i.e., retroactively terminated) if such coverage was gained due to an individual (or person seeking coverage on behalf of the individual) performing an act, practice or making an omission that constitutes fraud or intentional misrepresentation of a material fact.
- Coverage may be terminated during an open enrollment period. Coverage will cease on the last day of the plan year in which enrolled.
- Coverage may be terminated due to a qualifying status change. Refer to the Change in Coverage Due to a Qualifying Status Change section earlier in this document or visit hr.osu.edu/life-events for information. Coverage will cease on the date of the qualifying status change if the Health Election Form, available at hr.osu.edu/policies-forms, is submitted within 31 days of the qualifying status change. Enrollment changes can also be made by using eBenefits online at eprofile.osu.edu. Documentation of the status change may be required.
- Upon termination of coverage, individuals may be eligible for coverage continuation as described in the Coverage Continuation section of this booklet. However, if the university is not notified within 60 days of the last day of eligibility and/or coverage the dependent will not be eligible for coverage continuation as detailed.
- The university will make all determinations regarding when a covered person is no longer eligible under the Ohio State plans. It is the responsibility of the university to make all final determinations when coverage will terminate for a covered person and to communicate all terminations of coverage to CoreSource and ExpressScripts.
- Coverage under an Ohio State plan will terminate for all covered persons on the date on which the Ohio State plans terminate or is not renewed by the university. The university reserves the right to terminate the Ohio State plans, in whole or in part, at any time.

Certification of Group Health Plan Coverage

- When your coverage terminates, CoreSource can send a Certificate of Group Health Plan Coverage to you upon request. This certificate informs you of the length of group health plan coverage and may be required by another employer or health insurance company prior to providing your health insurance benefits.

COVERED SERVICES

The medical care services that may be covered under the Ohio State plans are listed below. For these services and supplies to be considered covered services, they must be authorized by a physician, rendered and billed by a provider (as defined in the “Definitions” section) and medically necessary (as defined in the “Definitions” section), except as specified in this document. (See your specific medical plan for coverage levels and applicable network provider requirements.)

ACUPUNCTURE

- Acupuncture is used to alleviate pain and to treat certain physical conditions. Acupuncture services and chiropractic care are limited to a combined maximum benefit of \$2,000 per plan year.

AMBULANCE

- Ambulance service is transportation by a vehicle designed, equipped and used only to transport the sick and injured, when medically necessary:
 - From your home, scene of accident or medical emergency to a hospital.
 - Between hospitals.
 - Between hospital and an extended care facility.
 - From a hospital or an extended care facility to your home.¹
 - From your home to an extended care facility, or provider office.
- Surface trips must be to the closest local facility that can give covered services appropriate for your condition. If none are available, you are covered for trips to the closest such facility outside your local area.
- Air transportation is covered when such transportation is medically necessary because of a life-threatening injury or sickness and availability of specialty care. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a hospital for inpatient care.

BEHAVIORAL (MENTAL) HEALTH SERVICES

All inpatient behavioral (mental) health services require prior authorization¹, unless admitted directly from the emergency room (notification to OSU Health Plan of hospital admission is then required within one business day) and include the assessment and treatment of mental and/or psychological disorders and substance abuse.

- Behavioral (mental) health services for the care and treatment of mental illness are covered on an inpatient or outpatient basis. Substance abuse services for the care and treatment of alcoholism and drug addiction are also covered on an inpatient or outpatient basis.
- The following services are covered on an inpatient or outpatient basis:
 - Individual psychotherapy
 - Group psychotherapy
 - Psychological testing
 - Intensive outpatient behavioral health
 - Family counseling – Counseling with family members to assist in your diagnosis and treatment, including marriage counseling
 - Convulsive therapy includes electroshock treatment or convulsive drug therapy
- A physician, mental health provider, hospital, specialized hospital, alcoholism treatment facility, or community mental health facility may provide behavioral (mental) health and substance abuse services.

CHIROPRACTIC CARE

- Chiropractic care is dedicated to the detection and correction of spinal displacement to eliminate interference that can adversely affect health.
- Chiropractic care and acupuncture services are limited to a combined maximum benefit of \$2,000 per plan year.

CONVENIENT CARE CLINIC

A Convenient Care Clinic is a walk-in health care clinic located in a retail store, supermarket or pharmacy that treats uncomplicated minor illnesses, injuries or conditions not serious enough for urgent or emergent care. These facilities are staffed with nurse practitioners and physician assistants who collaborate with physicians to treat minor illnesses and perform some preventive care services.

DENTAL SERVICES

- Expenses for dental work are covered if they are for prompt repair of an injury to the jaw, sound natural teeth, mouth, or face, which are required as a result of an accident.
- Dental services are limited to the initial treatment of the injury that is rendered within 72 hours of the injury. Injury as a result of chewing or biting is not considered an accidental injury.

CONTINUED ON PAGE 17

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

COVERED SERVICES

EMERGENCY CARE

- Emergency care is the service or treatment provided in the outpatient emergency department of a hospital or other facility within 72 hours of the onset of the emergency medical condition. An emergency medical condition is defined as a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
 - Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
 - Serious impairment of bodily functions; or
 - Serious dysfunction of a body organ or part.
- If a covered person is admitted to a hospital for an emergency care admission, notice of the admission must be provided to OSU Health Plan as soon as possible after the admission. The hospital, admitting physician, covered person, or friend/partner/family member of the covered person may give notice to OSU Health Plan.

EXTENDED CARE FACILITY SERVICES

- Covered services in an extended care facility are the same as those shown in the Covered Services – Hospitalization Services and Medical Services, Inpatient sections. Refer to your plan's Schedule of Benefits, Extended Care Facility Services, for coverage details.
- Extended care facility services are covered for up to 60 days per plan year.
- Prior authorization¹ is required before receipt of these services.
- Services must be medically necessary as a continuation of treatment for the condition for which you were hospitalized.

GENETIC COUNSELING/BRCA

The U.S. Preventive Services Task Force (USPSTF) recommends with a “B” rating to “screen women who have family members with breast, ovarian, tubal or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.” There is no cost to the member for these services when performed by a network provider with prior authorization.¹

GYNECOLOGICAL (GYN) EXAMINATIONS

Coverage is provided according to each specific medical plan's Schedule of Benefits.

HEARING AIDS AND EAR MOLDS

Coverage is provided for hearing aids and ear molds that are required to improve pure tone hearing ability for causes other than injury to the ear. The total maximum benefit is \$1,200 every four plan years.

- If acute hearing loss is the result of an injury to the ear, then the initial hearing aid and ear mold are covered as part of the prosthetic appliance benefit. See the Covered Services - Prosthetic Appliances section for further details.

Note: For dependents up to age 12, replacement ear molds that are medically necessary due to growth are covered and are not subject to the \$1,200 maximum benefit.

HOME HEALTH CARE SERVICES

- May be provided to you on a part-time basis in your home as a medically necessary alternative to inpatient care. A home health care provider must provide the services according to a physician-prescribed course of treatment that has been prior authorized.¹ Covered services include skilled nursing services, diagnostic services and therapy services.
- Benefits are not provided for a nurse who usually lives in the home or is a member of the immediate family.

HOSPICE

A medical care program providing a coordinated set of services rendered at home, in outpatient settings, or in institutional settings for covered persons suffering from a condition that has a terminal prognosis. A hospice must have an interdisciplinary group of personnel that includes at least one physician and one Registered Nurse (RN), and it must maintain standards of the National Hospice Organization (NHO) and applicable state licensing requirements. Covered services include, but are not limited to, room and board, nursing care, respite care, physical/occupational/respiratory therapy and bereavement counseling.

HOSPITALIZATION SERVICES

The following hospitalization services are covered:

- Room and board in a semi-private room containing two or more beds, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a special care unit approved by OSU Health Plan.
- Oral surgery, including the extraction of teeth, if hospitalization is medically necessary to safeguard the covered person's life or health due to a specific non-dental organic impairment. For these services to be covered, your physician must receive prior authorization.¹
- Ancillary services, such as:
 - Operating, delivery and treatment rooms and equipment

CONTINUED ON PAGE 18

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

COVERED SERVICES

- Prescribed drugs
- Anesthesia, anesthesia supplies and services given by an employee of the facility
- Medical and surgical dressings, supplies, casts and splints
- Blood and blood services
- Diagnostic services
- Radiation therapy, intravenous chemotherapy, kidney dialysis, respiratory therapy, physical therapy (as defined below), occupational therapy (as defined below) and speech therapy (as defined below)

Note: All hospitalizations require prior authorization¹, unless admitted directly from the emergency room (notice of the admission must be provided to OSU Health Plan as soon as possible after the admission).

HUMAN ORGAN TRANSPLANTS

- A human organ transplant is, for example, a human heart, heart-lung, liver, kidney, bone marrow, or pancreas transplant. Coverage will be provided for:
 - All covered services as applicable to the procedure.
 - Expenses related to the acquisition of a human organ, if donor's primary insurance does not cover donor expenses. Acquisition includes the preparation, transportation and storage of a human organ.
- In order to receive benefits for Human Organ Transplants, you must contact OSU Health Plan when you learn you are a candidate for transplant surgery. Prior authorization¹ will only be granted if the human organ transplant is medically necessary.
- No coverage will be provided for services or supplies that are considered by OSU Health Plan to be experimental/investigative, or that are related to a transplant surgery for which prior authorization was not obtained.

IMMUNIZATIONS

Immunizations are a method to trigger your immune system to prevent serious life-threatening diseases. They are an essential part of wellness programs for all ages.

INFERTILITY TREATMENT

In order to receive benefits for infertility treatment, an obstetrician or gynecologist (OB/GYN) or reproductive endocrinologist must diagnose the infertility. In addition, coverage is limited to you and your spouse. All infertility treatments are subject to a separate annual deductible. There is a separate lifetime maximum for infertility services. Any prescription medications included in this treatment are applied to the lifetime maximum.

Expenses for infertility treatment do not apply toward the annual out-of-pocket maximum. All infertility treatments are subject to OSU Health Plan guidelines as outlined in the Schedule of Benefits section for your medical plan. Requires prior authorization¹ and specific exclusions apply.

INJECTION/ADMINISTRATION OF MEDICATIONS

The injection or administration of prescription drugs by a medical professional.

MATERNITY SERVICES

- Coverage for inpatient and outpatient maternity services includes all covered services listed under the Hospitalization Services, Medical Services-Inpatient, Medical and Surgical Supplies and Outpatient Services sections of this booklet.
- Statement of Rights Under the Newborns' and Mothers' Health Protection Act
 - Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier.
 - Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
 - In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact OSU Health Plan at 614-292-4700.

MEDICAL AND SURGICAL SUPPLIES – OUTPATIENT

- Syringes, needles, oxygen, surgical dressings, splints and other similar items that serve only a medical purpose are covered. Covered services do not include items usually stocked in the home for general use, such as adhesive bandages, thermometers and petroleum jelly.
- Medical supplies, equipment and appliances must be rented or purchased by an agency or provider approved by OSU Health Plan. Expenses over \$2,000 require prior authorization.¹

CONTINUED ON PAGE 19

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

COVERED SERVICES

MEDICAL EQUIPMENT

The rental or purchase of medical equipment is covered when prescribed by a physician. Rental costs must not be more than the purchase price. The equipment must serve only a medical purpose and be able to withstand repeated use. Expenses over \$2,000 require prior authorization.¹

MEDICAL SERVICES – INPATIENT

The following medical services, when performed by a physician, are covered on an inpatient basis:

- Care and treatment while you are confined in a medical facility.
- One physician visit per day.
- Consultation by another physician when requested by your physician. Staff consultations required by hospital rules are excluded from coverage.
- Care by two or more physicians during one hospital stay when your condition requires the skills of separate physicians.
- Dental services that are required as a result of injury to the jaws, sound natural teeth, mouth, or face.

MEDICATIONS

- Federal legend drugs which are medications that require a prescription under federal law and are approved for general use by the Federal Drug Administration (FDA).
- Injectable insulin that does not require a prescription is considered to be a covered drug.
- Covered over-the-counter medications require a prescription for coverage. See the Prescription Drug Program section of this booklet for further details.

NEWBORN CARE

- Coverage for a newborn infant as described in this section is provided only as a covered person under two-person or family coverage. To have the services covered, you must add the newborn as a covered dependent under your medical plan in accordance with the requirements outlined in the General Plan Provisions – Change in Coverage Due to a Qualifying Status Change section of this booklet.
- If single coverage is already in place prior to the birth of the newborn infant, then you must elect employee + child(ren) coverage and enroll the newborn infant.
- If employee + spouse coverage is already in place prior to the birth of the newborn infant, then you must elect family coverage and enroll the newborn infant.
- If family or employee + child(ren) coverage is already in place prior to the birth of the newborn infant, you are still required to enroll the newborn infant.
- Coverage includes:
 - Routine nursery care of a newborn infant.
 - Inpatient visits to examine a newborn. A physician other than the physician who performed the obstetrical delivery must do the examination.

Note: To enroll the newborn infant in medical coverage, use eBenefits online at eprofile.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms, within 31 days of the date of birth.

NUTRITIONAL SERVICES

Nutritional services are services focused on food/nutrient intake or eating patterns. They can be provided by a licensed and registered dietician, physician, certified diabetic educator, or within an approved structured program. These services are appropriate when there is a condition or treatment that is directly influenced by food and nutrient intake such as diabetes, a malabsorption disorder such as celiac disease, an eating disorder, or obesity.

OCCUPATIONAL THERAPY

Occupational therapy is the treatment rendered on an inpatient or outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments. It is considered medically necessary only if the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational and vocational therapies (such as hobbies, art and crafts) . All outpatient occupational therapy and physical therapy services are limited to a combined maximum of 45 visits per plan year.

CONTINUED ON PAGE 20

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

COVERED SERVICES

OUTPATIENT SERVICES

The following services are covered on an outpatient basis:

- Blood and blood services, if provided and billed by a hospital or other facility.
- Diagnostic services including laboratory services.
- Home and office visits to examine, diagnose, or treat an injury or sickness.
- Outpatient surgical services and supplies; other outpatient visits to examine, diagnose or treat an injury or sickness, including emergency care and the administration of allergy injections.
- Pre-admission tests and studies required for a scheduled admission as an inpatient.
- Radiation therapy, inhalation therapy, intravenous chemotherapy, kidney dialysis and physical therapy. Occupational, physical and speech therapy services must be rendered by a licensed therapist.

PERVASIVE DEVELOPMENTAL DISORDER (PDD)

Treatment for the diagnosis of Pervasive Developmental Disorder (PDD) Spectrum including Autism is covered by when medical necessity criteria are met. Coverage includes the following:

- Up to 20 hours per week of therapeutic aide services until age 21, if criteria are met.¹
- Professional services provided by a licensed mental health provider – Refer to Behavioral Health Services, Mental Health and Substance Abuse, Outpatient section in each specific plan's Schedule of Benefits.
- Speech therapy – Refer to the Speech Therapy, Outpatient section of the schedule of benefits
- Physical therapy – Refer to the Physical Therapy and Occupational Therapy, Outpatient section in each specific plan's Schedule of Benefits.
- Occupational therapy – Refer to the Occupational Therapy and Physical Therapy, Outpatient section in each specific plan's Schedule of Benefits

PHYSICAL THERAPY

- Physical therapy is treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a physician or other professional are required.
- All outpatient physical therapy and occupational therapy (see prior page) services are limited to a combined maximum of 45 visits per plan year.

PREVENTIVE HEALTH CARE (PHYSICAL EXAMINATIONS)

Coverage is provided according to each specific medical plan's Schedule of Benefits and based on the guidelines in the Adult Preventive Health Care Guidelines and Pediatric Preventive Health Care Guidelines; guidelines found at osuhealthplan.com/forms-and-downloads.

Note: One physical examination per plan year provided for children (age 3 and older) and adults.

PROCEDURES – OUTPATIENT SERVICES

- Performed for primarily diagnostic purposes
- Non-invasive or minimally invasive
- Do not require an operating room environment (e.g., sterile OR setting, or room with specific monitoring or resuscitation equipment)
- Do not require full or prolonged sedation of the patient
- Require no or little post-recovery time for the patient

PROSTHETIC APPLIANCES

Purchase, fitting, needed adjustment, repairs and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body organ and its adjoining tissues.
- Replace all or part of the function of a permanently useless or malfunctioning body organ.

Note: Expenses over \$2,000 require prior authorization.¹

RADIOLOGY

Radiology is the examination of the inner structure and parts of the body using X-rays or other penetrating radiation.

SPEECH THERAPY

- Speech therapy is the active treatment for improvement of an organic medical or developmental condition causing speech impairment. Treatment must be post-operative or for the convalescent stage of an active illness or disease. The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.
- All outpatient speech therapy services are limited to a maximum benefit of 20 visits per plan year.

CONTINUED ON PAGE 21

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

COVERED SERVICES

SURGICAL SERVICES

- Surgery performed by a physician is covered on an inpatient or outpatient basis. Prior authorization¹ is required before receipt of inpatient surgical services that include:
 - Administration of anesthesia by a physician or other professional who is not the surgeon or assistant at surgery.
 - Multiple surgical procedures – when a physician performs more than one surgical procedure during the same operative session, the surgeon's bill will indicate the major or primary procedure performed and any secondary procedure(s).
- If two or more surgeries were performed during the same operative session, the following guidelines are normally used to determine the allowable expense for the claim:
 - 100% of UCR paid for the first or primary procedure
 - 50% of UCR paid for the second and each additional procedure

Note: If you use a network surgeon, you are not responsible for any balance in excess of the contract provider's fee schedule outside of normal deductible and co-insurance limits.

- Reconstructive surgery to restore bodily function. Coverage is limited to medical conditions caused by disease, injury, or birth defects. Reconstructive surgery does not include any surgery that is specifically identified as an exclusion or to correct cosmetic surgery. Refer to the Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads to determine the need for prior authorization.
- Second surgical opinion to help determine the need for elective surgery recommended by another physician. Coverage is provided for the physician's opinion and related diagnostic services. All network rules apply including deductible, copay, and coinsurance. If the first and second opinions differ, you may elect to receive a third surgical opinion, subject to the same provisions as for the second surgical opinion.
- Services of a physician who helps your surgeon in performing covered major surgery when a house staff member, intern, or resident cannot be present and is medically necessary.

TEMPOROMANDIBULAR DISORDER (TMD)

TMD is a disease of dysfunction of the joint linking the jawbone and skull and the muscles, nerves and other tissues related to the joint. TMD covered services include diagnostic services, orthotic or orthopedic devices, adjustments to orthotic or orthopedic devices and therapeutic injection of medication into the TMD. There is a \$3,000 maximum lifetime benefit for non-surgical procedures. Surgical procedures for the treatment of TMD are subject to the Surgical Services and Schedule of Benefits for your medical plan.

- No coverage is provided for crowns or for orthodontia (braces) – these services may be covered under your dental care plan.
- Appliances/orthotic devices over \$2,000 per device require prior authorization.¹

TOBACCO CESSATION PROGRAM

Tobacco cessation services are covered through the university medical plans. Services are paid at 100%. Over-the-counter nicotine replacement therapy (NRT) and prescription cessation medications (e.g., Chantix) are paid at 100% through the Prescription Drug Program. See the Prescription Drug Program section. A prescription must be obtained from a physician or nurse practitioner for all tobacco cessation products. Free cessation services can be obtained through Health Coaching at OSU Health Plan by calling 614-292-4700.

URGENT CARE

- Urgent care services are different than emergency medical services. An urgent condition is not life threatening, but may cause serious medical problems if not promptly treated. Urgent care is defined by the need to treat an unforeseen condition that requires immediate medical treatment for acute pain, acute infection, or protection of public health.
- Plan members should go to the emergency room for life-threatening medical emergencies.
- Urgent care is not intended for preventive or routine maintenance treatment such as school or annual physicals. These services will not be covered at urgent care facilities.
- Examples of conditions that require urgent care include: injuries, fever, sudden onset of pain (abdominal pain, severe headache), broken bones and cuts.

WEIGHT LOSS SURGERY

- Weight loss surgeries include but are not limited to gastric bypass, gastric banding, and gastric reduction. All services are subject to OSU Health Plan guidelines available at <https://osuhealthplan.com/forms-and-downloads> (see Weight Loss Surgery Policy). Prior authorization¹ is required.

WEIGHT MANAGEMENT PROGRAMS

- Hospital-based/physician-directed programs are reimbursed at 50% up to \$1,000 per plan year.
- Weight Watchers™ OnlinePlus and the Meetings Program are reimbursed at 50%. The reimbursement is applied to the month-to-month membership. Membership can be canceled at any time. For more information, or to join, visit go.osu.edu/weightwatchers.
- Expenses for Weight Management Programs are excluded from the annual out-of-pocket maximum.

CONTINUED ON PAGE 22

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

COVERED SERVICES

WOMEN'S HEALTH/CONTRACEPTIVE COVERAGE

At least one form of women's contraception in each of the 18 "methods" of contraception outlined in the FDA birth control guide. For details see the Birth Control Claim Processing Policy available online at osuhealthplan.com/forms-and-downloads.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits provided under your medical plan.

If you would like more information on WHCRA benefits, contact OSU Health Plan at 614-292-4700.

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

EXCLUSIONS OR LIMITATIONS

YOUR MEDICAL COVERAGE DOES NOT PROVIDE BENEFITS FOR SERVICES, SUPPLIES, OR CHARGES:

1. Which are not specified as covered services by your medical plan.
2. Which are experimental/investigative (as defined in the "Definitions" section), including investigational medical, surgical, or mental health procedures and pharmacological regimens, as well as associated health services and/or supplies as defined by the medical plan.
3. For services not medically necessary to the care and treatment of any injury, disease, or pregnancy or furnished without recommendation and approval of a physician acting within the scope of his/her license except for preventive services listed.
4. Which are for injury or sickness (as defined in the "Definitions" section) arising in the course of employment. This applies whether or not you claim any compensation or recover losses from a third party.
5. To the extent governmental units provide benefits.
6. For injury or sickness that occurs as a result of any act of war, declared or undeclared, when providing service in the armed forces of any country to the extent that such injury or sickness is provided for through any governmental plan or program.
7. Subject to Section 3923.82 of the Ohio Revised Code, incurred as a result of a covered person's voluntary involvement or participation in a felony or an illegal activity, including a riot or act of civil disobedience.
8. For which you have no legal obligation to pay in the absence of this or like coverage.
9. For treatment only to improve appearance.
10. For reconstructive surgery following cosmetic surgery.
11. Received from a member of your immediate family or self-administered/self-prescribed by you for your own benefit. Immediate family is defined as spouse, child, stepchild, parent, sibling, in-laws, or grandparents.
12. For personal hygiene and convenience items, including any item or service requested solely due to member preference.
13. For missed appointments, completion of claim forms, copying or obtaining medical records.
14. For services for custodial care or for services not needed to diagnose or treat an injury or sickness.
15. For reversal of sterilization.
16. For non-therapeutic abortions performed or induced when the life of the mother would not be endangered if the fetus were carried to term or when pregnancy of the mother was not the result of rape or incest reported to a law enforcement agency (even if pre-natal testing is covered), including but not limited to pre-and post-procedure diagnostic testing, imaging or surgeries due to complications.
17. For room, board and general nursing care for hospital admissions mainly for physical therapy or diagnostic studies.
18. For hospitalization for environmental change.
19. For services or supplies incurred prior to your effective date of coverage or after your termination date of coverage except as specified in this document.
20. For eye examinations for the purpose of prescribing or fitting of eye glasses or contact lenses, or for eye examinations for any occupational condition, ailment or injury arising out of or in the course of employment.
21. For services to correct visual acuity, such as radial keratotomy and corrective refractive surgery.
22. For eye glasses, sunglasses, safety glasses, safety goggles, subnormal vision aids or contact lenses (except for aphakic patients and soft lenses or sclera shells which are intended for use as corneal bandages or when needed because of an injury to the eye).
23. For services or supplies primarily for educational, vocational or training purposes.
24. For dentistry or dental processes to the teeth, the tissue surrounding the teeth and roots, including orthodontia, except as specified in this document.
25. For routine dental services.
26. For tooth transplantation including re-implantation from one site to another and splinting and/or stabilization.
27. For surgical removal of impacted teeth.
28. For surgical removal of residual tooth roots.
29. For endodontal and periodontal surgery.
30. For labial frenectomy.
31. For transportation or travel other than for use of ambulance services.
32. For medical equipment or appliances for comfort, appearance, or weight loss, or those for which an acceptable substitute may be made, even though prescribed by a physician; including but not limited to air conditioners, humidifiers, de-humidifiers and exercise equipment.
33. For any service or supply for which the Plan cannot by law provide such benefit.
34. For any service or supply for which a charge would not have been made in the absence of eligibility.
35. For any service or supply once the maximum benefits have been provided as outlined in the Schedule of Benefits for your medical plan.
36. For charges for herbal medicines, holistic or homeopathic care, including prescribed drugs.
37. For services rendered by a provider who is not specifically included in the definition of a physician or specifically listed as a covered provider.
38. For charges in excess of those considered reasonable and customary.
39. For claims filed later than 12 months from the date the charge was incurred.
40. For services, supplies or charges for oral or self-injectable medications that are capable of being given outpatient using the Prescription Drug Program.

CONTINUED ON PAGE 24

EXCLUSIONS OR LIMITATIONS

YOUR MEDICAL COVERAGE DOES NOT PROVIDE BENEFITS FOR SERVICES, SUPPLIES, OR CHARGES CONT'D:

41. For supplements and food including infant or adult formula even if prescribed by a physician.
42. Cord blood donation or storage.
43. For chelation therapy unless for the treatment of heavy metal or lead poisoning.
44. For blood cleaning therapy.
45. For hospital charges for observation which exceed 48 hours.
46. For routine vitamin injections.
47. For any test solely for the purpose of determining the sex of the fetus.
48. For environmental modifications, including but not limited to: air conditioner, air filters, humidifiers, vaporizers, heating pads, wheelchair lifts, ramps, home remodeling.
49. For long-term embryo, sperm, or egg storage.
50. For physicals and other medical services (e.g., vaccines, x-rays, labs, etc.) for administrative requirements such as: immigration, licensure, adoption, marriage, employment, camp, sports, or school.
51. For outpatient recreational therapy.
52. For living expenses even if related to a medical condition.
53. For hypnotherapy, music therapy, or remedial reading therapy.
54. For custodial/maintenance care or for services not needed to diagnose or treat an injury or illness.
55. For ambulance services for the convenience of the patient.
56. For educational lectures and counseling.
57. For exercise equipment including but not limited to: bicycles, weights, treadmills, ergometers and gym memberships.
58. Evaluations or treatment mandated by a third party unless considered medically necessary (for example, court, employer, or school), including documentation in the form of reports or summaries of clinical information.
59. For cosmetic services which include but are not limited to: breast reduction, breast enlargement, labiaplasty, wrinkle removal, collagen injections, dermabrasion, hair restoration, electrolysis, abdominoplasty, liposuction (except when performed as part of medically necessary breast cancer reconstruction), excision of excessive skin of thigh (thigh lift, thighplasty), leg, hip, buttock, arm (arm lift, brachioplasty), forearm or hand, or submental fat pad.
60. For services and supplies provided through research studies.
61. For charges incurred for the completion of claim forms or copying medical records.
62. For charges for time dedicated to claims resolution.
63. For charges for legal expenses or fees incurred in obtaining medical treatment.
64. For covered charges when there has been an incomplete claims submission.
65. For private duty nursing, homemaking or housekeeping services.
66. For free-standing birthing centers.
67. For home births.
68. For paternity testing.
69. For in-vitro fertilization, artificial insemination, assisted reproductive technologies and procedures, when either partner has undergone voluntary elective sterilization procedures, or for individuals who are not considered infertile according to the definition, or for a covered person other than the employee, or spouse. Donor services, including egg, sperm and embryo.
70. Selective reduction of a pregnancy and any related services, including but not limited to pre- and post-procedure diagnostic testing, imaging, or surgeries due to complications.
71. Charges for services and supplies which do not conform with generally accepted medical practices,
72. Charges that are not payable by the primary plan covering the patient solely due to the employee/patient's failure to comply with that plan's requirements for cost containment (including but not limited to failure to prior authorize, failure to obtain a second opinion, failure to execute subrogation agreements, etc.).
73. Charges that may be payable by the medical plan when a provider or plan participant fails to comply with this plan's request for information.
74. Expenses relating to a medical condition, illness, or injury, when the covered person receives a profit or wage (other than employer-based disability payments).
75. The return of mortal remains in the event of a death away from home.
76. For preventive or routine maintenance treatment such as school or annual physicals received by an urgent care provider or convenient care clinic.
77. Charges for shipping, handling and tax.
78. Prescriptions for medical marijuana.
79. For services rendered to or for a surrogate, including, but not limited to, costs for maternity care, if the surrogate is not a covered person under the Ohio State plans.
80. For costs incurred for a fertile woman to achieve a pregnancy as a surrogate, regardless of whether the woman is a covered person under the Ohio State plans. Costs include, but are not limited to, costs for drugs necessary to achieve implantation and embryo transfer.
81. Non-emergency use of an emergency room.

THE OHIO STATE HEALTH PLAN, INC.

OSU Health Plan works in partnership with OHR, CoreSource, and Express Scripts to assure access to quality medical and pharmaceutical care in the most cost-efficient manner.

BEHAVIORAL HEALTH REFERRALS

If mental health or substance abuse treatment is needed, OSU Health Plan can assist in matching patient needs to provider expertise. OSU Health Plan will take into consideration your cultural, demographic, gender and/or geographic issues when making referrals to appropriate behavioral health services.

CASE MANAGEMENT

OSU Health Plan provides case management services that promote quality cost-effective medical outcomes. To accomplish this, input is obtained from sources including providers, patients, family members and medical consultants.

COORDINATION OF MEDICAL COVERAGE WITH SPECIALIST REFERRALS FOR DENTAL AND VISION SERVICES

When your dental or vision care provider identifies necessary specialist care, OSU Health Plan will assist you in locating a specialist who is part of your university medical, dental, or vision network of providers.

MEDICAL PROVIDER NETWORKS

OSU Health Plan establishes the statewide network in Ohio. This network process includes credentialing of physicians and periodic quality reviews. OSU Health Plan provides information to members regarding physicians, behavioral health services, other medical services and case management. A listing of the network providers is available online at osuhealthplan.com/search.

PRIOR AUTHORIZATION OF SERVICES

OSU Health Plan determines the medical necessity of services and conducts treatment plan reviews for all of the university's medical plans. Network providers will obtain prior authorization of services for you when necessary. When you use an out-of-network provider, it is your responsibility to inform the provider when prior authorization is required.

HOW PAYMENT IS DETERMINED

Payment of the contracted or network provider's fee schedule, provider's reasonable charge, Usual, Customary and Reasonable (UCR) charge or the actual charge, whichever is less, will be provided for all covered services. All payments will be subject to any applicable annual deductible, coinsurance, copays, maximum benefits and other provisions and limitations and the Schedule of Benefits for your medical plan.

ANNUAL DEDUCTIBLE

- The annual deductible is the amount you owe for covered services before your medical plan begins to pay. For example, if your annual deductible is \$600 your medical plan won't pay anything until you have met your \$600 annual deductible for covered health care services subject to the annual deductible. The annual deductible may not apply to all services.
- Your annual deductible amount is shown in the Schedule of Benefits for your medical plan. CoreSource's records must show that you have reached this annual deductible. Therefore, to ensure proper record keeping, you should submit copies of all your bills, even those that you must pay to meet the annual deductible.
- If the family annual deductible amount is reached then the annual deductible will be waived for all others covered under family coverage for that plan year.

Prescription Drug Program Annual Deductible

The annual deductible for prescription drug purchases for Prime Care Advantage, Prime Care Choice and the Out-of-Area Plan is \$50 per person, \$100 per family per plan year. These are separate from the medical plans' annual deductible.

ANNUAL OUT-OF-POCKET MAXIMUM

The annual out-of-pocket maximum is the most you pay during a plan year before your medical plan begins to pay 100% of the eligible expenses for the remainder of the plan year with the exception of the excluded services listed below.

- An individual annual out-of-pocket maximum is the maximum amount that each covered person is required to pay in annual out-of-pocket expense in a plan year (includes annual deductibles, copays and coinsurances) with the exception of the excluded services listed below.
- A family annual out-of-pocket maximum is the maximum amount the family is required to pay in annual out-of-pocket expense in a plan year. If the family limit is satisfied, the annual out-of-pocket maximum will be waived for all others covered under family coverage for that plan year (See exceptions below).
- The following services are excluded from the annual out-of-pocket maximum:
 - Non-covered services and supplies
 - Any charge in excess of the contracted or network provider's fee schedule, UCR or provider's reasonable charge
 - Infertility services
 - Weight Management Programs
 - Prior authorization penalty
- You may submit claims for covered services that are not in the same order that you received the covered services. Regardless of the order claims were incurred, the annual out-of-pocket amounts will be applied to covered services in the sequence that claims are submitted and paid.

Prescription Drug Program Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum for prescription drug purchases for Prime Care Advantage, Prime Care Choice and the Out-of-Area Plan is \$2,500 per person, \$5,000 per family per plan year. The annual out-of-pocket maximum for prescription drug purchases for Prime Care Connect is \$2,000 per person, \$4,000 per family per plan year. These are separate from the medical plans annual out-of-pocket maximum.

COINSURANCE

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the eligible expense for the service. You may have to pay coinsurance in addition to any annual deductibles you owe, although some covered services may not be subject to an annual deductible. Refer to the Schedule of Benefits for your medical plan to see what your coinsurance is for each service.

COMMON ACCIDENT

If two or more family members are hurt in the same accident, only one individual annual deductible must be met for expenses relating to the accident. This special feature applies to eligible expenses each plan year for the same accident.

COPAY / COPAYMENT

A fixed amount (for example, \$35) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. Refer to the Schedule of Benefits for your medical plan to see what your copay/copayment is for each service.

CONTINUED ON PAGE 27

HOW PAYMENT IS DETERMINED

MAXIMUM BENEFIT LIMITS

- Maximum benefit limits are the maximum amount that will be paid for a covered service. Refer to the Schedule of Benefits for your medical plan for maximum benefit amounts.
- If a covered employee elects to change to another medical plan offered by the university, any amounts incurred toward a benefit limit by a covered person under the plan will apply under the new plan of coverage.

Maximum Lifetime Benefit Limit

There is no Maximum Lifetime Benefit Limit for the university medical plans unless indicated for a specific benefit.

Infertility Lifetime Benefit Limit

The lifetime benefit limit for expenses related to the treatment of infertility and related prescription drugs is \$15,000.

Temporomandibular Disorder (TMD) Lifetime Benefit Limit

The benefit for the treatment (except surgical procedures) of TMD has a \$3,000 maximum lifetime benefit limit.

PRIOR AUTHORIZATION

Prior authorization (see the Medical Prior Authorization Guide available at osuhealthplan.com/forms-and-downloads) is notification to OSU Health Plan of a request for benefits before receipt of specific services, as outlined in the Schedule of Benefits for your medical plan, or before elective admission to a hospital or facility. Emergency admissions must be authorized within one business day. If prior authorization is not obtained from OSU Health Plan, a penalty of 20% of the fee, up to \$1,000, per admission or service will be charged. This penalty does not apply toward the annual deductible or the annual out-of-pocket maximum.

PRE-EXISTING CONDITION LIMITATION

There is no pre-existing condition limitation applied to benefits when joining the university's medical plans.

USUAL, CUSTOMARY AND REASONABLE (UCR) CHARGE

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the eligible expenses.

- For out-of-network providers, the UCR amount is a fee most frequently allowed for a similar service or medical procedure by most similarly qualified physicians or other medical care providers in the particular geographic area where the service is rendered or a fee that has been negotiated with the provider. It takes into consideration any unusual circumstances and medical complications which may require additional time, skill and experience.
- The database used to establish UCR maximum amounts is updated annually.
- When a charge is submitted to CoreSource on behalf of the university for reimbursement of a covered service, payment will be made for the charge or the UCR maximum, whichever is less, subject to any applicable coinsurance amounts and other provisions or limitations of the plan.
- Unusual circumstances which reasonably require additional time, skill or experience for a provider's service are taken into consideration by CoreSource and may result in reimbursement of an amount above the UCR maximum but not exceeding the actual charge.

Note: Charges that exceed the UCR maximum do not apply to the annual deductible or annual out-of-pocket maximum.

MEDICAL CLAIMS PROCESSING

When you receive covered services, a claim must be filed for you to obtain benefits. Many providers will file claims for you. If you need to submit the claim yourself, the claim and appeal procedures are summarized here.

FILING A CLAIM

Claim Forms

Claim forms are available online at hr.osu.edu/policies-forms (under Form - Health Benefits - Medical - CoreSource Health Insurance Claim Form); or from the OHR Customer Service Center by calling 614-292-1050. Claim forms must be filled out completely and submitted as indicated on the form.

Initial Claim

Generally, all claims must be submitted within 12 months from the incurred date of service. In certain cases the plan may require you to obtain prior authorization for services (refer to osuhealthplan.com/benefit-plan-information) for a list of services requiring prior authorization).

Notice of Determination – If your claim is wholly or partially denied, you will receive a written notice of the decision that will generally contain:

- Specific reasons for the claim's denial (including denial codes, as required);
 - A description of additional material or information necessary for you to perfect your claim and an explanation of why such information is necessary;
 - Specific references to pertinent plan provisions;
 - A statement of your right to request an external review and a description of the plan's internal appeals and external review procedures, including your right to request an expedited internal and/or external review in certain circumstances; and
 - The availability of, and contact information for, the Ohio Department of Insurance.
- In addition, if an internal rule, guideline or protocol was relied on in making the benefit determination, or if the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, an explanation of such rule or protocol, or the scientific or clinical judgment used in the determination will be provided in the notice.

Time Frame for Notification – You will be notified of the decision on appeal within certain timeframes established by law. Refer to the Appendix at the end of this booklet titled "Claims Determination and Appeals Procedures" for additional details.

APPEAL PROCEDURE

If your claim is denied and you wish to have your claim reconsidered, you (or your representative) may appeal. Your appeal must be received in writing within 180 days after the initial determination. You may submit additional comments, records and documents related to your claim. You may also, upon request and at no charge, review copies of the documents and information relevant to your claim. The person who decides the appeal will not be the same individual who decided the claim (or a subordinate of that individual).

Notice of Determination – Notice of the decision will be in writing and will include generally the information detailed above for your initial claim, as it relates to your appeal.

Time Frame for Notification – You will be notified of the decision on appeal within certain timeframes established by law. Refer to the Appendix at the end of this booklet titled "Claim Determination and Appeals Procedures" for additional details.

Second-Level Appeal – For post-service claims (see "For More Information" below), if your claim is denied on the first appeal, you may ask for a second review. A request for a second review must be submitted, in writing, within 60 days after the date the claim is denied on the first appeal. Additional comments, documents or other information relating to your claim should also be submitted. You will be notified of a decision on your second appeal within 30 days.

External Review – If your appeal is denied, you may be entitled to an independent external review of the denial. External review is generally limited to denied appeals for medical benefits that involve medical judgment (e.g., medical necessity or a determination of whether a treatment is experimental or investigational). You must request an external review in writing (electronically or verbally if an expedited review) within 180 days after the notice on appeal. You must generally exhaust (or be deemed to have exhausted) the plan's internal claims appeals procedures to be eligible for an external review. You may be eligible for an expedited external review if the denial could seriously jeopardize your life or health. The assigned independent review organization must provide written notice of its decision within 30 days after request for a standard review, or within 72 hours for an expedited review.

FOR MORE INFORMATION

The above information provides only a summary of the plan's internal claims and appeals and external review procedures. To review the complete internal claims and appeals and external review procedures refer to the Appendix at the end of this booklet titled "Claim Determination and Appeals Procedures."

CONTINUED ON PAGE 29

MEDICAL CLAIMS PROCESSING

COORDINATION OF BENEFITS

- All benefits provided as described in this document, except prescription drugs obtained under the Prescription Drug Program, are subject to coordination of benefits (COB). COB determines whether a benefit plan is primary or secondary when a covered person is covered by more than one benefit plan.
- If you or your family members are covered by more than one medical plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals and it may be impossible to comply with both plans at the same time. Read the rules very carefully and compare them with the rules of any other plan that covers you or your family.
- In addition to the definitions in this document, the following definition of Other Contract applies to this section:
 - Any arrangement providing medical care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

Determining Primary/Secondary Coverage

Which plan provides primary or secondary coverage is determined by using the first of the following rules that applies:

- Another contract with no COB provision is always primary.
- The benefit plan covering you as an employee, member or subscriber (other than a dependent) is primary.
- When a dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the plan that covered the parent longer will be primary. If a dependent is covered by two benefit plans and the non-university contract does not have this COB "birthday" rule, then the rule of the other contract will determine the primary and secondary contract. If the other contract has a rule based on the gender of the parent, then the gender rule will determine the primary and secondary contract.
- If the parents are separated or divorced, the following rules apply:
 - If the parent with custody has not remarried, his or her coverage is primary.
 - If the parent with custody has remarried, his or her coverage is primary, the stepparent's is secondary and the coverage of the parent without custody pays last.
 - If a court decree specifies the parent who is financially responsible for the child's medical care expenses, the coverage of that parent is primary.
 - If the court decree states that both parent are responsible for the child's medical care expenses, then the following rules shall apply:
 1. the plan of the parent whose birthday falls earlier in the calendar year shall be primary; or
 2. if both parents have the same birthday, the plan that has covered either parent the longest is primary.
- If there is a court decree that orders joint custody and does not determine primary status for benefit coverage, the regular provisions establishing the primary status for children of active employees will apply.
- When a plan covers you as an active employee or a dependent of such employee and the other contract covers you as a laid-off or retired employee or as a dependent of such person, the plan which covers you as an active employee or dependent of such employee is primary.
- When a person whose coverage is provided under a right of continuation pursuant to federal or state law (such as COBRA) also is covered under another plan, the plan covering the person as an employee, member or subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.
- When the rules above do not apply, the plan that has covered you longer is primary.

COB Payment Process

COB affects benefits in the following manner when you are covered by more than one benefit plan:

- When this medical plan is primary, CoreSource will authorize the payment of benefits on behalf of the university without regard to any other contract.
 - If the total benefits for covered services to which you would be entitled as described in this booklet and under all other benefit plans exceed the covered services you receive, then the benefits provided will be determined according to this provision.
- When this medical plan is secondary, the following process will be followed. The primary plan pays benefits first. The primary plan will ignore the fact that the member is covered under a secondary plan and will pay the full eligible benefit. The secondary plan pays next by following these steps:
 1. The secondary plan will first calculate the plan benefits.
 2. The secondary plan will pay the lesser of:
 - a. The total patient responsibility (deductible, copay, coinsurance) under the primary plan; or
 - b. The amount OSU would pay as primary.

CONTINUED ON PAGE 30

MEDICAL CLAIMS PROCESSING

COB Example 1

	Primary	OSU (if primary)
Allowed Amount	\$2,800	2,800
Deductible	-\$800	-\$0
Coinsurance	-\$400	-\$280
Payment	\$1,600	\$2,520

In this example, as the secondary plan, Ohio State would pay \$1,200, which is the total patient responsibility under the primary plan (\$800 deductible and \$400 coinsurance). Ohio State would pay that amount because it is less than the amount Ohio State would pay if it was the primary plan (\$2,520).

COB Example 2

	Primary	OSU (if primary)
Allowed Amount	\$2,800	2,800
Deductible	-\$2,800	-\$0
Coinsurance	-\$0	-\$280
Payment	\$0	\$2,520

In this example, as the secondary plan, Ohio State would pay \$2,520, which is the amount Ohio State would pay if it were primary. Ohio State would pay that amount because it is less than the total patient responsibility under the primary plan (\$2,800 deductible).

ITEMIZED BILL

You have the right to receive a copy of an itemized bill. This bill identifies the services and supplies rendered to you. To receive a copy of the bill, send a written request to the provider from which you have received care. It is in your best interest to exercise this right so you have a copy of the bill for your personal files.

LIMITATION OF ACTION

No lawsuit can be brought to recover benefits unless you have complied with the applicable claims and appeals procedures and completed the appeal process. Specifically, you cannot bring a lawsuit until after the date of the decision on final appeal. No such action may be taken later than one year after the time limit for filing claims for the service.

PAYMENT OF CLAIMS

- CoreSource reserves the right to make payments to the provider or directly to you. For a contracting provider, when the provider of service submits the claim to CoreSource the payment will be issued to the provider. If the member submits the claim and the provider is not a contracting provider, then the payment will usually be issued to the member. Payments may not be directed to any other party. When a service has been rendered, CoreSource will not honor a request to withhold payment of the claim.
- If a covered employee dies or becomes mentally incompetent, any benefit owed may be paid to a relative by blood or marriage. CoreSource, on behalf of the university, would provide the benefit to a relative whom it judged to be entitled in fairness to the money. Any such payment would discharge any obligation to the extent of such payment.

MEDICARE

- When you are covered under the university's medical plan and are also eligible for Medicare due to age, you may:
 - Continue your coverage under this medical plan (to the extent you remain eligible) and defer enrollment in Medicare.
 - Continue your coverage under this medical plan and also enroll in Medicare. This medical plan would be your primary medical coverage and Medicare your secondary medical coverage as long as your coverage under this medical plan is attributable to current employment.
 - This medical plan would be your primary medical coverage and Medicare your secondary medical coverage as long as your coverage under this medical plan is attributable to current employment.
 - Drop your coverage under this medical plan and enroll in Medicare.
- If a grandfathered sponsored dependent is Medicare-eligible, he or she must enroll in Medicare coverage.
- The university medical plan will always follow the Medicare primary/secondary rules which are then in effect as determined by the federal government.

SUBROGATION AND REIMBURSEMENT

A covered person may incur medical expenses due to an injury or sickness that may be caused by the act or omission of a third party. Also, a third party (such as an insurance company) may be responsible for payment or agree to compensate a covered person on account of the actions of another person or entity. In such circumstances, the medical plan has a right to subrogation and/or reimbursement, as described below.

CONTINUED ON PAGE 31

MEDICAL CLAIMS PROCESSING

Third Party

For purposes of this section, “third party” means any person, entity or organization that is or may be liable or legally responsible to pay expenses, compensation or damages in connection with a covered person’s injury or sickness. A third party includes, but is not limited to: the party or parties alleged to have caused or that caused the illness or injury or sickness; the insurer, guarantor or other indemnifier of the party or parties alleged to have caused or that caused the illness or injury; a covered person’s own insurer (e.g., automobile, medpay, uninsured/ underinsured motorist, homeowners or other insurance policies); and any other person, entity or organization that is or may be liable or legally responsible for payment in connection with the illness or injury or sickness.

Subrogation Rights

If a third party is or may be responsible for paying the expense of, or agrees to compensate a covered person for, any injury or sickness covered by this medical plan, the medical plan has the right to take the covered person’s place in recovering payments directly from the third party. The medical plan’s right to do this is called its right of subrogation.

Reimbursement Rights

If a covered person receives a settlement or is otherwise compensated by a third party for any injury or sickness covered by this medical plan, the covered person is required to reimburse the medical plan for the payments made by the medical plan. This is called the medical plan’s right of reimbursement.

Amounts Subject to Subrogation and/or Reimbursement

Subject to Section 2323.44 of the Ohio Revised Code:

- All amounts recovered will be subject to subrogation and/or reimbursement.
- In no case will the amount subject to subrogation or reimbursement exceed the amount of benefits paid for the injury or sickness under the medical plan and the expenses incurred by the medical plan in collecting this amount.
- The medical plan has a priority over you and your dependent(s) as to any funds recovered.
- The medical plan has a right to recover in full, regardless of how amounts received from a third party may be characterized and regardless of whether or not the covered person(s) have been made whole.
- The medical plan has a right to recover in full, regardless of whether the amounts received from a third party are paid directly to the covered person, or placed in a trust or structured settlement for the benefit of the covered person.
- The medical plan’s subrogation and reimbursement rights will not be reduced to reflect any cost or attorneys’ fees incurred in obtaining the compensation unless separately agreed to, in writing, by the university in the exercise of its sole discretion.
- If a covered person fails to comply with any of the terms of the medical plan governing subrogation and reimbursement, in addition to any amount the covered person owes to the medical plan for subrogation and/or reimbursement, the covered person will be liable to the medical plan for its reasonable costs to enforce those terms, including but not limited to attorneys’ fees incurred by the medical plan.

Authorization by Covered Person

As a covered person under the medical plan, you agree to all of the terms of the medical plan regarding subrogation and reimbursement, including, but not limited to, the following:

- You agree that the medical plan has rights of subrogation and reimbursement.
- You will promptly refund to the medical plan any amount that is subject to the medical plan’s rights of subrogation and/or reimbursement.
- You, your dependent(s) and representative(s) will cooperate fully to help the medical plan enforce its rights of subrogation and reimbursement, and will not do anything that prejudices or impairs those rights.
- You will provide all information needed under the medical plan to recover the amount of medical or other benefits paid for the injury or sickness under the medical plan and expenses incurred by the medical plan in collecting this amount, and execute and deliver any papers necessary for such recovery.
- The medical plan may reduce any future benefits otherwise available to you and your dependent(s) under the medical plan by the full amount of the compensation received from the third party.
- You understand and agree that the third party may be sued in order to recover the payments made for you under the medical plan.
- You will notify the medical plan of any proposed settlement and obtain the medical plan’s written consent before signing any release or agreeing to any settlement. If a covered person or the covered person’s representative chooses to recover payment from a third party, the covered person or representative must include the amount paid by the medical plan in the requested settlement.

HOSPITALIZATION REVIEW

PRIOR AUTHORIZATION

- Prior authorization (see the Medical Prior Authorization Guide online at osuhealthplan.com/forms-and-downloads) is a determination made by OSU Health Plan of the medical necessity of an inpatient hospital setting and the appropriate length of stay. Authorization must be obtained for every hospital admission. Prior authorization for emergency admissions must be obtained within one business day.
- If the covered person sees a network provider, the network provider is responsible for obtaining the prior authorization.
- If the covered person is enrolled in a non-network medical plan or uses an out-of-network provider, it is his/her responsibility to obtain prior authorization and to inform the providers that he/she is enrolled in a medical plan that has prior authorization¹ requirements.
- In order for OSU Health Plan to conduct a pre-admission review, it must be:
 - Provided with information necessary to make a decision as to the medical necessity of the admission.
 - Informed no later than 10 business days prior to the admission to the hospital, unless the admission is an urgent care admission.
- The hospital, admitting physician, covered person, or any person on the patient's behalf can give notice to OSU Health Plan of a hospital admission.
- When the covered person contacts OSU Health Plan for prior authorization, he/she will need to provide the following information:
 - Name and identification number of the employee
 - Name, address, sex and birth date of the patient
 - Name, address and telephone number of the admitting physician
 - Name, address and telephone number of the admitting hospital
 - Date of proposed admission and reason for the admission.

Failure to Receive Prior Authorization

If OSU Health Plan is not informed of a covered person's hospital admission and prior authorization is not obtained, payment of benefits by CoreSource for eligible hospital expenses may be reduced, denied, or subject to penalties.¹

CONTINUED STAY REVIEW

During a covered person's hospital stay, a continued stay review will be conducted. This review applies to all hospital admissions. The purpose of this review is to:

- Provide OSU Health Plan with an update as to the covered person's condition/progress.
- If necessary, enable OSU Health Plan to re-evaluate the medical necessity of a continued hospital stay.

DISCHARGE PLANNING REVIEW

Review for discharge planning occurs during hospitalization review. The purpose is to:

- Identify patients requiring extended care following discharge.
- Determine the most appropriate setting for continued care, if applicable.

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

COVERAGE CONTINUATION

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 is a federal law commonly referred to as COBRA. COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called coverage continuation) at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to summarize your rights and obligations under the coverage continuation provisions of the law.

Note: COBRA coverage is available to the employee, spouse and eligible dependents if coverage under the medical plan ends.

Employee

If you are an employee covered by the medical plan, you have a right to choose this coverage continuation for up to 18 months if you lose your group health coverage due to:

- Reduction in your hours of employment that affects benefit eligibility; or
- Termination of your employment (for reasons other than gross misconduct on your part).

Coverage may be continued for up to 24 months if you are on a leave of absence for United States uniformed service.

Spouse

If your spouse/grandfathered same-sex domestic partner is covered by the medical plan, he or she has the right to choose this coverage continuation if group health coverage under the medical plan is terminated for any of the following reasons:

- Coverage may be continued for up to 18 months due to:
 - Termination of your employment (for reasons other than gross misconduct); or
 - Reduction in your hours of employment that affects benefit eligibility.
- Coverage may be continued for up to 24 months if you are on a leave of absence for United States uniformed service.
- Coverage may be continued for up to 36 months due to:
 - Death of the covered employee;
 - Divorce, or legal separation; or
 - Termination of your employment (for reasons other than gross misconduct on your part) or reduction in your hours of employment, coupled with your entitlement to Medicare benefits less than 18 months before your termination of employment or reduction in hours of employment. In this case, coverage may be continued for up to 36 months from the date of your Medicare entitlement.

Dependent Child/ Other Eligible Individuals as Defined by the University

In the case of a dependent child or other eligible individual as defined by the university (refer to General Plan Provisions – Eligible Dependents) covered by the medical plan, he or she has the right to choose this coverage continuation if group health coverage under the medical plan is terminated for any of the following reasons:

- Coverage may be continued for up to 18 months due to:
 - Termination of your employment (for reasons other than gross misconduct) or
 - Reduction in your hours of employment that affects benefit eligibility.
- Coverage may be continued for up to 24 months if you are on a leave of absence for United States uniformed service.
- Coverage may be continued for up to 36 months due to:
 - The death of the covered employee;
 - The covered employee's divorce, legal separation, or termination of grandfathered sponsored dependency (university affidavit required);
 - The dependent ceases to meet the eligibility requirements of a dependent as outlined in the General Plan Provisions – Eligible Dependents section; or
 - Termination of your employment (for reasons other than gross misconduct on your part) or reduction in your hours of employment, coupled with your entitlement to Medicare benefits less than 18 months before your termination of employment or reduction in hours of employment. In this case, coverage may be continued for up to 36 months from the date of your Medicare entitlement.

Although your eligible dependents other than your dependent children are not "qualified beneficiaries" for purposes of COBRA, the medical plan extends COBRA-like continuation rights to such dependents that are equivalent to the rights that a dependent child would have under COBRA.

Notification

- The employee or a family member is required to complete a COBRA Election Form, available from CoreSource, for a divorce, legal separation, termination of grandfathered sponsored dependency, or a child ceasing to be an eligible dependent under the medical plan. If such an event occurs, you should notify the medical plan within 60 days of the date the event occurs.
- If such notice is not provided within 60 days, the affected individuals will lose their right to elect coverage continuation under the medical plan with respect to such event.
- When the university is notified that one of these events has happened, or if any other qualifying event occurs, then CoreSource will notify you and your family of the right to choose coverage continuation.

CONTINUED ON PAGE 34

COVERAGE CONTINUATION

Election Period

You have 60 days from the later of (i) the date you lose coverage, as described in the previous section, or (ii) the date CoreSource provides the COBRA notice (i.e. a COBRA Election Form) to you.

Health Coverage

- If you do not elect coverage continuation, your group health coverage will end on the last day of the pay period in which employment or coverage terminates.
- If you elect coverage continuation, your medical plan coverage will continue and will be identical to the same benefit as provided under that plan to similarly situated employees or family members (such as active employees and their dependents).
- You may change your medical plan and/or coverage level during the university's annual open enrollment period or at the time of a qualifying status change.

Disability Extension

- The 18-month coverage continuation period may be extended to 29 months in certain situations involving a disabled individual.
- An extension to 29 months is available if:
 - The event that resulted in the loss of health coverage under the medical plan is the employee's termination of employment or reduction in hours; and
 - The covered person is disabled (as determined by the Social Security Administration) on any day during the first 60 days of COBRA coverage continuation; and
 - The covered person notifies OHR Customer Service Center within 60 days after the later of:
 - (i) The Social Security Administration's determination of disability,
 - (ii) The date of the employee's termination of employment or reduction in hours, or
 - (iii) The date that health coverage would otherwise be lost as a result of such termination or reduction, and before the end of the original 18-month maximum coverage period.

Termination of Coverage Continuation

You are no longer eligible for coverage continuation and may be terminated from the medical plan for any of the following reasons:

- The premium for your coverage continuation is not paid on time. (See the "Payment" section below.)
- After first electing coverage continuation, you become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition.
- After first electing coverage continuation, you become entitled to Medicare.
- You reach the end of your coverage continuation period.
- In the event that you are receiving extended coverage continuation as a result of your being disabled under the Social Security Act, your extended coverage continuation may be terminated by the medical plan on the first day of the month at least 31 days after a final determination that you are no longer disabled. You must notify the medical plan within 31 days of the date of any final determination under the Social Security Act that you are no longer disabled.
- The university no longer provides group health coverage to any of its employees.

Evidence of Insurability (EOI)

It is not necessary for you to show that you are insurable to choose coverage continuation.

Payment

All payments are due by the first day of each month to CoreSource. The full premium for coverage continuation plus an administrative charge must be paid. (Although monthly payments are due on the first day of every month, you will be given a grace period of 30 days to make each monthly payment. If you pay a monthly payment later than the first day of the month, but before the end of the grace period for the coverage period, your coverage may be suspended and then retroactively reinstated when the monthly payment is received. If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to continuation coverage.) The premium for an extended coverage continuation period due to a total disability may be higher than the premium due for the first 18 months.

Changes

Notify CoreSource if there are changes in the following:

- The covered person becomes entitled to other group health coverage or Medicare.
- The Social Security Administration determines the covered person is no longer disabled.
- The covered person's marital status.
- The covered person's home mailing address.

PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program is available to those enrolled in any of the university-sponsored medical plans.

ELIGIBILITY

You must be enrolled in one of the university-sponsored medical plans.

MEDICAL/PRESCRIPTION DRUG ID CARDS

Your medical/prescription drug ID card is combined and will be sent to you from CoreSource. Please visit mycoresource.com if you need replacement or additional cards.

PROGRAM HIGHLIGHTS

- The program offers three main categories of prescription medications:
 - Generic drugs
 - Formulary brand name drugs
 - Non-formulary brand name drugs
- The Express Scripts National Preferred Formulary can be found online at hr.osu.edu/benefits/prescription.
- At the time of your medical visit, you are encouraged to discuss with your health care provider the medical and financial advantages of generic and formulary brand name prescription drugs.
- Prescription drug coverage is provided through the Express Scripts Advantage Network which includes both preferred and non-preferred pharmacies. If you utilize a preferred retail pharmacy, you will receive a greater benefit than at a non-preferred pharmacy. No benefits are payable if you utilize a pharmacy this is not in the Express Scripts Advantage Network. Refer to express-scripts.com or contact Express Scripts for the location of network pharmacies near you. A nationwide toll free number is located on the front of your medical/prescription drug ID card.
- You may also receive your prescription drugs through the mail by using Express Scripts Home Delivery.
- Both the retail and Express Scripts Home Delivery are coordinated for complete service (customer service, prescription profile and annual out-of-pocket charges). The program also provides for the monitoring of your prescriptions for potential drug interactions and improper drug dosing through a drug utilization review program.

ANNUAL OUT-OF-POCKET MAXIMUM

The annual out-of-pocket maximum is the maximum total amount each covered person or family pays toward covered prescription drug costs in a plan year. Once this limit is met, no more prescription drug member cost share is required for the remainder of the plan year, except as indicated below. Refer to the Prescription Drug Program – Benefit Summary section of this booklet for details.

- Infertility and erectile dysfunction and hypoactive sexual desire disorder medications are excluded from this limit.
- Any medication paid for out-of-pocket that is not covered by the medical or prescription drug program is excluded from this limit.
- The Prescription Drug Program annual out-of-pocket maximum is separate from your medical plan limits.

ANNUAL DEDUCTIBLE

The annual deductible for prescription drug purchases for Prime Care Advantage, Prime Care Choice and the Out-of-Area Plan is \$50 per person, \$100 per family per plan year. These are separate from your medical plan's annual deductible. There is no annual deductible for prescription drug purchases for Prime Care Connect.

COORDINATION OF BENEFITS (COB)

There is no coordination of pharmacy benefits. This prescription drug program does not cover prescription drugs as a secondary payer.

COVERED DRUGS

- Covered drugs are medications that require a prescription under federal law and are approved for general use by the Food and Drug Administration. Prescription drugs must be dispensed for your outpatient use by a licensed pharmacy on or after your coverage effective date.
- Covered over-the-counter (OTC) drugs require a prescription for coverage under the Prescription Drug Program and must be dispensed for your outpatient use by a licensed pharmacy on or after your coverage effective date.
- The administration of prescription drugs is not covered under the Prescription Drug Program, with the exception of certain vaccines via the Express Scripts Retail Vaccination Program. The administration of covered and non-covered prescription drugs may be covered under your university medical plan.

Note: Under Ohio law, Naloxone may be dispensed to you for use by an individual who there is reason to believe is at risk of experiencing an opioid-related overdose. In that case, the Naloxone will be treated as being dispensed for your outpatient use under the Prescription Drug Program.

COVERED PERSON'S RESPONSIBILITIES

For the program to work effectively, there are certain procedures, which you, as a covered person, must follow. In general, when receiving prescription drugs:

- If a generic medication is not available or appropriate for your condition, you should discuss formulary options with your health care provider while referring to a copy of the Express Scripts National Preferred Formulary, available online at hr.osu.edu/benefits/prescription.

CONTINUED ON PAGE 36

PRESCRIPTION DRUG PROGRAM

- Present your medical/prescription drug ID card to the pharmacist at participating retail pharmacies. You may also contact Express Scripts directly for the location of the nearest Express Advantage Network pharmacy in the area, or search online at express-scripts.com.

FORMULARY

The Express Scripts National Preferred Formulary is a list of medications that are chosen based on comparative clinical effectiveness, safety profiles and opportunities to help contain costs. The formulary list used by the university's Prescription Drug Program is available online at hr.osu.edu/benefits/prescription.

- Certain medications are excluded from coverage and will be subject to the full retail price. A list of medications excluded under the Prescription Drug Program are available on the Express Scripts National Preferred Formulary list online at hr.osu.edu/benefits/prescription.

GENERIC DRUGS

Network pharmacies will dispense a generic equivalent drug whenever possible. Generic drugs, like brand name drugs, are federally controlled to meet the same standards of composition, safety, strength, purity and quality. If you receive a generic drug, you may pay a lower amount than if the prescribed drug is on the Express Scripts National Preferred Formulary.

EXPRESS SCRIPTS HOME DELIVERY (EXCLUDES SPECIALTY MEDICATIONS)

With the convenience of home delivery, members taking maintenance medications may receive a 90-day supply of medication per prescription. Maintenance medications can include those that are used for birth control, hormone replacement therapy, or to treat asthma, diabetes, high blood pressure, or any chronic health condition. The prescription is sent to the Express Scripts Home Delivery service where it is subject to the same monitoring parameters as in a local (or retail) pharmacy. The filled prescription is then mailed to you.

ERECTILE DYSFUNCTION MEDICATIONS

- Covered erectile dysfunction drugs (brand or generic) are subject to a 50% coinsurance with no maximum.
- The prescription drug program annual out-of-pocket maximum does not apply to erectile dysfunction drugs.

INFERTILITY MEDICATIONS

Infertility medications are subject to the following conditions:

- Excluded from the Prescription Drug Program's maximum copay for formulary/non-formulary medications.
- Excluded from the Prescription Drug Program's annual out-of-pocket maximum.
- Subject to the Infertility Lifetime Benefit Limit (see Maximum Benefit Limits as defined under the How Payment Is Determined section of this booklet).

LOW-COST GENERIC DRUG PROGRAM

Low-Cost Generic Drugs (Home Delivery): A limited list of generic maintenance medications is available through Express Scripts home delivery at a cost of \$10 per 90 day supply. The Low-Cost Generic Drug Program details and drug list can be found at hr.osu.edu/benefits/prescription.

OUT-OF-NETWORK PHARMACY

Prescriptions filled at out-of-network pharmacies are not covered unless they are approved by OSU Health Plan due to an emergency situation. For more information, contact OSU Health Plan.

PHARMACY BENEFIT MANAGER

Express Scripts is the university's pharmacy benefit manager. Express Scripts processes prescription drug claims and provides prior authorization for certain medications.

PRIOR AUTHORIZATION

Your Prescription Drug Program provides coverage for some medications only if they are prescribed for certain uses. For this reason, some medications must receive prior authorization before the drugs can be covered under your plan. If your prescription drug is not approved for coverage under the prescription drug program, you will be responsible for paying the full cost of the medication. For a current list of medications requiring prior authorization, refer online to hr.osu.edu/benefits/prescription or contact OSU Health Plan.

QUANTITY LEVEL LIMITS (QLL)

Some medications have quantity level limits allowing coverage for an amount of medication consistent with the prescription drug plan's intent for the benefit.

STEP THERAPY

Step Therapy is an authorization review program which requires initial utilization of clinically sound and cost-effective treatment options before more expensive medications are covered. If a medication is prescribed that does not meet the step therapy criteria, it may not be covered. Individuals should always consult with their physician about an alternative therapy. For a current list of therapeutic categories and/or medications subject to step therapy refer to hr.osu.edu/benefits/prescription or contact OSU Health Plan at 614-292-4700.

CONTINUED ON PAGE 37

PRESCRIPTION DRUG PROGRAM

VALUE BASED DRUG PLAN

Faculty, staff and their dependents who use a preferred pharmacy within the Express Scripts Advantage Network and actively participate in ongoing calls with a Care Coordinator (refer to osuhealthplan.com/members/care-coordination) for management of asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart disease (coronary artery disease or congestive heart failure) are eligible for the Value-Based Drug Plan. This benefit will reduce or eliminate the cost of the prescription medications taken specifically to treat these chronic conditions. By participating in the Care Coordination Program, the copay for certain generic drugs taken to treat the chronic condition will be waived and the coinsurance amount for certain formulary brand-name drugs taken to treat the chronic condition will reduce by 50%. If a member chooses not to use a preferred pharmacy or not to participate in the Care Coordination Program they will not be eligible for the Value-Based Drug Plan. Members must also use a preferred pharmacy within the Express Scripts Advantage Network in order to receive the Value-Based Drug Plan benefit. Visit osuhealthplan.com/members/care-coordination to learn more about the Care Coordination Program.

For More Information

Express Scripts' contact information is listed on the front of your medical/prescription drug ID card and the first page of this document.

FILING A CLAIM

Claim Forms

- Claim forms are available online at osuhealthplan.com/forms-and-downloads.
- Claim forms must be filled out completely and mailed to the address provided on the form.

Initial Claim

All claims must be submitted within 12 months from the incurred date of service. In certain cases the plan may require you to obtain prior authorization for some medications (refer to osuhealthplan.com/forms-and-downloads) for a complete list of medications requiring prior authorization).

Notice of Determination – If your claim is wholly or partially denied, you will receive a written notice of the decision that will generally contain:

- Specific reasons for the claim's denial (including denial codes, as required);
 - A description of additional material or information necessary for you to perfect your claim and an explanation of why such information is necessary;
 - Specific references to pertinent plan provisions;
 - A statement of your right to request an external review and a description of the plan's internal appeals and external review procedures, including your right to request an expedited internal and/or external review in certain circumstances; and
 - The availability of, and contact information for, the Ohio Department of Insurance.
- In addition, if an internal rule, guideline or protocol was relied on in making the benefit determination, or if the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, an explanation of such rule or protocol, or the scientific or clinical judgment used in the determination will be provided in the notice.

Time Frame for Notification – You will be notified of the decision on appeal within certain timeframes established by law. Refer to the Appendix at the end of this booklet titled "Claims Determination and Appeals Procedures" for additional details.

APPEAL PROCEDURE

If your claim is denied and you wish to have your claim reconsidered, you (or your representative) may appeal. Your appeal must be received in writing within 180 days after the initial determination. You may submit additional comments, records and documents related to your claim. You may also, upon request and at no charge, review copies of the documents and information relevant to your claim. The person who decides the appeal will not be the same individual who decided the claim (or a subordinate of that individual).

Notice of Determination – Notice of the decision will be in writing and will include generally that information detailed above for your initial claim, as it relates to your appeal.

Time Frame for Notification – You will be notified of the decision on appeal within certain timeframes established by law. Refer to the Appendix at the end of this booklet titled "Claims Determination and Appeals Procedures" for additional details.

Second-Level Appeal – For post-service claims, if your claim is denied on the first appeal, you may ask for a second review. A request for a second review must be submitted, in writing, within 60 days after the date the claim is denied on the first appeal. Additional comments, documents or other information relating to your claim should also be submitted. You will be notified of a decision on your second appeal within 30 days.

External Review – If your appeal is denied, you may be entitled to an independent external review of the denial. External review is generally limited to denied appeals for medical benefits that involve medical judgment (e.g., medical necessity or a determination of whether a treatment is experimental or investigational). You must request an external review in writing (electronically or verbally if an expedited review) within 180 days after the notice on appeal. You must generally exhaust (or be deemed to have exhausted) the plan's internal claims appeals procedures to be eligible for an external review. You may be eligible for an expedited external review if the denial could seriously jeopardize your life or health. The assigned independent review organization must provide written notice of its decision within 30 days after request for a standard review, or within 72 hours for an expedited review.

FOR MORE INFORMATION

The above information provides only a summary of the plan's internal claims and appeals and external review procedures. To review the complete internal claims and appeals and external review procedures refer to the Appendix at the the end of this booklet titled "Claim Determination and Appeals Procedures."

CONTINUED ON PAGE 38

PRESCRIPTION DRUG PROGRAM

PRESCRIPTION DRUG EXCLUSIONS

Allergens	Allergy shots
Compound Medications	Are not covered if the product lacks documented clinical evidence and FDA approval for use within compounds
Cosmetic Drugs	Photo-aged skin products Hair growth products (e.g., Propecia) Injectable cosmetics (e.g., Botox Cosmetic) Topical treatment products for Onychomycosis (toe nail fungus) Depigmentation products (e.g., Lustra-AF, Glyquin/XM, Alphaquin HP, Solaquin Forte)
Erectile Dysfunction Drugs	Yohimbine
Durable Medical Equipment	e.g., Wheelchairs, crutches, nebulizers, peak flow meters, ostomy supplies
Diabetic Supplies	e.g., Glucowatch, Pump Supplies, Alcohol Swabs
Legend Vitamins	Legend multivitamins and supplemental agents with OTC equiv. (e.g., Nephrocaps, Biotin)
Legend Homeopathic Drugs	e.g., Psorzide Ultra, Vertigoheel
Hemophilia Products	e.g., Recombinate
Miscellaneous Exclusions	Medical products and medical supplies
Schedule 1 Drugs	e.g., medical marijuana
Non-Sedating Antihistamines	e.g., Clarinex and Xyzal
OTC Equivalents	e.g., Hydrocortisone 1% cream, Mentax, Ranitidine 150mg
OTC Products	Except insulin, certain diabetic supplies, Nexium 24HR and certain OTC preventive medications (see: hr.osu.edu/benefits/RxPreventiveNo-Cost.pdf for a list of Preventive Medications and Devices, some of which are OTC and available with no out-of-pocket costs)

Certain other restrictions may apply. Contact Express Scripts for additional information.

NETWORK PHARMACIES

The complete pharmacy directory is available online at Express-Scripts.com, where it is regularly updated.

PRESCRIPTION DRUG – SCHEDULE OF BENEFITS

EFFECTIVE JANUARY 1 – DECEMBER 31, 2019

PRESCRIPTION DRUG PLAN

	PRIME CARE ADVANTAGE			PRIME CARE CONNECT		
	PRIME CARE CHOICE					
	OUT OF AREA PLAN					
Annual Out-of-Pocket Maximum ¹	\$2,500 per person, \$5,000 per family			\$2,000 per person, \$4,000 per family		
Deductible ²	\$50 per person, \$100 per family			No deductible		
	Preferred Pharmacy	Non-Preferred Pharmacy	Home Delivery or Retail ⁹⁰ Pharmacy ³	Preferred Pharmacy	Non-Preferred Pharmacy	Home Delivery or Retail ⁹⁰ Pharmacy ³
Supply Limitations	30-day supply	30-day supply	90-day supply	30-day supply	30-day supply	90-day supply
Generic Drug	\$10 copay	\$20 copay	\$25 copay	\$8 copay	\$18 copay	\$20 copay
Formulary Brand Name Drug	30% coinsurance, up to \$100	35% coinsurance, up to \$110	30% coinsurance, up to \$250	30% coinsurance, up to \$40	35% coinsurance, up to \$50	30% coinsurance, up to \$100
Non-Formulary Brand Name Drug	50% coinsurance, no maximum	55% coinsurance, no maximum	50% coinsurance, no maximum	50% coinsurance, no maximum	55% coinsurance, no maximum	50% coinsurance, no maximum

VALUE BASED DRUG PLAN^{4, 5, 6}

	PRIME CARE ADVANTAGE		PRIME CARE CONNECT	
	PRIME CARE CHOICE			
	OUT OF AREA PLAN			
	Preferred Pharmacy	Home Delivery or Retail ⁹⁰ Pharmacy ³	Preferred Pharmacy	Home Delivery or Retail ⁹⁰ Pharmacy ³
Supply Limitations	30-day supply	90-day supply	30-day supply	90-day supply
Generic Drug	\$0	\$0	\$0	\$0
Formulary Brand Name Drug	15% coinsurance, up to \$50	15% coinsurance, up to \$125	15% coinsurance, up to \$20	15% coinsurance, up to \$50
Non-Formulary Brand Name Drug	50% coinsurance, no maximum	50% coinsurance, no maximum	50% coinsurance, no maximum	50% coinsurance, no maximum

SPECIALTY MEDICATION PLAN

FEATURE	RETAIL DELIVERY	OSUWMC PHARMACY AND ACCREDO
Supply Limitations	30-day supply	
Generic Drug	Not Available	20% coinsurance, up to \$50
Formulary Brand Name Drug		20% coinsurance, up to \$100
Non-Formulary Brand Name Drug		50% coinsurance, no maximum

INFERTILITY MEDICATION PLAN^{7, 8, 9, 10}

FEATURE	RETAIL DELIVERY	HOME DELIVERY
Lifetime Maximum Benefit	\$15,000	
Supply Limitations	30-day supply	
Generic Drug	20% coinsurance, up to \$50	20% coinsurance, up to \$50
Formulary Brand Name Drug	30% coinsurance, no maximum	30% coinsurance, no maximum
Non-Formulary Brand Name Drug	50% coinsurance, no maximum	50% coinsurance, no maximum

¹ The Prescription Drug Program annual out-of-pocket maximum is based on plan enrollment and is separate from the medical plan annual out-of-pocket maximum.

² The deductible applies to brand name medications only.

CONTINUED ON PAGE 40

PRESCRIPTION DRUG – SCHEDULE OF BENEFITS

- 3 Retail90, also known as Smart90, is Express Scripts' program which allows individuals to fill their prescriptions for up to a 90-day supply via select retail pharmacies.
- 4 The Value-Based Drug Plan eligibility is based on actively participating in the Care Coordination Program for management of specific chronic conditions (asthma, chronic obstructive pulmonary disease (COPD), diabetes, and heart disease). Visit yp4h.osu.edu to learn more about the Care Coordination Program.
- 5 Non-Formulary Brand Name Drugs are not eligible for the Value-Based Drug Plan.
- 6 The Value-Based Drug Plan is not available at Non-Preferred Pharmacies.
- 7 The infertility treatment medical benefit includes the cost of prescription medications and requires prior authorization from OSU Health Plan.
- 8 The Prescription Drug Program annual out-of-pocket maximum does not apply to infertility medications.
- 9 Infertility treatment has a separate lifetime maximum benefit.
- 10 The infertility drug coinsurance does not have a maximum coinsurance per prescription for formulary and non-formulary brand name medications.

Note: The Prescription Drug Plan, Value-Based Drug Plan and Specialty Medication Plan designs have a combined deductible and annual out-of-pocket maximum.

PREVENTIVE DRUG LIST

DRUG CATEGORY	ELIGIBILITY CRITERIA
Aspirin for cardiovascular disease	Men age 45 to 79 years AND Women age 55 to 79 years
Aspirin for preeclampsia	Women of child-bearing years, who are at increased risk of preeclampsia after 12 weeks gestation
Oral fluoride supplementation	Children from birth through 5 years old
Iron supplementation in children	Children from birth to 12 months of age
Folic acid supplementation	All women planning or capable of pregnancy
Breast cancer prevention	Subject to prior authorization: <ul style="list-style-type: none"> • Tamoxifen (generic) • Raloxifene (generic) • Soltamox (Tamoxifen liquid) (brand)
Vaccines	See osuhealthplan.com/forms-and-downloads
Bowel Preparations	Certain bowel preparation agents for screening colonoscopy for men and women ages 50 to 75 years
Statin drugs for the primary prevention of cardiovascular disease	Low- to moderate-dose statins for men and women age 40-75 years. These medications include: <ul style="list-style-type: none"> • atorvastatin • Fluvastatin IR and XL • Lovastatin • Pravastatin • Simvastatin • Rosuvastatin

WOMEN'S HEALTH/CONTRACEPTIVE COVERAGE

DRUG/ DEVICE CATEGORY	ELIGIBILITY CRITERIA
At least one form of women's contraception in each of the 18 "methods" of contraception outlined in the FDA birth control guide. See osuhealthplan.com/forms-and-downloads .	Women only. No age restriction.

TOBACCO CESSATION COVERAGE

DRUG CATEGORY	ELIGIBILITY CRITERIA
Prescription and Over-the-Counter products with a physician prescription	Men and women age 18 and older.

PRIME CARE ADVANTAGE

ELIGIBLE EMPLOYMENT

- University faculty and staff with eligible appointments.
- University affiliated group employees with eligible appointments at:
 - Central Ohio Technical College (COTC)
 - Ohio State University Physicians, Inc. (OSUP)

ENROLLMENT

Refer to the General Provisions – Enrollment section of this booklet for detail. To enroll in this option, use eBenefits online at eprofile.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms.

ENROLLMENT CHANGES

Refer to the General Provisions – Change in Coverage Due to a Qualifying Status Change section of this booklet.

COVERAGE ACCESS OUTSIDE OHIO

Access to out-of-area coverage is available with special application (online at hr.osu.edu/policies-forms see Out-of-Area Benefit Election Form) to individuals enrolled in Prime Care Advantage who will reside outside Ohio for at least 30 consecutive days. Benefits for medical services received outside of Ohio while on approved out-of-area coverage will be paid in accordance with the Out-of-Area Plan. Examples of circumstances to enroll are:

- You have a dependent child who does not live with you and resides outside Ohio
- You have a dependent who is enrolled in a college outside Ohio
- You will be outside Ohio on an approved leave of absence or an approved professional leave
- You will be outside Ohio during an off-duty term if you have a nine-month appointment and receive compensation and benefits over a 12-month period

Note: When seeking care outside Ohio or the United States, use Ohio State Travel Assistance. Refer to the Ohio State Travel Assistance section of this booklet for details.

CONTRIBUTION

The current contribution rates are available online at hr.osu.edu/benefits/rates.

COVERED PERSON'S RESPONSIBILITIES

For the medical plan to work effectively, you must follow these procedures, when appropriate:

- Coordinate all medical care with your primary care physician.
- Confirm that all providers (physicians, labs, etc.), including those to whom you are referred, are participating statewide network providers in order to ensure coverage under the medical plan.
- Present your medical/prescription drug ID card to the provider before receiving medical services.
- Notify OSU Health Plan if a physician admits you to a hospital.
- Request prior authorization¹ of benefits before receipt of certain designated services or elective admission to a hospital or facility.

SPECIAL POINTS TO CONSIDER WHEN USING YOUR PLAN

- When receiving medical services it is important to understand that:
 - There are no benefits if services are rendered outside the statewide network (except for emergency care services and except as described above in "Coverage Access Outside Ohio").
 - All medical treatment should be coordinated through your physician.
- Some services are fully covered while other services require a deductible, coinsurance, or both. When receiving covered services within the network, simply present your medical/prescription drug ID card to your medical service provider.
- This medical plan requires the use of a statewide network of providers.
 - When seeking medical care inside Franklin County, the OSU Health Plan network of physicians and facilities must be used. A current list of plan providers is available online at osuhealthplan.com/search or by contacting OSU Health Plan at 614-292-4700.
 - When seeking medical care outside Franklin County, the Ohio PPO Connect network of physicians and facilities must be used. A current list of plan providers is available online at osuhealthplan.com/search or by contacting OSU Health Plan at 614-292-4700.
 - If you are traveling outside Ohio or the United States and require emergency medical care and use Ohio State Travel Assistance services for assistance in receiving emergency medical care. Refer to the Ohio State Travel Assistance section of this booklet for detail.

CONTINUED ON PAGE 42

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE ADVANTAGE

PROVIDER SELECTION

The provider network is available online at osuhealthplan.com/search, where it is updated regularly.

Referrals to Specialists

While you may schedule an appointment directly with a network specialist, some specialists may require a referral from your primary care physician before making an appointment. Your physician should refer you to a specialist within the network, unless the care you need is not available within the network. If your physician refers you to a provider outside the network, it is your responsibility to obtain authorization in advance from OSU Health Plan at 614-292-4700. If your authorization is approved, your medical care covered services will be paid according to the network benefit.

Note: Following emergency or specialist care, you should notify your primary care physician in order to keep him/her informed of your medical condition.

HOW PAYMENT IS DETERMINED

Refer to How Payment is Determined, Exclusions or Limitations and Prime Care Advantage – Schedule of Benefits sections of this booklet for details.

Network

Payments for covered services are based upon the network provider's fee schedule. You are not responsible for any balance in excess of the network provider's fee schedule. In other words, covered services obtained from network providers are not subject to balance billing.

Urgent Care

- Payment for covered urgent care services received from network urgent care providers will be based upon the contracted or network provider's fee schedule. You are not responsible for any balance in excess of the network provider's fee schedule.
- Urgent care is not intended for preventive or routine maintenance treatment, such as school or annual physicals, and these types of services will not be covered when received from an urgent care provider.
- Services received from an out-of-network urgent care provider in Ohio will not be covered.
- Urgent care received outside of Ohio will be paid at the network benefit.

Emergency Care

Payments for covered emergency care services are based on the deductible and coinsurance shown on the Schedule of Benefits in this section.

PRIME CARE ADVANTAGE – SCHEDULE OF BENEFITS

Annual Deductible:	
Individual:	\$450 per person
Family:	\$900 per family
Prescription Drug Program:	A separate deductible of \$50 per person, \$100 per family
Infertility:	A separate deductible of \$1,000 per person, excludes prescription drugs
Annual Out-of-Pocket Maximum:	Excludes infertility treatment, Weight Management Programs and non-prior authorization penalty
Individual:	\$2,600 per person
Family:	\$5,200 per family
Prescription Drug Program:	A separate limit of \$2,500 per person, \$5,000 per family applies; see program description
Maximum Benefits:	
Lifetime:	No limit, except as noted for specific benefits
Infertility:	\$15,000 lifetime maximum benefit per person, includes prescription drugs used for infertility treatment
Temporomandibular Disorder (TMD)	\$3,000 lifetime maximum benefit per person for all non-surgical TMD covered services
Acupuncture Services and Chiropractic Care:	Paid at 80% of network fee schedule after annual deductible; up to a combined maximum benefit of \$2,000 per plan year
Ambulance Services:	Paid at 80% of network fee schedule after annual deductible, when medically necessary
Behavioral Health Services:	Prior authorization ¹ is required for inpatient and facility-based behavioral health services
Mental Health and Substance Abuse – Inpatient:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Mental Health and Substance Abuse – Outpatient:	Paid at 80% of network fee schedule no annual deductible
Chiropractic Care and Acupuncture Services:	Paid at 80% of network fee schedule after annual deductible; up to a combined maximum benefit of \$2,000 per plan year
Diabetes Education	Paid at 80% of network fee schedule after annual deductible; no prior authorization
Emergency Room Visits:	Paid at 80% of network fee schedule after annual deductible
Extended Care Facility Services:	Paid at 80% of network fee schedule after annual deductible; limit of up to 60 days per plan year; prior authorization ¹ required
GYN Examination:	One preventive exam per plan year paid at 100% of network fee schedule, no annual deductible; additional diagnostic exams paid at 80% of network fee schedule after annual deductible
Hearing Aids:	Paid at 80% of the billed amount after annual deductible, for up to \$1,200 in total benefits; every four (4) plan years; no network provider restrictions
Hearing Test (Audiometry):	Per guidelines under the Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines and as medically necessary for suspected hearing loss; charts found at osuhealthplan.com/forms-and-downloads
Ear Molds for Hearing Aids:	Paid at 80% of the billed amount after annual deductible, every four (4) plan years, as part of the \$1,200 total benefit. Note: For dependents up to age 12, ear molds that are medically necessary due to growth are paid at 80% of the billed amount after annual deductible and are not subject to the \$1,200 maximum benefit
Home Health Care Services:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Hospice Care:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required

CONTINUED ON PAGE 44

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE ADVANTAGE – SCHEDULE OF BENEFITS

Hospitalization:	
Hospital Charges:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Physician, Surgeon and Consultation Charges:	Paid at 80% of network fee schedule after annual deductible
Human Organ Transplants:	
Hospital Charges:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Physician, Surgeon and Consultation Charges:	Paid at 80% of network fee schedule after annual deductible
Immunizations	Paid at 100% of the network fee schedule, no annual deductible; per OSU Health Plan guidelines
Infertility Treatment:	Paid at 50% of network fee schedule after separate \$1,000 annual deductible and following diagnosis by a network OB/GYN; subject to OSU Health Plan guidelines (contact OSU Health Plan for details); \$15,000 lifetime maximum benefit includes any prescription drugs used for the treatment of infertility; expenses excluded from annual out-of-pocket maximum; benefit applies to an enrolled employee or spouse; requires prior authorization. ¹
Laboratory Services:	
Inpatient:	Paid at 80% of network fee schedule after annual deductible
Outpatient:	Paid at 80% of network fee schedule after annual deductible
Maternity Services:	
Inpatient:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Professional Services:	Paid at 80% of network fee schedule after annual deductible
Medical Equipment and Supplies:	Paid at 80% of network fee schedule after annual deductible; expenses over \$2,000 require prior authorization ¹
Medications, Outpatient:	Paid at 80% of network fee schedule after annual deductible; for injectable/oral/intravenous (includes chemotherapy) medications dispensed on an outpatient (e.g., providers' office) basis
Medications – Specialty:	Paid at 80% of network fee schedule after annual deductible; specialty medications for certain conditions are not covered under the medical plans, but are covered under the Prescription Drug Program. See: hr.osu.edu/benefits/prescription
Nutritional Services:	
Visit 1 – 3:	Paid at 100% of network fee schedule no annual deductible
Visit 4 – 6:	Paid at 80% of network fee schedule after annual deductible
Occupational Therapy and Physical Therapy, Outpatient:	Paid at 80% of network fee schedule after annual deductible; combined maximum of 45 visits per plan

CONTINUED ON PAGE 45

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE ADVANTAGE – SCHEDULE OF BENEFITS

<p>Office Visits: (includes surgical procedures performed in the office)</p> <p>(excludes lab and x-ray):</p>	<ul style="list-style-type: none"> • Paid at 100% of network fee schedule no annual deductible per visit for a Primary Care Provider (PCP). A PCP is a generalist physician who is designated as a family medicine, general internal medicine, geriatric medicine or general pediatrics provider. This includes primary care services provided by a Primary Care Nurse Practitioner who practices with a PCP, visits to University Health Connection, and Convenient Care Clinics. • Paid at 80% of network fee schedule after annual deductible – All other providers excluding behavioral health • Paid at 80% of network fee schedule per visit for Behavioral Health Services, no annual deductible <p>A list of providers is available online at osuhealthplan.com/search</p>
<p>Outpatient Services:</p>	<p>See descriptions of covered services for Office Visits, Behavioral Health, Laboratory Services, Occupational Therapy, Physical Therapy, Speech Therapy and Surgical Procedures</p>
<p>Preventive Health Care: (Physical Examinations)</p>	<p>Paid at 100% of network fee schedule no annual deductible; includes related laboratory tests, per Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines; charts found at osuhealthplan.com/forms-and-downloads</p> <p>Note: One physical examination per plan year provided for adults</p>
<p>Physical Therapy and Occupational Therapy:</p>	<p>Paid at 80% of network fee schedule after annual deductible; combined maximum of 45 visits per plan year</p>
<p>Pre-Admission Testing:</p>	<p>Paid at 80% of network fee schedule after annual deductible</p>
<p>Prescription Drugs:</p>	<p>See the “Prescription Drug Program” section of this booklet</p>
<p>Procedures, Outpatient:</p>	<p>Paid at 80% of network fee schedule after annual deductible</p>
<p>Prosthetic Devices:</p>	<p>Paid at 80% of network fee schedule after annual deductible; expenses over \$2,000 require prior authorization¹</p>
<p>Radiology Outpatient (X-ray Services):</p>	<p>Paid at 80% of network fee schedule after annual deductible</p>
<p>Speech Therapy, Outpatient:</p>	<p>Paid at 80% of network fee schedule after annual deductible; limited to 20 visits per plan year</p>
<p>Surgery, Outpatient:</p>	<p>Paid at 80% of network fee schedule after annual deductible; subject to OSU Health Plan guidelines (osuhealthplan.com/forms-and-downloads)</p>
<p>Surgical Services, Second Opinion:</p>	<p>Paid at 80% of network fee schedule, after annual deductible</p>
<p>Temporomandibular Disorder (TMD):</p>	<p>Paid at 80% of network fee schedule after annual deductible; subject to a lifetime maximum of \$3,000 for all non-surgical TMD covered services</p>
<p>Tobacco Cessation:</p>	<p>Tobacco cessation services are covered through the university medical plans. Services are paid at 100% no annual deductible. Over-the-counter nicotine replacement therapy (NRT) and prescription cessation medications (e.g. Chantix) are paid at 100% through the Prescription Drug Program. A prescription must be obtained from a physician or nurse practitioner for all tobacco cessation products. Free cessation services can be obtained through Health Coaching at OSU Health Plan.</p>
<p>Urgent Care Services:</p> <p>In Ohio:</p> <p>Outside Ohio:</p>	<p>Paid at 80% of network fee schedule, no annual deductible; limited to network providers</p> <p>Paid at 80% of network fee schedule no annual deductible; no network restriction.</p>
<p>Weight Management Programs:</p>	<p>Hospital-based/Physician-directed programs and Weight Watchers™ programs have a combined maximum benefit of \$1,000 per plan year; expenses excluded from annual out-of-pocket maximum</p>
<p>Hospital-based/Physician-directed Program</p>	<p>50% of reimbursement of approved billed charges no annual deductible, up to a combined maximum benefit of \$1,000 per plan year</p>
<p>Weight Watchers™</p>	<p>50% reimbursement for Online Plus and the Meetings Program no annual deductible; up to a combined maximum benefit of \$1,000 per plan year</p> <p>Note: The reimbursement is applied to the month-to-month membership. Membership can be canceled at any time. For more information, or to join, visit go.osu.edu/weightwatchers</p>

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE CHOICE

ELIGIBLE EMPLOYMENT

- University faculty and staff with eligible appointments.
- University affiliated group employees with eligible appointments at:
 - Central Ohio Technical College (COTC)
 - Ohio State University Physicians, Inc. (OSUP)

ENROLLMENT

Refer to the General Provisions – Enrollment section of this booklet for detail. To enroll in this option, use eBenefits online at eprofile.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms.

Enrollment Changes

Refer to the General Provisions – Change in Coverage Due to a Qualifying Status Change section of this booklet.

COVERAGE ACCESS OUTSIDE OHIO

Access to out-of-area coverage is available with special application (online at hr.osu.edu/policies-forms see Out-of-Area Benefit Election Form) to individuals enrolled in Prime Care Choice who will be outside Ohio for at least 30 consecutive days. Benefits for medical services received outside of Ohio while on approved out-of-area coverage will be paid in accordance with the Out-of-Area Plan. Examples of circumstances to enroll are:

- You have a dependent child who does not live with you and resides outside Ohio
- You have a dependent who is enrolled in a college outside Ohio
- You will be outside Ohio on an approved leave of absence or an approved professional leave
- You will be outside Ohio during an off-duty term if you have a nine-month appointment and receive compensation and benefits over a 12-month period.

Note: When seeking care outside Ohio or the United States, use Ohio State Travel Assistance services. Refer to the Ohio State Travel Assistance section of this booklet for details.

CONTRIBUTION

The current contribution rates are available online at hr.osu.edu/benefits/rates.

PRIME CARE CHOICE – NETWORK SERVICES

COVERED PERSON'S RESPONSIBILITIES

For the medical plan to work effectively, you must follow these procedures, when appropriate:

- Coordinate all medical care with your primary physician.
- Confirm that all providers (physicians, labs, etc.), including those to whom you are referred, are participating statewide network providers in order to ensure coverage under the medical plan.
- Present your medical/prescription drug ID card to the provider before receiving medical services.
- Notify OSU Health Plan if a physician admits you to a hospital.
- Request prior authorization¹ for benefits before receipt of specific services or elective admission to a hospital or facility.

SPECIAL POINTS TO CONSIDER WHEN USING YOUR PLAN

When receiving medical services it is important to understand that:

- Some services are fully covered while other services require a deductible, coinsurance or both. When receiving covered services within the network, simply present your medical/prescription drug ID card.
- In order to receive the network-benefit level, you must use network providers.
 - When seeking network medical care inside Franklin County, the OSU Health Plan network of physicians and facilities must be used. A current list of network plan providers is available online at osuhealthplan.com/search or by contacting OSU Health Plan at 614-292-4700.
 - When seeking medical care outside Franklin County, the Ohio PPO Connect network of physicians and facilities must be used. A current list of network plan providers is available online at osuhealthplan.com/search or by contacting OSU Health Plan at 614-292-4700.
 - If you are traveling outside Ohio or the United States and require emergency medical care, use the Ohio State Travel Assistance services for assistance in receiving emergency medical care. Refer to Ohio State Travel Assistance section of this booklet for details.

PROVIDER SELECTION

You may select any physician from the statewide network listing, available online at osuhealthplan.com/search.

Referrals to Specialists

While you may schedule an appointment directly with a network specialist, some specialists may require a referral from your primary care physician before making an appointment. Your physician should refer you to a specialist within the network, unless the care you need is not available within the network. If your physician refers you to a provider outside the network, it is your responsibility to obtain authorization in advance from OSU Health Plan by calling 614-292-4700. If approved, your medical care covered services will be paid according to the network benefit.

Note: Following emergency or specialist care, you should notify your physician in order to keep him/her informed of your medical condition.

HOW PAYMENT IS DETERMINED

Payments for network covered services will be based upon the network fee schedule. You are not responsible for any balance in excess of the network fee schedule. In other words, covered services obtained from network providers are not subject to balance billing. Refer to the How Payment is Determined, Exclusions or Limitations, Prime Care Choice Network – Schedule of Benefits sections of this booklet for details.

Urgent Care

- Payments for covered urgent care services received from network urgent care providers will be based upon the contracted or network provider's fee schedule. You are not responsible for any balance in excess of the network provider's fee schedule subject to applicable deductible and coinsurance.
- Services received from an out-of-network, urgent care provider in Ohio will be covered at the out-of-network benefit level. The provider network is available online at osuhealthplan.com/search,
- Urgent care received outside of Ohio will be paid at the network benefit level.
- Urgent care is not intended for preventive or routine maintenance treatment such as school or annual physicals and will not be covered when received from an urgent care provider.

Emergency Care

Payments for covered emergency care services are based on the deductible and coinsurance shown on the Schedule of Benefits in this section.

PRIME CARE CHOICE NETWORK – SCHEDULE OF BENEFITS

Annual Deductible:	
Individual:	\$950 per person
Family:	\$1,900 per family
Prescription Drug Program:	A separate deductible of \$50 per person, \$100 per family
Infertility:	A separate deductible of \$1,000 per person, excludes prescription drugs
Annual Out-of-Pocket Maximum:	Network annual out-of-pocket expenses do not apply to the Out-of-Network Annual Out-of-Pocket Maximum. However, out-of-network annual out-of-pocket expenses do apply to the Network Annual Out-of-Pocket Maximum. Excludes infertility treatment, Weight Management Programs and non-prior authorization penalty
Individual:	\$3,750 per person
Family:	\$7,500 per family
Prescription Drug Program:	A separate limit of \$2,500 per person, \$5,000 per family applies; see program description
Maximum Benefits:	
Lifetime:	No limit, except as noted for specific benefits
Infertility:	\$15,000 lifetime maximum benefit per person, includes prescription drugs used for infertility treatment
Temporomandibular Disorder (TMD)	\$3,000 lifetime maximum benefit per person for all non-surgical TMD covered services
Acupuncture Services and Chiropractic Care:	Paid at 80% of network fee schedule after annual deductible, up to a combined maximum benefit of \$2,000 per plan year
Ambulance Services:	Paid at 80% of network fee schedule after annual deductible, when medically necessary
Behavioral Health Services:	Prior authorization ¹ required for inpatient and facility-based behavioral health services
Mental Health and Substance Abuse – Inpatient:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Mental Health and Substance Abuse – Outpatient:	Paid at 80% of network fee schedule after annual deductible
Chiropractic Care and Acupuncture Services:	Paid at 80% of network fee schedule after annual deductible, up to a combined maximum benefit of \$2,000 per plan year
Diabetes Education:	Paid at 80% of network fee schedule after annual deductible; no prior authorization
Emergency Room Visits:	Paid at 80% of network fee schedule after annual deductible
Extended Care Facility Services:	Paid at 80% of network fee schedule after annual deductible; limit of up to 60 days per plan year prior authorization ¹ required
GYN Examination:	One preventive exam per plan year paid at 100% of network fee schedule no annual deductible; additional diagnostic exams paid at 80% of network fee schedule after annual deductible
Hearing Aids:	Paid at 80% of the billed amount after annual deductible, for up to \$1,200 in total benefits; every four (4) plan years; no network provider restrictions
Hearing Test (Audiometry):	Per guidelines under the Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines and as medically necessary for suspected hearing loss; charts found at osuhealthplan.com/forms-and-downloads
Ear Molds for Hearing Aids:	Paid at 80% of billed amount after annual deductible, every four (4) plan years Note: For dependents up to age 12, ear molds that are medically necessary due to growth are paid at 80% of billed amount after annual deductible and are not subject to the \$1,200 maximum benefit
Home Health Care Services:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Hospice Care:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required

CONTINUED ON PAGE 49

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE CHOICE NETWORK – SCHEDULE OF BENEFITS

Hospitalization:	
Hospital Charges:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Physician, Surgeon and Consultation Charges:	Paid at 80% of network fee schedule after annual deductible
Human Organ Transplants:	
Hospital Charges:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Physician, Surgeon and Consultation Charges:	Paid at 80% of network fee schedule after annual deductible
Immunizations:	Paid at 100% of the network fee schedule no annual deductible, per OSU Health Plan guidelines
Infertility Treatment:	Paid at 50% of network fee schedule after separate \$1,000 annual deductible and following diagnosis by a network OB/GYN; subject to OSU Health Plan guidelines (contact OSU Health Plan for details); \$15,000 lifetime maximum benefit includes any prescription drugs used for the treatment of infertility; expenses excluded from annual out-of-pocket maximum; benefit applies to an enrolled employee or spouse requires prior authorization. ¹
Laboratory Services:	
Inpatient:	Paid at 80% of network fee schedule after annual deductible
Outpatient:	Paid at 80% of network fee schedule after annual deductible
Maternity Services:	
Inpatient:	Paid at 80% of network fee schedule after annual deductible; prior authorization ¹ required
Professional Services:	Paid at 80% of network fee schedule after annual deductible
Medical Equipment and Supplies:	Paid at 80% of network fee schedule after annual deductible; expenses over \$2,000 require prior authorization ¹
Medications, Outpatient:	Paid at 80% of OSU Health Plan fee schedule after annual deductible for injectable/oral/intravenous (includes chemotherapy) medications dispensed on an outpatient (e.g., providers' office) basis after annual deductible
Medications – Specialty:	Paid at 80% of network fee schedule after annual deductible; specialty medications for certain conditions are not covered under the medical plans, but are covered under the Prescription Drug Program. See: hr.osu.edu/benefits/prescription .
Nutritional Services:	
Visit 1 – 3:	Paid at 100% of network fee schedule no annual deductible
Visit 4 – 6:	Paid at 80% of network fee schedule after annual deductible
Occupational Therapy and Physical Therapy, Outpatient:	Paid at 80% of network fee schedule after annual deductible, combined maximum of 45 visits per plan year
Office Visits: (includes surgical procedures performed in the office):	<ul style="list-style-type: none"> • Paid at 100% of network fee schedule per visit, no annual deductible, for a Primary Care Provider (PCP). A PCP is a generalist physician who is designated as a family medicine, general internal medicine, geriatric medicine or general pediatrics provider. This includes primary care services provided by a Primary Care Nurse Practitioner who practices with a PCP, visits to University Health Connection, and network Convenient Care Clinics. • Paid at 80% of network fee schedule after annual deductible for other practitioners. <p>A list of providers is available online at osuhealthplan.com/search</p>

CONTINUED ON PAGE 50

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE CHOICE NETWORK – SCHEDULE OF BENEFITS

Outpatient Services:	See descriptions of covered services for Office Visits, Behavioral Health, Laboratory Services, Occupational Therapy, Physical Therapy, Speech Therapy and Surgical Procedures
Preventive Health Care (Physical Examinations):	Paid at 100% of network fee schedule no annual deductible, includes related laboratory tests, per Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines; charts found at osuhealthplan.com/forms-and-downloads Note: One physical examination per plan year provided for adults
Physical Therapy and Occupational Therapy, Outpatient:	Paid at 80% of network fee schedule after annual deductible, combined maximum of 45 visits per plan year
Pre-Admission Testing:	Paid at 80% of network fee schedule after annual deductible
Prescription Drugs:	See the “Prescription Drug Program” section of this booklet
Procedures, Outpatient:	Paid at 80% of network fee schedule after annual deductible; subject to OSU Health Plan guidelines (osuhealthplan.com/forms-and-downloads)
Prosthetic Devices:	Paid at 80% of network fee schedule after annual deductible; expenses over \$2,000 require prior authorization ¹
Radiology (X-ray Services):	Paid at 80% of network fee schedule after annual deductible
Speech Therapy, Outpatient:	Paid at 80% of network fee schedule after annual deductible; limited to 20 visits per plan year
Surgery, Outpatient:	Paid at 80% of network fee schedule after annual deductibles; subject to OSU Health Plan guidelines (osuhealthplan.com/sites/all/themes/osuhealthplan/pdf/prior-authorization/SRMNR.pdf)
Surgical Services, Second Opinions:	Paid at 80% of network fee schedule, after annual deductible
Temporomandibular Disorder (TMD):	Paid at 80% of network fee schedule after annual deductible; subject to a lifetime maximum of \$3,000 for all non-surgical TMD covered services
Tobacco Cessation:	Tobacco cessation services are covered through the university medical plans. Services are paid at 100% no annual deductible. Network restrictions apply. Over-the-counter nicotine replacement therapy (NRT) and prescription cessation medications (e.g., Chantix) are paid at 100% through the Prescription Drug Program. A prescription must be obtained from a physician or nurse practitioner for all tobacco cessation products. Free cessation services can be obtained through Health Coaching at OSU Health Plan.
Urgent Care Services:	
In Ohio:	Paid at 80% of network fee schedule after annual deductible; limited to network providers
Outside Ohio:	Paid at 80% of UCR after annual deductible; no network restriction
Weight Management Programs:	Hospital-based/Physician-directed programs and Weight Watchers™ programs have a combined maximum benefit of \$1,000 per plan year; expenses excluded from annual out-of-pocket maximum
Hospital-based/Physician-directed Program:	50% of reimbursement of network fee schedule, no annual deductible, up to a combined maximum benefit of \$1,000 per plan year
Weight Watchers™:	50% reimbursement for OnlinePlus and the Meetings Program, no annual deductible, up to a combined maximum benefit of \$1,000 per plan year Note: The reimbursement is applied to the month-to-month membership. Membership can be canceled at any time. For more information, or to join, visit go.osu.edu/weightwatchers .

CONTINUED ON PAGE 51

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE CHOICE OUT-OF-NETWORK – SCHEDULE OF BENEFITS

COVERED PERSON'S RESPONSIBILITIES:

For the medical plan to work effectively, you must follow these procedures when appropriate:

- Present your medical/prescription drug ID card before receiving medical care services.
- Notify OSU Health Plan if a physician admits you to a hospital.
- Request prior authorization¹ of benefits before receipt of specific services or elective admission to a hospital or facility.

SPECIAL POINTS TO CONSIDER WHEN USING YOUR PLAN:

- You may visit any physician or go to any recognized hospital and receive benefits for covered services.
- When using an out-of-network provider, you may be required to file claims with CoreSource. See the "Submitting Claims" section below for further details.
- If you are traveling outside Ohio or the United States and require assistance obtaining emergency medical care, use the Ohio State Travel Assistance referral services for assistance in receiving emergency medical care. Refer to the Ohio State Travel Assistance section of this booklet for details.

HOW PAYMENT IS DETERMINED

Payment for covered services will never exceed the actual charge for any procedure. All payments will be subject to any applicable deductible, coinsurance, maximum benefits and other provisions and limitations outlined and the Schedule of Benefits. Refer to How Payment is Determined, Exclusions or Limitations, Prime Care Choice Out-of-Network – Schedule of Benefits sections of this booklet for details.

Submitting Claims

If the provider does not submit the claim to CoreSource directly, you must submit an itemized bill or completed claim form to CoreSource yourself. The address for claims submission is on your medical/prescription drug ID card. A supply of claim forms may be obtained from CoreSource, online at hr.osu.edu/policies-forms (see CoreSource Health Insurance Claim Form), or the OHR Customer Service Center by calling 614-292-1050.

Claims Payment

Out-of-network claims submitted for payment are considered based on UCR allowances. The UCR allowances are based upon the amount charged by the vast majority of physicians for a particular procedure in the geographical area in which services are performed. The determined amount may be less than your physician's fee for that procedure. This means you may have to pay the difference between the billed amount and the UCR.

Note: Any amount you pay over the UCR does not apply to your annual deductible or out-of-pocket maximum.

PRIME CARE CHOICE OUT-OF-NETWORK – SCHEDULE OF BENEFITS

Annual Deductible:	
Individual:	\$1,900 per person
Family:	\$3,800 per family
Prescription drug program:	A separate deductible of \$50 per person, \$100 per family
Infertility:	A separate deductible of \$1,000 per person, excludes prescription drugs
Annual Out-of-Pocket Maximum:	Out-of-Network annual out-of-pocket expenses do apply to the Network Annual Out-of-Pocket Maximum. However, network annual out-of-pocket expenses do not apply to the Out-of-Network Annual Out-of-Pocket Maximum Excludes infertility treatment, Weight Management Programs and non-prior authorization penalty
Individual:	\$7,500 per person
Family:	\$15,000 per family
Prescription Drug Program:	A separate limit of \$2,500 per person, \$5,000 per family applies; see program description
Maximum Benefits:	
Lifetime:	No limit
Infertility:	\$15,000 lifetime maximum benefit per person, includes prescription drugs used for infertility treatment
Temporomandibular Disorder (TMD)	\$3,000 lifetime maximum benefit per person for all non-surgical TMD covered services
Acupuncture Services and Chiropractic Care:	Paid at 60% of UCR after annual deductible for up to a combined maximum benefit of \$2,000 per plan year; subject to balance billing
Ambulance Services:	Paid at 80% of UCR after network annual deductible, when medically necessary; subject to balance billing
Behavioral Health Services:	Prior authorization ¹ required for inpatient and facility-based behavioral health services; subject to balance billing
Mental Health and Substance Abuse – Inpatient:	Paid at 60% of UCR after annual deductible; prior authorization ¹ required; subject to balance billing
Mental Health and Substance Abuse – Outpatient:	Paid at 60% of UCR after annual deductible; subject to balance billing
Chiropractic Care and Acupuncture Services:	Paid at 60% of UCR after annual deductible for up to a combined maximum benefit of \$2,000 per plan year; subject to balance billing
Diabetes Education:	Paid at 60% of UCR after annual deductible; subject to balance billing; no prior authorization
Emergency Room Visits:	Paid at 80% of UCR after network annual deductible
Extended Care Facility Services:	Paid at 60% of UCR after annual deductible; limit of up to 60 days per plan year; prior authorization ¹ required; subject to balance billing
GYN Examination:	Paid at 60% of UCR after annual deductible and subject to balance billing
Hearing Aids:	Paid at 80% of UCR after network annual deductible for up to \$1,200 in total benefits; every four plan years; subject to balance billing
Hearing Test (Audiometry):	Per guidelines under the Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines and as medically necessary for suspected hearing loss, charts found at osuhealthplan.com/forms-and-downloads
Ear Molds for Hearing Aids:	Paid at 80% of billed amount after network annual deductible, every four (4) plan years, as part of the \$1,200 total benefit Note: For dependents up to age 12, ear molds medically necessary due to growth are paid at 80% of billed amount after annual deductible and are not subject to the \$1,200 maximum benefit; subject to balance billing
Home Health Care Services:	Paid at 60% of UCR after annual deductible; prior authorization ¹ required; subject to balance billing
Hospice Care:	Paid at 60% of UCR after annual deductible; prior authorization ¹ required; subject to balance billing

CONTINUED ON PAGE 53

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE CHOICE OUT-OF-NETWORK – SCHEDULE OF BENEFITS

Hospitalization:	
Hospital Charges:	Paid at 60% of UCR after annual deductible; subject to balance billing; prior authorization ¹ required
Physician, Surgeon and Consultation Charges:	Paid at 60% of UCR after annual deductible; subject to balance billing
Human Organ Transplants:	
Hospital Charges:	Paid at 60% of UCR fee schedule after annual deductible; prior authorization ¹ required
Physician, Surgeon and Consultation Charges:	Paid at 60% of UCR fee schedule after annual deductible
Immunizations:	Paid at 60% of UCR after annual deductible; subject to balance billing; per OSU Health Plan guidelines
Infertility Treatment:	Paid at 50% of UCR after separate \$1,000 annual deductible and following diagnosis by an OB/GYN; subject to OSU Health Plan guidelines (contact OSU Health Plan for details); \$15,000 maximum benefit includes any prescription drugs used for the treatment of infertility; expenses excluded from annual out-of-pocket maximum; subject to balance billing; benefit applies to an enrolled employee or spouse requires prior authorization ¹
Laboratory Services:	
Inpatient:	Paid at 60% of UCR after annual deductible; subject to balance billing
Outpatient:	Paid at 60% of UCR after annual deductible; subject to balance billing
Maternity Services:	
Inpatient:	Paid at 60% of UCR after annual deductible; subject to balance billing; prior authorization ¹ required
Professional Services:	Paid at 60% of UCR after annual deductible; subject to balance billing
Medical Equipment and Supplies:	Paid at 60% of UCR after annual deductible; subject to balance billing; expenses over \$2,000 require prior authorization ¹
Medications, Outpatient:	Paid at 60% of UCR after annual deductible for injectable/oral/intravenous (includes chemotherapy) medications dispensed on an outpatient (e.g., providers' office) basis
Medications – Specialty:	Paid at 60% of UCR after annual deductible; specialty medications for certain conditions are not covered under the medical plans, but are covered under the Prescription Drug Program. See: hr.osu.edu/benefits/prescription
Nutritional Services:	
Visit 1 – 3:	Paid at 60% of UCR after annual deductible, subject to balance billing
Visit 4 – 6:	Paid at 60% of UCR after annual deductible, subject to balance billing
Occupational Therapy and Physical Therapy, Outpatient:	Paid at 60% of UCR after annual deductible for up to a combined maximum of 45 visits per plan year; subject to balance billing
Office Visits: (includes surgical procedures performed in the office)	Paid at 60% of UCR, after annual deductible, subject to balance billing
Outpatient Services:	See descriptions of covered services for Office Visits, Behavioral Health, Laboratory Services, Occupational Therapy, Physical Therapy, Speech Therapy and Surgical Procedures

CONTINUED ON PAGE 54

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE CHOICE OUT-OF-NETWORK – SCHEDULE OF BENEFITS

Preventive Health Care (Physical Examinations):	Paid at 60% of UCR after annual deductible, subject to balance billing, includes related laboratory tests, per Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines; charts found at osuhealthplan.com/forms-and-downloads Note: One physical examination per plan year provided for adults.
Physical Therapy and Occupational Therapy, Outpatient:	Paid at 60% of UCR after annual deductible for up to a combined maximum of 45 visits per plan year; subject to balance billing
Pre-Admission Testing:	Paid at 60% of UCR after annual deductible; subject to balance billing
Prescription Drugs:	See the “Prescription Drug Program” section of this booklet.
Procedures, Outpatient:	Paid at 60% of UCR after annual deductible; subject to balance billing and subject to OSU Health Plan guidelines (osuhealthplan.com/forms-and-downloads)
Prosthetic Devices:	Paid at 60% of UCR after annual deductible; subject to balance billing; expenses over \$2,000 require prior authorization ¹
Radiology (X-ray Services):	Paid at 60% of UCR after annual deductible; subject to balance billing
Speech Therapy, Outpatient:	Paid at 60% of UCR after annual deductible; subject to balance billing; limited to 20 visits per plan year
Surgery, Outpatient:	Paid at 60% of UCR after annual deductible; subject to balance billing and subject to OSU Health Plan guidelines (osuhealthplan.com/forms-and-downloads)
Surgical Second Opinion:	Paid at 60% of UCR, after annual deductible; subject to balance billing
Temporomandibular Disorder (TMD):	Paid at 60% of UCR after annual deductible; subject to balance billing; subject to a lifetime maximum of \$3,000 for all non-surgical TMD covered services
Tobacco Cessation:	Tobacco cessation services are covered through the university medical plans. Services are paid at 100% of UCR no annual deductible. Over-the-counter nicotine replacement therapy (NRT) and prescription cessation medications (e.g., Chantix) are paid at 100% through the Prescription Drug Program. A prescription must be obtained from a physician or nurse practitioner for all tobacco cessation products. Free cessation services can be obtained through Health Coaching at OSU Health Plan.
Urgent Care Services:	
In Ohio:	Paid at 60% of UCR after annual deductible; subject to balance billing
Outside Ohio:	Paid at 80% of UCR after annual deductible; subject to balance billing, no network restriction
Weight Management Programs:	Hospital-based/Physician-directed programs and Weight Watchers™ programs have a combined maximum benefit of \$1,000 per plan year; expenses excluded from annual out-of-pocket maximum
Hospital-based/ Physician-directed Program	50% of reimbursement of approved billed charges no annual deductible, up to a combined maximum benefit of \$1,000 per plan year
Weight Watchers™:	50% reimbursement for Online <i>Plus</i> and the Meetings Program, no annual deductible, up to a combined maximum benefit of \$1,000 per plan year Note: The reimbursement is applied to the month-to-month membership. Membership can be canceled at any time. For more information, or to join, visit go.osu.edu/weightwatchers .

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE CONNECT – SCHEDULE OF BENEFITS

ELIGIBLE EMPLOYMENT

University faculty and staff with eligible appointments.

Note: COTC, OSUP and Graduate Associates are not eligible for this plan

ENROLLMENT

To enroll in this medical plan option, you must apply during an annual open enrollment period or within 31 days of meeting all of the following requirements:

- You must be a full-time university employee (75–100% FTE) who is eligible for the full-time medical contribution rate
- **You must have a maximum household income level** of 175% of the federal poverty level as established annually by the U.S. Department of Health and Human Services and which was in effect on October 1, 2018. See chart below to determine if you fall within this level. A change in household income during the plan year is not an event that triggers eligibility for enrollment during the plan year. Household income is based on your Adjusted Gross Income (AGI) as indicated on your most recent tax return. If you meet all of the requirements above and are interested in applying, contact OSU Health Plan at 614-292-4700 or 800-678-6369 to begin the application process. An advocate will perform an initial screening to determine eligibility for the plan and generate an application for you to complete, if requirements are met.

PERSONS IN FAMILY	MAXIMUM HOUSEHOLD INCOME BASED ON ADJUSTED GROSS INCOME (AGI) FROM MOST RECENT TAX RETURN
1	\$21,245
2	\$28,805
3	\$36,365
4	\$43,925
5	\$51,485
6	\$59,045
7	\$66,605
8	\$74,165
9 and up	add \$7,560 per person

To apply, contact OSU Health Plan at 614-292-4700 or 800-678-6369.

Note: Documentation will be required to confirm household income. Once the application has been submitted and reviewed, an approval or denial letter will be sent to your home address. To ensure medical plan coverage, be sure you enroll in one of Ohio State's other medical plans while waiting to hear if you have been approved for this plan.

CHANGE IN ENROLLMENT

Refer to the General Provisions – Change in Coverage Due to a Qualifying Status Change section of this booklet for details.

TERMINATION OF COVERAGE

If an event occurs which results in you not meeting all of the enrollment criteria, you must notify OHR and submit a new university Health Election Form available online at hr.osu.edu/policies-forms within 31 days of the event.

COVERAGE ACCESS OUTSIDE OHIO

Access to coverage outside the network is available if you permanently reside outside of Ohio or with special application (online at hr.osu.edu/policies-forms see Out-of-Area Benefit Election Form) to individuals enrolled in Prime Care Connect who will be outside Ohio for at least 30 consecutive days. Benefits for medical services received outside of Ohio while on approved out-of-area coverage will be paid in accordance with the Prime Care Connect provisions. Examples of circumstances to enroll are:

- You have a dependent child who does not live with you and resides outside Ohio
- You have a dependent who is enrolled in a college outside Ohio
- You will be outside Ohio on an approved leave of absence or an approved professional leave
- You will be outside Ohio during an off-duty term if you have a nine-month appointment and receive compensation and benefits over a 12-month period.

Note: When seeking care outside Ohio or the United States, use Ohio State Travel Assistance referral services

CONTRIBUTION

The current contribution rates are available online at hr.osu.edu/benefits/rates.

CONTINUED ON PAGE 56

PRIME CARE CONNECT – SCHEDULE OF BENEFITS

COVERED PERSON'S RESPONSIBILITIES

For the medical plan to work effectively, you must follow these procedures, when appropriate:

- Coordinate all medical care with your primary physician.
- Confirm that all providers (physicians, labs, etc.), including those to whom you are referred, are participating statewide network providers in order to ensure coverage under the medical plan the provider network is available online at osuhealthplan.com/search.
- Present your medical/prescription drug ID card to the provider before receiving medical services.
- Notify OSU Health Plan if a physician admits you to a hospital.
- Request prior authorization¹ of benefits before receipt of certain designated services or elective admission to a hospital or facility.

SPECIAL POINTS TO CONSIDER WHEN USING YOUR PLAN

- When receiving medical services it is important to understand that:
 - There are no benefits if services are rendered outside the statewide network (except for emergency care services).
 - All medical treatment should be coordinated through your physician.
- Some services are fully covered while other services require a copay or coinsurance. When receiving covered services within the network, simply present your medical/prescription drug ID card to your medical service provider.
- This medical plan requires the use of a statewide network of providers.
 - When seeking medical care **inside Franklin County**, the OSU Health Plan network of physicians and facilities must be used. A current list of plan providers is available online at osuhealthplan.com/search or by contacting OSU Health Plan.
 - When seeking medical care **outside Franklin County**, the Ohio PPO Connect network of physicians and facilities must be used. A current list of plan providers is available online at osuhealthplan.com/search or by contacting OSU Health Plan.
 - If you are traveling outside Ohio or the United States and require emergency medical care and are outside Ohio or the United States, use Ohio State Travel Assistance referral services for assistance in receiving emergency medical care. Refer to the Ohio State Travel Assistance section of this booklet for details.

PROVIDER SELECTION

The provider network is available online at osuhealthplan.com/search, where it is updated regularly.

Referrals to Specialists

While you may schedule an appointment directly with a network specialist, some specialists may require a referral from your primary care physician before making an appointment. Your physician should refer you to a specialist within the network, unless the care you need is not available within the network. If your physician refers you to a provider outside the network, it is your responsibility to obtain authorization in advance from OSU Health Plan by calling 614-292-4700. If your authorization is approved, your medical care covered services will be paid according to the network benefit.

Note: Following emergency or specialist care, you should notify your primary care physician in order to keep him/her informed of your medical condition.

HOW PAYMENT IS DETERMINED

Refer to the How Payment is Determined, Exclusions or Limitations and Prime Care Connect – Schedule of Benefits sections of this booklet for details.

Network

Payments for covered services are based upon the network provider's fee schedule. You are not responsible for any balance in excess of the network provider's fee schedule. In other words, covered services obtained from network providers are not subject to balance billing.

Urgent Care

- Payment for covered urgent care services received from network urgent care providers will be based upon the contracted or network provider's fee schedule. You are not responsible for any balance in excess of the network provider's fee schedule.
- Urgent care is not intended for preventive or routine maintenance treatment, such as school or annual physicals and these types of services will not be covered when received from an urgent care provider.
- Services received from an out-of-network urgent care provider in Ohio will not be covered. The provider network is available at osuhealthplan.com/search.
- Urgent care received outside of Ohio will be paid at the network benefit.

Emergency Care

Payments for covered emergency care services are based on the copay shown on the Schedule of Benefits in this section.

PRIME CARE CONNECT – SCHEDULE OF BENEFITS

Annual Deductible:	
Individual:	\$150 per person
Family	\$300 per family
Infertility:	A separate deductible of \$1,000 per person, excludes prescription drugs
Annual Out-of-Pocket Maximum:	Excludes infertility treatment, Weight Management Programs and non-prior authorization penalty
Individual:	\$1,500 per person
Family:	\$3,000 per family
Prescription Drug Program:	A separate limit of \$2,000 per person, \$4,000 per family; see program description
Maximum Benefits:	
Lifetime:	No limit, except as noted for specific benefits
Infertility:	\$15,000 lifetime maximum benefit per person, includes prescription drugs used for infertility treatment
Temporomandibular Disorder (TMD)	\$3,000 lifetime maximum benefit per person for all non-surgical TMD covered services
Acupuncture Services and Chiropractic Care:	\$20 copay per visit no annual deductible, up to a combined maximum benefit of \$2,000 per plan year
Ambulance Services:	Paid at 100% of network fee schedule no annual deductible when medically necessary
Behavioral Health Services:	Prior authorization ¹ is required for inpatient and facility-based behavioral health services
Mental Health and Substance Abuse – Inpatient:	\$200 copay per admission ¹ ; no annual deductible, prior authorization ¹ required
Mental Health and Substance Abuse – Outpatient:	Paid at 100% of network fee schedule no annual deductible
Chiropractic Care and Acupuncture Services:	\$20 copay per visit no annual deductible; up to a combined maximum benefit of \$2,000 per plan year
Diabetes Education:	Paid at 85% of network fee schedule after annual deductible; no prior authorization
Emergency Room Visits:	\$100 copay per visit no annual deductible Note: The emergency room copay is waived if the covered person is admitted to the hospital directly from the emergency department. A hospitalization copay will be charged.
Extended Care Facility Services:	\$50 copay per admission no annual deductible; limit of up to 60 days per plan year; prior authorization ¹ required
GYN Examination:	One preventive exam per plan year paid at 100% of network fee schedule no annual deductible; additional diagnostic exams subject to \$20 copay no annual deductible
Hearing Aids:	Paid at 85% of the billed amount after annual deductible for up to \$1,200 in total benefits; every four (4) plan years; no network provider restrictions
Hearing Test (Audiometry):	Per guidelines under the Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines and as medically necessary for suspected hearing loss; charts found at osuhealthplan.com/forms-and-downloads
Ear Molds for Hearing Aids:	Paid at 85% of the billed amount after annual deductible, every four (4) plan years, as part of the \$1,200 total benefit Note: For dependents up to age 12, ear molds that are medically necessary due to growth are paid at 85% of the billed amount and are not subject to the \$1,200 maximum benefit
Home Health Care Services:	Paid at 85% of network fee schedule after annual deductible; prior authorization ¹ required
Hospice Care:	Paid at 100% of network fee schedule no annual deductible; prior authorization ¹ required

CONTINUED ON PAGE 58

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE CONNECT – SCHEDULE OF BENEFITS

Hospitalization:	
Hospital Charges:	\$200 copay per admission no annual deductible; prior authorization ¹ required
Physician, Surgeon and Consultation Charges:	Paid at 100% of network fee schedule no annual deductible
Human Organ Transplants:	
Hospital Charges:	\$200 copay per admission no annual deductible; prior authorization ¹ required
Physician, Surgeon and Consultation Charges:	Paid at 100% of network fee schedule no annual deductible
Immunizations:	Paid at 100% of network fee schedule no annual deductible
Infertility Treatment:	Paid at 50% of network fee schedule after separate \$1,000 annual deductible and following diagnosis by a network OB/GYN; subject to OSU Health Plan guidelines (contact OSU Health Plan for details); \$15,000 lifetime maximum benefit includes any prescription drugs used for the treatment of infertility; expenses excluded from annual out-of-pocket maximum; benefit applies to an enrolled employee or spouse requires prior authorization ¹
Laboratory Services:	
Inpatient:	Paid at 100% of network fee schedule no annual deductible
Outpatient:	Paid at 85% of network fee schedule no annual deductible
Maternity Services:	
Inpatient:	\$200 copay per admission no annual deductible; prior authorization ¹ required
Professional Services:	Paid at 100% of network fee schedule no annual deductible
Medical Equipment and Supplies:	Paid at 85% of network fee schedule after annual deductible; expenses over \$2,000 require prior authorization ¹
Medications, Outpatient:	Paid at 85% of network fee schedule after annual deductible for injectable/oral/intravenous (includes chemotherapy) medications dispensed on an outpatient (e.g., providers' office) basis
Medications – Specialty:	Paid at 85% of network fee schedule after annual deductible;. Specialty medications for certain conditions are not covered under the medical plans, but are covered under the Prescription Drug Program. See: hr.osu.edu/benefits/prescription
Nutritional Services:	
Visit 1 – 3:	Paid at 100% of network fee schedule no annual deductible
Visit 4 – 6:	\$20 copay per visit no annual deductible
Occupational Therapy and Physical Therapy, Outpatient:	\$20 copay per visit no annual deductible; combined maximum of 45 visits per year
Office Visits (includes surgical procedures performed in the office):	<ul style="list-style-type: none"> • Paid at 100% of network fee schedule no annual deductible for a Primary Care Provider (PCP). A PCP is a generalist physician who is designated as a family medicine, general internal medicine, geriatric medicine or general pediatrics provider. This includes primary care services provided by a Primary Care Nurse Practitioner who practices with a PCP, visits to University Health Connection, and network Convenient Care Clinics • Paid at 100% of network fee schedule for Behavioral Health Services • \$20 copay per visit no annual deductible – Gynecologists, Chiropractors, Physical Therapists, Occupational Therapists, Speech Therapists, Acupuncturists, Nutritionists • \$20 copay per visit no annual deductible – Specialists <p>A list of providers is available online at osuhealthplan.com/search</p>

CONTINUED ON PAGE 59

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

PRIME CARE CONNECT – SCHEDULE OF BENEFITS

Outpatient Services:	See descriptions of covered services for Office Visits, Behavioral Health, Laboratory Services, Occupational Therapy, Physical Therapy, Speech Therapy and Surgical Procedures
Preventive Health Care (Physical Examinations):	Paid at 100% of network fee schedule no annual deductible; includes related laboratory tests, per Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines (osuhealthplan.com/forms-and-downloads) Note: One physical examination per plan year provided for adults.
Physical Therapy and Occupational Therapy Outpatient:	\$20 copay per visit no annual deductible; combined maximum of 45 visits per plan year
Pre-Admission Testing:	Paid at 85% of network fee schedule no annual deductible
Prescription Drugs:	See the "Prescription Drug Program" section of this booklet.
Procedures, Outpatient:	\$75 copay per procedure no annual deductible; copay applies to all outpatient procedures, subject to OSU Health Plan guidelines (osuhealthplan.com/forms-and-downloads)
Prosthetic Devices:	Paid at 85% of network fee schedule after annual deductible; expenses over \$2,000 require prior authorization ¹
Radiology (X-ray Services):	Paid at 85% of network fee schedule no annual deductible
Speech Therapy, Outpatient:	\$20 copay per visit no annual deductible; limited to 20 visits per plan year
Surgery, Outpatient:	\$150 copay per visit no annual deductible; subject to OSU Health Plan guidelines (osuhealthplan.com/forms-and-downloads)
Surgical Services, Second Opinions:	\$20 copay per visit no annual deductible
Temporomandibular Disorder (TMD):	Paid at 85% of network fee schedule after annual deductible; subject to a lifetime maximum of \$3,000 for all non-surgical TMD covered services
Tobacco Cessation:	Tobacco cessation services are covered through the university medical plans. Services are paid at 100% no annual deductible. Network restrictions apply. Over-the-counter nicotine replacement therapy (NRT) and prescription cessation medications (e.g., Chantix) are paid at 100% through the Prescription Drug Program. A prescription must be obtained from a physician or nurse practitioner for all tobacco cessation products. Free cessation services can be obtained through Health Coaching at OSU Health Plan.
Urgent Care Services:	
In Ohio:	\$35 copay per visit no annual deductible; limited to network providers
Outside Ohio:	\$35 copay per visit no annual deductible; no network restriction
Weight Management Programs:	Hospital-based/Physician-directed programs and Weight Watchers™ programs have a combined maximum benefit of \$1,000 per plan year; expenses excluded from annual out-of-pocket maximum.
Hospital-based/Physician-directed Program:	50% of reimbursement of network fee schedule no annual deductible; up to a combined maximum benefit of \$1,000 per plan year
Weight Watchers™:	50% reimbursement for Online <i>Plus</i> and the Meetings Program no annual deductible; up to a combined maximum benefit of \$1,000 per plan year Note: The reimbursement is applied to the month-to-month membership. Membership can be canceled at any time. For more information, or to join, visit go.osu.edu/weightwatchers .

CONTINUED ON PAGE 60

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

OUT-OF-AREA PLAN – SCHEDULE OF BENEFITS

ELIGIBLE EMPLOYMENT

- University faculty and staff with eligible appointments.
- University affiliated group employees with eligible appointments at:
 - Central Ohio Technical College (COTC)
 - Ohio State University Physicians, Inc. (OSUP)

ELIGIBLE ZIP CODES

Enrollment in this medical plan is **only** available to:

- Any eligible employee who lives in a qualifying Ohio zip code
- Any eligible employee living outside the state of Ohio

Note: To determine if you live in a qualifying Ohio zip code, go to Plan Eligibility by Zip Code at hr.osu.edu/benefits/medical (see Plan Eligibility by Zip Code).

ADDITIONAL ACCESS TO OUT-OF-AREA PLAN COVERAGE

Access to the coverage under the Out-of-Area Plan is also available with special application (available online at hr.osu.edu/policies-forms see Out-of-Area Benefit Election Form) to individuals enrolled in Prime Care Advantage, Prime Care Choice or Prime Care Connect who will be outside Ohio for at least 30 consecutive days. Benefits for medical services received outside of Ohio while on approved out-of-area coverage will be paid in accordance with the Out-of-Area Plan. Examples of circumstances to enroll are:

- You have a dependent child who does not live with you and resides outside Ohio
- You have a dependent who is enrolled in a college outside Ohio
- You will be outside Ohio on an approved leave of absence or an approved professional leave
- You will be outside Ohio during an off-duty term if you have a nine-month appointment and receive compensation and benefits over a 12-month period.

Note: When seeking care outside Ohio or the United States, use Ohio State Travel Assistance referral services.

ENROLLMENT

Refer to the General Provisions – Enrollment section of this booklet for detail. To enroll in this option, use eBenefits online at eprofile.osu.edu or submit a completed Health Election Form, available at hr.osu.edu/policies-forms.

Enrollment Changes

Refer to General Provisions – Change in Coverage Due to a Qualifying Status Change section of this booklet for details.

CONTRIBUTION

The current contribution rates are available online at hr.osu.edu/benefits/rates.

COVERED PERSON'S RESPONSIBILITIES

For the medical plan to work effectively, you must follow these procedures, when appropriate:

- Coordinate all medical care with your primary care physician.
- Present your medical/prescription drug ID card before receiving medical care services.
- Notify OSU Health Plan if a physician admits you to a hospital.
- Request prior authorization¹ of benefits before receipt of designated services or elective admission to a hospital or facility.

SPECIAL POINTS TO CONSIDER WHEN USING YOUR PLAN

- You may visit any physician or go to any recognized hospital and receive benefits for covered services; however, you will need to pay a percentage of the costs for the covered services you receive.
- You may be required to file your own claims with CoreSource. See the “Submitting Claims” section below.

If you are outside of Ohio or the United States and require assistance obtaining emergency medical care, use Ohio State Travel Assistance referral services for assistance in receiving emergency medical care. Refer to the Ohio State Travel Assistance section of this booklet for details.

CONTINUED ON PAGE 61

OUT-OF-AREA PLAN – SCHEDULE OF BENEFITS

HOW PAYMENT IS DETERMINED

Payment for covered services will never exceed the actual charge for any procedure. All payments will be subject to any applicable deductible and/or coinsurance, maximum benefit amounts and other provisions and limitations outlined in the Schedule of Benefits. Refer to the How Payment is Determined, Exclusions or Limitations and Out-of-Area – Schedule of Benefits sections of this booklet for details.

Negotiated Rates

If you use an Ohio State Travel Assistance participating provider, listed on the Ohio State Travel Assistance card, they will typically accept negotiated rates, which can reduce your out-of-pocket expenses. Refer to the Ohio State Travel Assistance section of this booklet for details.

Submitting Claims

If the provider does not submit the claim to CoreSource directly, you must submit an itemized bill or completed claim form to CoreSource yourself. The address for claims submission is on your medical/prescription drug ID card and the inside front cover. Claim forms may be obtained from CoreSource, online at hr.osu.edu/policies-forms (see CoreSource Health Insurance Claim Form) or the OHR Customer Service Center by calling 614-292-1050.

Claims Payment

Claims submitted for payment are considered based on UCR allowances. The UCR allowances are based upon the amount charged by the vast majority of physicians for a particular procedure in the geographical area in which services are performed. The determined amount may be less than your provider's fee for that procedure. This means you may have to pay the difference between the billed amount and UCR, even if your annual deductible has been met. This is referred to as balance billing (see below).

Note: Any amount you pay over UCR does not apply to your annual deductible or out-of-pocket maximum.

Balance Billing

- You may avoid balance billing outside of Ohio by choosing a participating provider listed on the Ohio State Travel Assistance card. Refer to the Ohio State Travel Assistance section of this booklet.

OUT-OF-AREA PLAN – SCHEDULE OF BENEFITS

Annual Deductible:	
Individual:	\$450 per person
Family:	\$900 per family
Prescription drug program:	A separate deductible of \$50 per person, \$100 per family
Infertility:	A separate deductible of \$1,000 per person, excludes prescription drugs
Annual Out-of-Pocket Maximum:	Excludes infertility treatment, Weight Management Programs and non-prior authorization penalty
Individual:	\$2,600 per person
Family:	\$5,200 per family
Prescription Drug Program:	A separate limit of \$2,500 per person, \$5,000 per family applies; see program description
Maximum Benefits:	
Lifetime:	No limit, except as noted for specific benefits
Infertility:	\$15,000 lifetime maximum benefit per person, includes prescription drugs used for infertility treatment
Temporomandibular Disorder (TMD)	\$3,000 lifetime maximum benefit per person for all non-surgical TMD covered services
Acupuncture Services and Chiropractic Care	Paid at 80% of UCR after annual deductible, for up to a combined maximum benefit of \$2,000 per plan year; subject to balance billing
Ambulance Services:	Paid at 80% of the UCR after annual deductible, when medically necessary; subject to balance billing
Behavioral Health Services:	Prior authorization ¹ required for inpatient and facility-based behavioral health services
Inpatient:	Paid at 80% of UCR ¹ after annual deductible; prior authorization ¹ required
Outpatient:	Paid at 80% of UCR after annual deductible, subject to balance billing
Chiropractic Care and Acupuncture Services:	Paid at 80% of UCR after annual deductible, for up to a combined maximum benefit of \$2,000 per plan year; subject to balance billing
Diabetes Education:	Paid at 80% of UCR after annual deductible; no prior authorization, subject to balance billing
Emergency Room Visits:	Paid at 80% of UCR after annual deductible
Extended Care Facility Services:	Paid at 80% of UCR after annual deductible; limit of up to 60 days per plan year; prior authorization ¹ required; subject to balance billing
GYN Examination:	One preventive exam per plan year paid at 100% of UCR, no annual deductible additional diagnostic exams paid at 80% of UCR after annual deductible; subject to balance billing
Hearing Aids:	Paid at 80% of billed amount after annual deductible for up to \$1,200 in total benefits; every four (4) plan years
Hearing Test (Audiometry):	Per guidelines under the Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines and as medically necessary for suspected hearing loss; charts found at osuhealthplan.com/members/preventiveguidelines.php
Ear Molds for Hearing Aids:	Paid at 80% of the billed amount after annual deductible every four (4) plan years, as part of the \$1,200 total benefit Note: For dependents up to age 12, ear molds that are medically necessary due to growth are paid at 80% of the billed amount after annual deductible, and are not subject to the \$1,200 maximum benefit.
Home Health Care Services:	Paid at 80% of UCR after annual deductible; prior authorization ¹ required, subject to balance billing
Hospice Care:	Paid at 80% of UCR after annual deductible; prior authorization ¹ required, subject to balance billing

CONTINUED ON PAGE 63

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

OUT-OF-AREA PLAN – SCHEDULE OF BENEFITS

Hospitalization:	
Hospital Charges:	Paid at 80% of UCR after annual deductible; prior authorization ¹ required, subject to balance billing
Physician, Surgeon and Consultation Charges:	Paid at 80% of UCR after annual deductible, subject to balance billing
Human Organ Transplants:	
Hospital Charges:	Paid at 80% of UCR after annual deductible; prior authorization ¹ required
Physician, Surgeon and Consultation Charges:	Paid at 80% of UCR after annual deductible
Immunizations	Paid at 100% of UCR no annual deductible; per OSU Health Plan guidelines
Infertility Treatment:	Paid at 50% of UCR after separate \$1,000 annual deductible and following diagnosis by an OB/GYN; subject to OSU Health Plan guidelines (contact OSU Health Plan for details); \$15,000 lifetime maximum benefit includes any prescription drugs used for the treatment of infertility; expenses excluded from annual out-of-pocket maximum; benefit applies to an enrolled employee or spouse; subject to balance billing; requires prior authorization ¹ .
Laboratory Services:	Paid at 80% of UCR after annual deductible, subject to balance billing
Maternity Services:	
Inpatient:	Paid at 80% of UCR after annual deductible, subject to balance billing; prior authorization ¹ required
Professional (Obstetrical) Services:	Paid at 80% of UCR after annual deductible, subject to balance billing
Medical Equipment and Supplies:	Paid at 80% of UCR after annual deductible, expenses over \$2,000 require prior authorization ¹ , subject to balance billing
Medications, Outpatient:	Paid at 80% of UCR after annual deductible for injectable/oral/intravenous (includes chemotherapy) medications dispensed on an outpatient (e.g., providers' office) basis
Medications – Specialty:	Paid at 80% of UCR after annual deductible, subject to balance billing. Specialty medications for certain conditions are not covered under the medical plans, but are covered under the Prescription Drug Program. See: hr.osu.edu/benefits/prescription
Nutritional Services:	
Visit 1 – 3:	Paid at 100% of UCR, no annual deductible, subject to balance billing
Visit 4 – 6:	Paid at 80% of UCR after annual deductible, subject to balance billing
Occupational Therapy and Physical Therapy, Outpatient:	Paid at 80% after annual deductible of UCR for up to a combined maximum of 45 visits per plan year, subject to balance billing
Office Visits (includes surgical procedures performed in the office):	<ul style="list-style-type: none"> • Paid at 100% of UCR no annual deductible for a Primary Care Provider (PCP). A PCP is a generalist physician who is designated as a family medicine, general internal medicine, geriatric medicine or general pediatrics provider. Primary care services can also be provided by a Primary Care Nurse Practitioner who practices with a PCP, visits to University Health Connection and Convenient Care Clinics. • Paid at 80% of UCR after annual deductible for all other visits, subject to balance billing
Outpatient Services:	See descriptions of covered services for Office Visits, Behavioral Health, Laboratory Services, Occupational Therapy, Physical Therapy, Speech Therapy and Surgical Procedures.

CONTINUED ON PAGE 64

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

OUT-OF-AREA PLAN – SCHEDULE OF BENEFITS

Preventive Health Care: (Physical Examinations)	Paid at 100% of UCR no annual deductible, includes related laboratory tests, per Pediatric Preventive Health Care Guidelines and Adult Preventive Health Care Guidelines; charts found at osuhealthplan.com/members/preventiveguidelines.php Note: One physical examination per plan year provided for adults.
Physical Therapy and Occupational Therapy, Outpatient:	Paid at 80% of UCR after annual deductible; combined maximum of 45 visits per plan year, subject to balance billing
Pre-Admission Testing:	Paid at 80% of UCR after annual deductible, subject to balance billing
Prescription Drugs:	See the “Prescription Drug Program” section of this booklet.
Procedures, Outpatient:	Paid at 80% of UCR after annual deductible, subject to balance billing and subject to OSU Health Plan guidelines (osuhealthplan.com/forms-and-downloads)
Prosthetic Devices:	Paid at 80% of UCR after annual deductible, expenses over \$2,000 require prior authorization ¹ , subject to balance billing
Radiology (X-ray Services):	Paid at 80% of UCR after annual deductible, subject to balance billing
Speech Therapy, Outpatient:	Paid at 80% of UCR after annual deductible, subject to balance billing; limited to 20 visits per plan year
Surgery, Outpatient:	Paid at 80% of UCR after annual deductible, subject to balance billing and subject to OSU Health Plan guidelines (osuhealthplan.com/forms-and-downloads)
Surgical Second Opinion:	Paid at 80% of UCR after annual deductible, subject to balance billing
Temporomandibular Disorder (TMD):	Paid at 80% of UCR after annual deductible; subject to a maximum of \$3,000 for all non-surgical TMD covered services; subject to balance billing
Tobacco Cessation:	Tobacco cessation services are covered through the university medical plans. Services covered are paid at 100% of UCR no annual deductible. Over-the-counter nicotine replacement therapy (NRT) and prescription cessation medications (e.g., Chantix) are paid at 100% through the Prescription Drug Program. A prescription must be obtained from a physician or nurse practitioner for all tobacco cessation products. Free cessation services can be obtained through Health Coaching at OSU Health Plan.
Urgent Care Services:	Paid at 80% of UCR after annual deductible, subject to balance billing
Weight Management Programs:	Hospital-based/Physician-directed programs and Weight Watchers™ programs have a combined maximum benefit of \$1,000 per plan year; expenses excluded from annual out-of-pocket maximum
Hospital-based/Physician-directed Program:	50% reimbursement of approved billed charges, no annual deductible, to a combined maximum benefit of \$1,000 per plan year
Weight Watchers™:	50% reimbursement for Online <i>Plus</i> and the Meetings Program no annual deductible, up to a combined maximum benefit of \$1,000 per plan year. Note: The reimbursement is applied to the month-to-month membership. Membership can be canceled at any time. For more information, or to join, visit go.osu.edu/weightwatchers .

¹ Prior authorization (see Medical Prior Authorization Guide available online at osuhealthplan.com/forms-and-downloads) of certain designated services is required to determine medical necessity. If prior authorization, where indicated, is not obtained from OSU Health Plan, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to \$1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket maximum.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

A Health Reimbursement Account (HRA) is an employer-funded account that can be used to reimburse eligible health care expenses (as defined below). Faculty and staff who are enrolled in an Ohio State medical plan are eligible to earn credits to an HRA.

The HRA program is intended to qualify as a health reimbursement arrangement under Section 105 of the Code and will be interpreted in a manner consistent with such Code section and the Treasury regulations thereunder. Employees are not permitted to make contributions to an HRA.

TASC (Total Administrative Services Corporation) is the university's third-party administrator for the HRA.

ELIGIBILITY FOR PARTICIPATION

Faculty and staff who are enrolled in an Ohio State medical plan are eligible to receive credits each calendar quarter under the HRA by completing wellness activities as part of the Your Plan for Health (YP4H) Incentive Program. To learn more visit yp4h.osu.edu. HRA Credits will be earned as follows:

Employees

- If an employee completes Level 1 of the YP4H Incentive Program, the university will automatically open an HRA for the employee and will credit \$15 to the HRA.
- If the employee completes Level 2 of the YP4H Incentive Program, the university will credit \$20 to the HRA.
- If the employee completes Level 3 of the YP4H Incentive Program, the university will credit \$20 to the HRA.
- If the employee completes Level 4 of the YP4H Incentive Program, the university will credit \$20 to the HRA.

Spouse

An employee's spouse must be enrolled as the employee's dependent in an Ohio State medical plan to earn HRA credits.

- If the spouse completes Level 1 of the YP4H Incentive Program, the university will credit \$15 to the employee's HRA.
- If the spouse completes Level 2 of the YP4H Incentive Program, the university will credit \$20 to the employee's HRA.
- If the spouse completes Level 3 of the YP4H Incentive Program, the university will credit \$20 to the employee's HRA.
- If the spouse completes Level 4 of the YP4H Incentive Program, the university will credit \$20 to the HRA.

REASONABLE ALTERNATIVE STANDARD

YP4H Reasonable Alternative Standard. Rewards for participating in YP4H may be earned by benefits-eligible employees and enrolled spouses. If you think you might be unable to meet a standard for a reward under YP4H, you may qualify for an opportunity to earn the same reward by different means. Contact YP4H by emailing yp4h@osu.edu and YP4H will work with you (and, if you wish, your doctor) to find a wellness activity with the same reward that is right for you in light of your health status.

AVAILABILITY OF FUNDS

- Once funds are credited to an employee's HRA, the employee can submit claims for reimbursement of eligible health care expenses from the HRA.
- HRA credits may be used to reimburse eligible health care expenses incurred at any time during the plan year on or after the employee's effective date of participation in the Ohio State medical plan.
- Reimbursements from an HRA will be limited to the then current balance in the HRA.
- The deadline to submit claims for eligible health care expenses incurred during a plan year is March 31 of the following plan year. Any unused HRA funds will automatically rollover to the next plan year as long as you are a covered employee under the Plan, or an employee who has continuation of coverage under COBRA, at the time HRA balances are rolled over. The rollover will occur by mid-April.

ORDERING OF ACCOUNT REIMBURSEMENTS (HRA and Health Care Flexible Spending Account)

The HRA and The Ohio State University Health Care Flexible Spending Account (HCFSA) are separate accounts. Refer to the Flexible Spending Accounts Specific Plan Details Document for additional details on the HCFSA. An eligible employee may participate in both an HRA and an HCFSA, subject to the following terms:

- If an incurred health care expense could be reimbursed from either the HCFSA or the HRA, the reimbursement will be paid from the HCFSA first.
- All HCFSA funds must be exhausted before HRA funds are used.
- Employees are not permitted to make contributions to an HRA.

Note: If you are a COTC or OSUP employee, contact your benefits office with questions related to their administration of the ordering rule.

ACCOUNT ACCESS

- **Online Access:** You can access your HRA online 24 hours a day, seven days a week. From your online account, you can check your account balance, track expenses, file a manual claim and set up communication preferences. To access your account, log in to Employee Self Service using your Ohio State user name and password at eprofile.osu.edu. Click on the My FSA/HRA link under Benefits.
- **Benefits by eflex mobile app:** With the mobile app, you can manage your account, securely check real-time balances, request a reimbursement, view transaction details and use your mobile device's camera to take a picture of any receipt. The Benefits by eflex app is a free download from the Apple iTunes App Store and Google Play. To download the mobile app go to the Apple iTunes App Store or Google Play, and search for Benefits by eflex.
- **Call TASC Customer Service:** 855-FLEX-OSU (353-9678).

CONTINUED ON PAGE 66

HEALTH REIMBURSEMENT ACCOUNT (HRA)

USING HRA FUNDS

- If you incur an eligible health care expense, you may be reimbursed from your HRA by:
 - Using your Health Care Debit Card.
 - Filling out a TASC Reimbursement Claim form available online at hr.osu.edu/benefits/fsa/health-care/.
 - Filing a claim online: log on to Employee Self Service, click on the My FSA/HRA link under Benefits. Scan and upload appropriate receipts.
 - Filing a claim using the Benefits by eflex mobile app and using your mobile device to take a photo of appropriate receipts.

As described above, reimbursement from the HRA will occur only after all funds in your HCFSAs have been exhausted.

- Eligible health care expenses for which you are requesting reimbursement must be incurred during the plan year, subject to your eligibility to participate in the HRA.

Important: An eligible health care expense must be incurred before you can be reimbursed from your HRA. You “incur” expenses when the services giving rise to the claimed expense are rendered, rather than when you are billed or pay for the services.

REIMBURSEMENT OPTIONS

- **Direct deposit:** With direct deposit, reimbursement is quick and easy. Once your claim is approved, your reimbursement will be deposited into your bank account in less than 72 hours if funds are available. Online account management gives you the flexibility to direct reimbursements to one or more accounts. Setting up direct deposit is easy:
 1. Log on to Employee Self Service, click on the My FSA/HRA link under eBenefits.
 2. Click on Tools and Support.
 3. Click Direct Deposit Online Instructions.
 4. Fax completed form to TASC at 877-231-1287 or mail to: TASC, PO Box 7511, Madison, WI 53707-7511.
- **Check:** If you have not set up direct deposit, once your claim is approved, a check will be mailed to your home address.
- **Health Care Debit Card:** Present your Health Care Debit Card at the point-of-service to directly access your HRA funds when paying for eligible expenses for you and your eligible dependents. You should retain your receipts for the expenses that you pay for with your Health Care Debit Card, as you may be required to substantiate those expenses. If documentation for expenses is requested and you do not supply documentation upon that request, the expenses will be considered ineligible and you will have to repay that expense to your HRA. Your Health Care Debit Card will be inactive until your account is reimbursed.

Important: Your Health Care Debit Card is valid for a three-year period. You should retain your card for future plan years.

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES

The term “eligible health care expenses” means those expenses incurred by the employee and his or her dependents while enrolled in an Ohio State medical plan that are for medical care as defined in Section 213(d) of the Code (and permitted by Section 105 of the Code).

The following list, while not intended to be complete, illustrates expenses that may be reimbursed under the HRA. Restrictions may apply. For detailed explanations of these expenses, or for additional information regarding eligible health care expenses, you should review the list online at hr.osu.edu/benefits/hra.

- Eligible health care expenses must be primarily to alleviate or prevent a physical or mental defect or illness and may include, but are not limited to:
 - Breast pumps and supplies that assist lactation.
 - Deductibles, copayments and coinsurance for medical, dental, vision or prescription drug expenses.
 - Diabetic supplies, including blood-sugar test kits and test strips, glucose-monitoring equipment and insulin.
 - Laboratory fees when they are part of medical care.
 - Vision correction procedures, including laser procedures such as Lasik and radial keratotomy.

Note: Over-the-counter (OTC) medications and drugs purchased without a prescription, except insulin, are not eligible health care expenses.

EXAMPLES OF INELIGIBLE HEALTH CARE EXPENSES

The following list, while not intended to be complete, illustrates expenses that cannot be reimbursed under the HRA. For detailed explanations of these expenses, or for additional information regarding ineligible expenses, you should review the information online at hr.osu.edu/benefits/hra.

- Controlled substances (e.g., marijuana, laetrile) in violation of federal law
- Cosmetic procedures, including, but not limited to, face lifts, hair removal or transplants, electrolysis, teeth whitening and veneers
- Cosmetics and toiletries, including but not limited to: face creams, cologne, dental floss, deodorant, feminine hygiene products, hair colorants, hand lotion, lipsticks, makeup, moisturizers, mouthwash, nail polish, perfume, permanent waves, shampoos, shaving cream or lotion, skin moisturizers, soaps, toothbrush and toothpaste
- Over-the-counter (OTC) medications

IMPORTANT DATES AND DEADLINES

HRA Plan Year 2019, subject to your eligibility to participate in the HRA:

- Plan Year January 1 – December 31, 2019
- HRA funds will be credited to your account during the plan year in which they are earned.
- Incurred Date Window January 1, 2019 – December 31, 2019
 - You may use funds in your 2019 HRA for eligible health care expenses if incurred in 2019 by yourself or an eligible dependent enrolled in an Ohio State medical plan on the date the service was incurred.

CONTINUED ON PAGE 67

HEALTH REIMBURSEMENT ACCOUNT (HRA)

- Reimbursement Period January 1, 2019 – March 31, 2020
 - You may request reimbursement for eligible health care expenses incurred in 2019 during the reimbursement period. All requests for reimbursements must be received by TASC no later than March 31, 2020.
- Rollover Period January 1, 2020 – Mid-April, 2020
 - During the rollover period HRA funds for 2020 expenses will not be available. By mid-April, 2020, any remaining 2019 HRA funds will rollover to your 2020 HRA account, as long as you are a covered employee under the Plan or an employee who has continuation of coverage under COBRA at the time HRA balances are rolled over. You will then have access to the 2019 rollover funds and any funds credited for 2020 Eligible expenses incurred in 2020 cannot be reimbursed from the HRA until the prior year's rollover has occurred and all HCFA funds have been exhausted.

TERMINATION OF PARTICIPATION

Your account will terminate on the earlier of the following dates:

1. The date on which your Ohio State medical coverage terminates, unless you elect COBRA continuation coverage.
2. The date on which the HRA program terminates.

CONTINUING HRA PARTICIPATION UNDER COBRA

Even if you are no longer eligible to participate in the HRA, you can continue to access and earn HRA credits for a limited time under a federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act). In order to be eligible for COBRA continuation coverage, you must elect to continue your Ohio State medical plan coverage under COBRA. Refer to the Coverage Continuation section of this booklet for details.

APPEALING A DENIED CLAIM

- If a claim under your HRA is denied in whole or in part, you will receive a written notice. The notice will be provided within 30 days after receipt of the claim and will include the following:
 - The reason for denial;
 - A reference to the pertinent HRA program provisions on which the denial is based;
 - A description of any additional material or information necessary for you to perfect the claim and an explanation of why that material is necessary; and
 - An explanation of the claim review procedures and time limits applicable to those procedures.
- If you wish to appeal a denied claim, you may request a review of the denial by completing a benefits appeal form within 180 days after you receive the notice described above. A decision will be made on the appeal within 60 days after the request for review is received. Please contact the Office of Human Resources, Customer Service at 614-292-1050 or HR@osu.edu if you have questions or to receive an appeal form.
- All determinations by the university's HRA administrator are final and binding. You must exhaust the claims and appeal procedures of the HRA before you may file suit in court. If you exhaust those procedures and decide to file suit in court, that suit must be brought within 180 days following the date that the decision to deny your appeal was made.

AMENDMENT OR TERMINATION OF THE HRA PROGRAM

The university unilaterally reserves the right to amend, modify or terminate the HRA program at any time and for any reason or no reason. Any termination will be done without prejudice to claims incurred prior to the termination date.

DEFINITIONS

Aggregate Health Information

Information that may be individually identifiable health information that:

- Summarizes claim history, claim expenses, or types of claim experienced by individuals for whom the university has provided health benefits under a group medical plan; and
- From which all identifiers described above have been deleted. Geographic information need only be aggregated to a five digit zip code level.

Alcoholism Treatment Facility

A facility primarily engaged in the treatment of alcoholism or drug addiction. The facility must have in effect plans for utilization and peer review and programs for rehabilitation or rehabilitation and detoxification of alcoholism. The facility must also be approved, licensed and certified by the appropriate regulatory authority.

Ambulatory Health Facility

A facility or distinct part of one that provides services on an outpatient basis in a fixed location or specifically designed mobile unit and does not provide overnight accommodations.

Ambulatory Surgical Facility

A facility with an organized staff of physicians that must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Association and 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 other professional.

Ancillary Services

Ancillary services are certain service, supplies and treatment received while a patient is in a hospital:

- Room and board at the hospital's average semi-private room rate
- Intensive care unit, coronary care unit or other special care units
- Use of operating, delivery, recovery and treatment rooms
- Laboratory and x-ray services
- Anesthesia and its administration by a hospital employee
- Use of incubators and oxygen
- Physical therapy, chemotherapy and radiation therapy
- Drugs and medicines consumed on the premises
- Dressings, supplies and casts

Annual Deductible

- The annual deductible is the amount you owe for covered services before your medical plan begins to pay. For example, if your annual deductible is \$600 your medical plan won't pay anything until you have met your \$600 annual deductible for covered medical care services subject to the annual deductible. The annual deductible may not apply to all services.
- Your annual deductible amount is shown in the Schedule of Benefits for your medical plan. CoreSource's records must show that you have reached this annual deductible. Therefore, to ensure proper record keeping, you should submit copies of all your bills, even those that you must pay to meet the annual deductible.
- If the family annual deductible amount is reached then the annual deductible will be waived for all others covered under family coverage for that plan year.
- Refer to the Schedule of Benefits for your medical plan to see what your annual deductible is, and whether it applies for each service.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you pay during a plan year before your medical plan begins to pay 100% of the eligible expenses (for the remainder of the plan year). Refer to the Schedule of Benefits for your medical plan for more information on your annual out-of-pocket maximum.

Balance Billing

When a provider bills you for the difference between the provider's charge and the eligible expense. For example, if the provider's charge is \$100 and the eligible expense is \$70, the provider may bill you for the remaining \$30. A network provider may not balance bill you for covered services.

Behavioral Health Services

Includes assessment and treatment of mental and/or psychological and substance abuse disorders at any level of care.

CONTINUED ON PAGE 69

DEFINITIONS

Coinsurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the eligible expense for the service. You may have to pay coinsurance in addition to any annual deductibles you owe, although some covered services may not be subject to an annual deductible. Refer to the Schedule of Benefits for your medical plan to see what your coinsurance is for each service.

Community Mental Health Facility

A facility primarily engaged in the treatment of mental illness, including substance abuse. The facility must have in effect utilization and peer review plans. The facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Mental Health.

Convenient Care Clinic

A Convenient Care Clinic is a walk-in health care clinic located in a retail store, supermarket or pharmacy that treats uncomplicated minor illnesses, injuries or conditions not serious enough for urgent or emergent care. These facilities are staffed with nurse practitioners and physician assistants who collaborate with physicians to treat minor illnesses and perform some preventive care services.

Copay/Copayment

A fixed amount (for example, \$35) you pay for a covered medical care service, usually when you receive the service. The amount can vary by the type of covered medical care service. Refer to the Schedule of Benefits for your medical plan to see what your copay/copayment is for each service.

Coverage

The payment for covered services as specified and limited by this document.

Covered Drugs

Covered drugs are medications that require a prescription under federal law and are approved for general use by the Food and Drug Administration. Prescription drugs must be dispensed for your outpatient use by a licensed pharmacy on or after your coverage effective date.

Covered Employee

The person employed by the university, whose name appears on the medical/prescription ID card and who is not enrolled as a dependent.

Covered Persons

The enrolled employee and any enrolled dependents who are eligible for coverage.

Covered Service

A service or supply shown and given by a provider for which benefits will be provided. A covered service may be subject to an annual deductible, copay, or coinsurance. To be a covered service, services must be:

- Authorized by a physician;
- Medically necessary, except as otherwise specified;
- Consistent with the condition(s) for which the covered person was admitted when an inpatient; and,
- Within the scope of the license of the provider performing the 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.

Diagnostic Services

Tests and procedures performed when you have specific symptoms to detect or to monitor your disease or condition. Diagnostic services include, but are not limited to, the following: X-ray and other radiology services; laboratory and pathology services; cardiographic, encephalographic and radioisotope tests.

Effective Date of Coverage

The date on which your coverage begins.

Eligible Expenses

Maximum amount on which payment is based for covered medical care services. Eligible expenses do not include expenses in excess of the contracted or network provider's fee schedule, UCR or the provider's reasonable charge.

CONTINUED ON PAGE 70

DEFINITIONS

Experimental/Investigative

Any healthcare services, supplies, procedures, therapies, or devices not recognized as standard medical care for the condition, disease, illness, or injury being treated. The determination of whether any of the above is experimental or investigational is based on but not limited to:

- Applicable governmental regulations, such as FDA approval,
- Available scientific evidence is inconclusive regarding safety and efficacy and there is no clear medical consensus regarding its safety and/or efficacy; i.e., a lack of an abundance of scientific literature and well-designed clinical trials,
- When the service is not proven to be as safe or effective as alternative accepted treatment or when the service does not improve health outcomes, or when the service is not proven to be outside the research setting.

Extended Care/Skilled Nursing Facility

A facility providing mainly inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of physicians. An extended care facility is not, other than incidentally, a place that provides minimal custodial care, ambulatory or part time care or that provides treatment for mental illness, alcoholism, drug abuse, or tuberculosis. The Medicare program must certify the extended care facility.

Home Health Care

A facility providing skilled nursing and other services on a visiting basis in your home and is responsible for providing the delivery of such services under a plan prescribed and approved in writing by the attending physician. A home medical care provider must be certified by Medicare or accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

Hospital

An institution licensed by the jurisdiction in which it is located and approved by the Joint Commission on the Accreditation of Healthcare Organizations or certified under Medicare. It must provide inpatient medical care and treatment, a staff of physicians and nurses, facilities for diagnosis and major surgery, but cannot be mainly a place for the aged or for treatment of alcoholism or drug addiction. It may include care for mental health.

Infertility

Infertility is the condition of an individual who has been unable to conceive or produce conception during a period of one year up to the age of 35 and six months if over the age of 35. Infertility can arise in both men and women. A woman is considered infertile if she is unable to conceive or produce conception after the stated period of frequent, unprotected heterosexual intercourse with a fertile male. A woman without a male partner may be considered infertile if she is unable to conceive after at least 12 cycles of donor insemination if under the age of 35 and six cycles if over the age of 35. A woman must be pre-menopausal or experiencing menopause at a premature age, before the age of 43, and reasonably expect fertility as a natural state.

Benefits are not provided for in-vitro fertilization, artificial insemination, assisted reproductive technologies and procedures, when either partner has undergone voluntary elective sterilization procedures, or for individuals who are not considered infertile according to the definition.

Injury

An accidental bodily injury caused by external and violent means. Injury to the teeth as a result of biting, chewing, or grinding is not considered an accidental bodily injury.

Inpatient

A covered person admitted to a hospital or other facility as a registered inpatient.

Intensive Outpatient Program (IOP)

An Intensive Outpatient Program (IOP) is a freestanding or hospital-based program that maintains hours of service for at least three hours per day, two or more days per week. It may be used as an initial point of entry into care, as a step up from routine outpatient services, or as a step down from acute inpatient, residential care or a partial hospitalization program. An IOP can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance use disorder.

Medical/Prescription Drug ID Card

The card on which you will be given your identification number and that you must present to your medical/prescription drug provider in order to verify your coverage.

Medicare

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

CONTINUED ON PAGE 71

DEFINITIONS

Medically Necessary/Medical Necessity

In order for covered services to be paid, the services must be medically necessary. This is the criteria used by CoreSource and OSU Health Plan to determine the medical necessity of medical services explained. To be medically necessary, covered services must also be provided at the most appropriate level of care and in the most appropriate type of medical care facility. Only your medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of medical care facility is appropriate. To be medically necessary, covered services must:

- Be rendered in connection with an injury or sickness;
- Be consistent with the diagnosis and treatment of your condition;
- Be in accordance with the standards of good medical practice;
- Not be considered experimental or investigative; and
- Not be for your convenience or your physician's convenience.

Note: Any service failing to meet the medical necessity criteria will be the covered employee's liability.

Network

A group of providers who have agreed with OSU Health Plan or Ohio PPO Connect to furnish medical care to covered persons. This medical care is furnished in accordance with written agreements the providers enter into with OSU Health Plan or Ohio PPO Connect.

Network Provider

A physician, provider, or group that has a network service contract in effect with OSU Health Plan or Ohio PPO Connect to provide services under the statewide network. A network provider may not balance bill you for covered services.

Network Provider's Fee Schedule

The reimbursement amounts as determined by the network provider for payment of covered services.

Ohio PPO Connect

The university has contracted with Ohio PPO Connect to allow covered persons in network plans to use providers who are part of the Ohio PPO Connect network when seeking medical services outside of Franklin County. For a list of network providers, visit osuhealthplan.com/search.

OHR

Office of Human Resources at The Ohio State University.

OSU Health Plan

The Ohio State University Health Plan, Inc.

Out-of-Network Provider

A physician or provider who does not have a network service contract in effect with OSU Health Plan or Ohio PPO Connect.

Outpatient

A covered person who receives medical care or treatment when he or she is not an inpatient.

Partial Hospitalization

Partial Hospitalization, also known as PHP (partial hospitalization program) is a type of program used to treat mental illness and substance abuse. In partial hospitalization, the patient continues to reside at home but commutes to a treatment center up to seven days a week.

Pharmacy

A facility that is a licensed establishment where a pharmacist dispenses prescription drugs under applicable state laws.

Physician

One of these professionals licensed under the applicable state laws:

- Doctor of Medicine (MD)
- Doctor of Osteopathy (DO)
- Podiatrist (DPM)
- Dental Surgeon or Dentist (DDS)
- Chiropractor (DC)
- Doctor of Optometry (OD)

Plan Administrator

The Ohio State University or the person(s) designated by the university as the plan administrator.

Plan Year

January 1 through December 31.

CONTINUED ON PAGE 72

DEFINITIONS

Plan Sponsor

The Ohio State University.

Preventive Health Services

Preventive services are:

- Services with an “A” or “B” rating from the U.S. Preventive Services Task Force;
- Immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screening for women provided for in the comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration.

A new recommendation or guideline applies in the first calendar year beginning on or after the one-year anniversary of the date that the guideline or recommendation is issued.

The Preventive Health Guidelines can be found online at osuhealthplan.com/members/preventiveguidelines.php

Prior Authorization

Prior authorization (see osuhealthplan.com/benefit-plan-information for a list of services requiring prior authorization) is notification to OSU Health Plan of a request for benefits before receipt of specific services, as outlined in the Schedule of Benefits for your medical plan, or before elective admission to a hospital or facility. Emergency admissions must be authorized within one business day. If prior authorization is not obtained from OSU Health Plan, a penalty of 20% of the fee, up to \$1,000, per admission or service will be charged. This penalty does not apply toward the annual deductible or the annual out-of-pocket maximum.

Prior Authorization Penalty

A benefit reduction of 20%, up to \$1,000, per admission or service of care will occur when prior authorization is not received from OSU Health Plan before receipt of services or before elective admission to a hospital or facility. This penalty does not apply toward the annual deductible or the annual out-of-pocket maximum.

Protected Health Information (PHI)

Information that is created, received, maintained, or transmitted by the university medical plan and relates to the past, present, or future physical or mental health of a covered person; the provision of medical care to a covered person; or the past, present, or future payment for the provision of medical care to a covered person; and that identifies the covered person or there is a reasonable basis to believe that the information could be used to identify the covered person. It includes information about living or deceased people. The following components of a covered person's health information when created, received, maintained, or transmitted by the university plans are also considered PHI:

- Names
- Street address, city, county, precinct, zip code
- Dates directly related to a covered person (including dates of birth, admission, discharge, death)
- Telephone numbers, fax numbers and electronic mail addresses
- Social Security numbers
- Medical record numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers, serial numbers and license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Biometric identifiers (including finger and voice prints)
- Full face photographic images or comparable images
- Any other unique identifying number, characteristic or code
- Health plan beneficiary ID numbers
- Internet protocol (IP address numbers)

CONTINUED ON PAGE 73

DEFINITIONS

Provider

The facilities or professionals listed below which are licensed and are operating within the scope of that license:

Facility

- Ambulatory health facility
- Ambulatory surgical facility
- Behavioral health day/nightcare center
- Community mental health facility
- Convenient care clinic
- General acute care hospital
- Home medical care provider
- Hospice provider (hospital)
- Long-term acute care facility
- On-site Birthing Center
- Pharmacy
- Psychiatric hospital
- Skilled nursing facility
- Specialized hospital
- Substance abuse treatment facility
- Urgent care facility

Professional

- Acupuncturist
- Audiologist
- Certified Nurse Midwife
- Certified Nurse Practitioner
- Clinical Nurse Specialist
- Independent Chemical Dependency Counselor
- Independent Social Worker
- Laboratory (must be Medicare approved)
- Marriage and Family Therapist
- Nurse Practitioner
- Occupational Therapist
- Pharmacist
- Physician
- Physician Assistant
- Professional Ambulance Service
- Professional Clinical Counselor
- Physical Therapist
- Psychologist
- Registered Dietician
- Registered Nurse Anesthetist
- Speech Pathologist
- Speech Therapist

Provider's Reasonable Charge

The charge that CoreSource, on behalf of the university, determines is reasonable for covered services. Refer to the definition of UCR for additional information.

Schedule of Benefits

A separate schedule showing payment information with respect to your medical plan coverage.

Sickness

Any physical disease or mental illness. Pregnancy, premature birth, congenital anomalies and birth anomalies are considered to be sicknesses.

Specialized Hospital

A facility primarily engaged in providing diagnostic and therapeutic services for the inpatient treatment of mental illness. Such services must be provided by or under the supervision of an organized staff of physicians. Continuous nursing services must also be provided under the supervision of a registered nurse.

Usual, Customary and Reasonable Charge (UCR)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the eligible expense.

- For out-of-network providers, UCR is the fee most frequently allowed for a similar service or medical procedure by most similarly qualified physicians or other medical care providers in the particular geographic area where the service is rendered or a fee that has been negotiated with the provider.
- The database used to establish UCR maximum amounts is updated on a regular basis, at least annually.
- When a charge is submitted to CoreSource on behalf of the university for reimbursement of a covered service, payment will be made for the charge or the UCR maximum, whichever is less, subject to any applicable coinsurance amounts and other provisions or limitations of the medical plan.
- Unusual circumstances which reasonably require additional time, skill or experience for a provider's service are taken into consideration by CoreSource and may result in reimbursement of an amount above the UCR maximum but not exceeding the actual charge.

Note: Charges that exceed the UCR maximum do not apply to the annual deductible or out-of-pocket maximum.

OHIO STATE TRAVEL ASSISTANCE

Eligibility

Any individual enrolled in one of the university-sponsored medical plans automatically has access to Ohio State Travel Assistance services.

TRAVELING OUTSIDE OHIO AND WITHIN THE UNITED STATES

Services Provided by Zelis

Medical Care Provider Network

If you need to see a doctor, visit a clinic or be admitted to a hospital, Zelis will refer you to the appropriate medical provider. Prior authorization (see osuhealthplan.com/benefit-plan-information for a list of services requiring prior authorization) from OSU Health Plan may be required. If you have a medical emergency that requires immediate medical assistance, please dial 911 or go to the nearest emergency room. You should also notify OSU Health Plan if a medical provider is seen.

Negotiated Rates

If you use a Zelis-participating provider (listed on the Ohio State Travel Assistance card), the provider is typically contracted at a negotiated rate which can reduce your out-of-pocket expenses.

Zelis Does Not:

- Provide referral services within the state of Ohio or outside the United States;
- Administer plan benefits;
- Determine eligibility;
- Pay expenses for medical care;
- Practice medicine or diagnose medical conditions;
- Represent the quality of medical care that you will receive; or
- Provide direct control or direction over medical providers' practices.

TRAVELING OUTSIDE THE UNITED STATES

Services Provided by RedpointWTP LLC

24 hour Access to Medical Professionals

When you contact RedpointWTP LLC, you will receive direct access to medical and security experts.

Services Include But Are Not Limited To:

- Medical evacuation
- Transportation to the nearest appropriate medical center
- Medically necessary repatriation
- Mortal remains repatriation
- Assistance recovering lost or stolen luggage, medications, eyeglasses, wallets or other important documents
- ID theft assistance while traveling
- Dental, legal and bail bond referrals
- Emergency message relay and counseling
- Online pre-trip resources; security and crime alerts, political instability alerts, passport and visa information

ADDITIONAL SERVICES WHEN TRAVELING 100 OR MORE MILES FROM HOME

Benefits Provided by RedpointWTP LLC

- Medical Evacuation
- Mortal Remains Repatriation

For a complete list of all available RedpointWTP LLC services, resources and the Terms of Service, visit LifeBenefits.com/travel.

APPENDIX

THE OHIO STATE UNIVERSITY FACULTY AND STAFF HEALTH PLANS CLAIM DETERMINATION AND APPEAL PROCEDURES

TABLE OF CONTENTS

INTRODUCTION	76
PRE-SERVICE CLAIMS (NOT INVOLVING URGENT CARE)	76
POST-SERVICE CLAIMS	78
URGENT CARE CLAIMS	80
CONCURRENT CARE CLAIMS	82
RESCISSIONS OF COVERAGE	83
VOLUNTARY EXTERNAL REVIEW PROCESS	84

CLAIM DETERMINATION AND APPEAL PROCEDURES

These procedures describe how benefit claims and appeals of adverse benefit determinations are made under The Ohio State University Faculty and Staff Health Plans (Plan). You should consult The Ohio State University Faculty and Staff Health Plans Specific Plan Details (SPD) document for details regarding the benefits provided under the Plan.

INTRODUCTION

Types of Claims

The type of claim you make determines the time frame under which a determination is made regarding your claim. There are four categories of claims, each with somewhat different claim determination and appeal rules. The primary difference is the time frame within which claims and appeals of adverse benefit determinations must be determined:

- 1. Pre-Service Claim:** A “Pre-Service Claim” generally is any claim for a benefit where the Plan conditions receipt of the benefit, in whole or in part, on prior authorization or approval of the benefit in advance of obtaining medical care.
- 2. Urgent Care Claim:** An “Urgent Care Claim” generally is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or in the opinion of the physician with knowledge of the patient’s medical condition, a delay would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- 3. Concurrent Care Claim:** A “Concurrent Care Claim” generally is any claim involving a decision to reduce or terminate an ongoing course of treatment or a decision regarding your request to extend a course of treatment beyond what has already been approved.
- 4. Post-Service Claim:** A “Post-Service Claim” generally is any claim that is not an Urgent Care Claim, a Pre-Service Claim or a Concurrent Care Claim.

Definitions

- Adverse Benefit Determination. An “adverse benefit determination” means: (1) a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit, including as a result of (a) a determination of eligibility to participate in the Plan; (b) the application of any utilization review; (c) a determination that a health care service or item does not meet the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments; (d) a determination that a health care service is not a covered benefit; or (e) the imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered; and (2) a rescission of your coverage.
- Authorized Representative. Your “authorized representative” means an individual who may act on your behalf with respect to a benefit claim or appeal under these procedures and who is any of the following: (1) a person to whom you have given express, written consent in the Appointment of Authorized Representative section of an Appeal Form to represent you in an internal appeals process or external review process of an adverse benefit determination; (2) a person authorized by law to provide substituted consent for you; or (3) a family member or a treating health care professional, but only when you are unable to provide consent. An authorized representative shall not include a designee of a physician rendering the service for which a bill has been submitted.
- Benefits Appeals Committee. “Benefits Appeals Committee” means OSUHP’s Benefits Appeals Committee.
- OSUHP. “OSUHP” means The Ohio State University Health Plan, Inc.
- Rescission of Coverage. A “rescission of coverage” means a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it is attributable to a failure to pay contributions towards the cost of coverage on a timely basis. The University shall determine who meets the requirements for eligibility under the Plan.
- Third Party Administrator. “Third Party Administrator” means the University’s third party administrator for medical claims processing, which is CoreSource, Inc.
- University. “University” means The Ohio State University.
- You. Any reference to “you” in these procedures includes you and your authorized representative.

Full and Fair Review

In connection with a claim or internal appeal, you will be provided, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. Such evidence or rationale will be provided in advance of the date on which a notice of a final adverse benefit determination is required to be provided, in order to give you an opportunity to respond prior to that date.

PRE-SERVICE CLAIMS (NOT INVOLVING URGENT CARE)

Consideration of Initial Pre-Service Claim

- Pre-Service Claims must be submitted to OSUHP by completing a prior authorization form available at osuhealthplan.com/forms-and-downloads. If you submit a Pre-Service Claim properly with all necessary information, you will receive written notice of the claim decision from OSUHP within a reasonable period of time appropriate to the medical circumstances, but not later than 10 days from receipt of the Pre-Service Claim. OSUHP may request a one-time extension of no longer than 10 days for matters beyond its control if, prior to expiration of the initial 10 day period, you are notified of the circumstances requiring the extension and the date by which a decision will be rendered.

If you file a Pre-Service Claim improperly, you will receive a notice of the improper filing and how to correct it as soon as possible, but not later than five days after your Pre-Service Claim is received. Once you receive notice of the improper filing, you then will have 45 days to provide any needed information.

CONTINUED ON PAGE 77

CLAIM DETERMINATION AND APPEAL PROCEDURES

If Your Initial Pre-Service Claim is Denied

If you receive a notice of an adverse benefit determination, the notice will set forth:

- Information sufficient to identify the claim or health care service involved, including the name of the health care provider, the date of service and claim amount, if applicable;
- The specific reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code and each code's corresponding meaning;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why the material or information is necessary;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A description of the Plan's standard, if any, that was used in making the determination;
- A statement of your right to request an external review and a description of the Plan's internal appeals and external review procedures and the time limits applicable to such procedures, including information about how to initiate an appeal and an external review;
- A statement informing you that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 of the Ohio Revised Code;
- A statement informing you that if the adverse benefit determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 or 3922.10 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If a medical necessity or experimental treatment or a similar exclusion or limit was relied upon in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

Mandatory Internal Appeal

- If your initial Pre-Service Claim is denied in whole or in part, you have the right to appeal the adverse benefit determination by sending a written request for review, in a form prescribed by the University, to the Benefits Appeals Committee within 180 days following your receipt of notice of the adverse benefit determination. Your written request should state why you think your claim should not have been denied and should include any adverse benefit determination notice you received and any additional documents, records, information or comments you think may have a bearing on your claim. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- Upon receipt of your request, the Benefits Appeals Committee will conduct a review that takes into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial adverse benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.
- If the adverse benefit determination was based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), the Benefits Appeals Committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who was consulted in connection with the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, OSUHP will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination.
- The Benefits Appeals Committee will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 10 days after receipt of your request for review of an adverse benefit determination.

If Your Pre-Service Claim is Denied Upon Mandatory Internal Appeal

If your internal appeal is denied (a "final adverse benefit determination"), you will be notified of the following, in a manner to be understood by you:

- Information sufficient to identify the claim or health care service involved, including the name of the health care provider, the date of service and claim amount, if applicable;
- A discussion of the determination;
- The specific reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code and each code's corresponding meaning;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A description of the Plan's standard, if any, that was used in making the determination;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;

CONTINUED ON PAGE 78

CLAIM DETERMINATION AND APPEAL PROCEDURES

- A statement of your right to request an external review within 180 days after the date of the notice of the final adverse benefit determination and a description of the Plan's internal appeals and external review procedures and the time limits applicable to such procedures, including information about how to initiate an appeal and an external review;
- A statement that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of a standard external review pursuant to Section 3922.08 of the Ohio Revised Code would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may file a request for an expedited external review pursuant to Section 3922.09 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If the Benefits Appeals Committee relied upon an internal rule, guideline, protocol, or other similar criterion in making the final adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Benefits Appeals Committee relied upon a medical necessity or experimental treatment or similar exclusion or limit in making the final adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

POST-SERVICE CLAIMS

Filing a Post-Service Claim

- When you receive a covered service, a Post-Service Claim must be filed for you to obtain benefits under the Plan. Your provider may file a Post-Service Claim for you. However, if your provider does not file the Post-Service Claim for you, you should file the Post-Service Claim yourself.
- Claim forms are available: online at hr.osu.edu/policies-forms; by contacting the OHR Customer Service Center by phone at 614-292-1050 or (800) 678-6010 or email at HR@osu.edu; or by contacting the Third Party Administrator.
- Claim forms must be filled out completely and then sent to: CoreSource, Inc., P.O. Box 2310, Mt. Clemens, MI 48046.
- No Post-Service Claims may be submitted more than 12 months from the date of service or supply is provided. Claims filed after that date will not be honored.
- If a Post-Service Claim is submitted, you will receive written notice from the Third Party Administrator reflecting the benefit determination within a reasonable period of time, but not later than 30 days following the date the Third Party Administrator receives the Post-Service Claim, as long as the claim contains all necessary information. The Third Party Administrator may request a one-time extension of no longer than 15 days for matters beyond its control if, prior to the expiration of the initial 30-day period, the Third Party Administrator notifies you of the circumstances requiring the extension and the date by which the Third Party Administrator expects to render a decision.
- If additional information is needed to process your Post-Service Claim, you will be notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then will have 45 days to provide any needed information.

If Your Initial Post-Service Claim is Denied

If you receive a notice of an adverse benefit determination, the notice will set forth:

- Information sufficient to identify the claim or health care service involved, including the name of the health care provider, the date of service and claim amount, if applicable;
- The specific reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code and each code's corresponding meaning;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why the material or information is necessary;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A description of the Plan's standard, if any, that was used in making the determination;
- A statement of your right to request an external review and a description of the Plan's internal appeals and external review procedures and the time limits applicable to such procedures, including information about how to initiate an appeal and an external review;
- A statement informing you that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 of the Ohio Revised Code;
- A statement informing you that if the adverse benefit determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 or 3922.10 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If a medical necessity or experimental

CONTINUED ON PAGE 79

CLAIM DETERMINATION AND APPEAL PROCEDURES

treatment or a similar exclusion or limit was relied upon in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

Mandatory First Level of Internal Appeal

- If your initial Post-Service Claim is denied in whole or in part, you have the right to appeal the adverse benefit determination by sending a written request for review, in a form prescribed by the University, to the Third Party Administrator within 180 days following your receipt of notice of the adverse benefit determination. Your written request should state why you think your claim should not have been denied and should include any adverse benefit determination notice you received and any additional documents, records, information or comments you think may have a bearing on your claim. Upon your request, you will be provided, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim.
- Upon receipt of your request, the Third Party Administrator will conduct a review that takes into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial adverse benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.
- If the adverse benefit determination was based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), the Third Party Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who was consulted in connection with the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Third Party Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination.
- The Third Party Administrator will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If Your Post-Service Claim is Denied Upon Mandatory First Level of Internal Appeal

If your mandatory first level of internal appeal is denied, you will be notified of the following, in a manner to be understood by you:

- Information sufficient to identify the claim or health care service involved, including the name of the health care provider, the date of service and claim amount, if applicable;
- A discussion of the determination;
- The specific reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code and each code's corresponding meaning;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A description of the Plan's standard, if any, that was used in making the determination;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A statement of your right to request an external review and a description of the Plan's internal appeals and external review procedures and the time limits applicable to such procedures, including information about how to initiate an appeal and an external review;
- A statement informing you that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 of the Ohio Revised Code;
- A statement informing you that if the adverse benefit determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 or 3922.10 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If the Third Party Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making its denial, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Third Party Administrator relied upon a medical necessity or experimental treatment or similar exclusion or limit in making its denial, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

Mandatory Second Level of Internal Appeal

- If you disagree with the Third Party Administrator's first level of internal appeal decision, you have the right to request a second level of internal appeal by sending a written request for review, in a form prescribed by the University, to OSUHP within 60 days following your receipt of notice of the Third Party Administrator's decision. Your written request should state why you think your claim should not have been denied and should include any adverse benefit determination notices you received and any additional documents, records, information or comments you think may have a bearing on your claim. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

CONTINUED ON PAGE 80

CLAIM DETERMINATION AND APPEAL PROCEDURES

- Upon receipt of your request, OSUHP (and in certain cases, the Benefits Appeals Committee) will conduct a review that takes into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the previous adverse benefit determinations. The review will not afford any deference to the previous adverse benefit determinations and will be conducted by an individual who is neither the individual who made an adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. If OSUHP determines that all or a portion of your Post-Service Claim should be denied, the Benefits Appeals Committee also will conduct a review of your Post-Service Claim as described in this paragraph.
- If the adverse benefit determination was based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), OSUHP and, if applicable, the Benefits Appeals Committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who was consulted in connection with the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, OSUHP and, if applicable, the Benefits Appeals Committee will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination.
- OSUHP or, if applicable, the Benefits Appeals Committee will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If Your Post-Service Claim is Denied Upon Mandatory Second Level of Internal Appeal

If your mandatory second level of internal appeal is denied (a "final adverse benefit determination"), you will be notified of the following, in a manner to be understood by you:

- Information sufficient to identify the claim or health care service involved, including the name of the health care provider, the date of service and claim amount, if applicable;
- A discussion of the determination;
- The specific reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code and each code's corresponding meaning;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A description of the Plan's standard, if any, that was used in making the determination;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A statement of your right to request an external review within 180 days after the date of the notice of the final adverse benefit determination and a description of the Plan's internal appeals and external review procedures and the time limits applicable to such procedures, including information about how to initiate an appeal and an external review;
- A statement informing you that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of a standard external review pursuant to Section 3922.08 of the Ohio Revised Code would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may file a request for an expedited external review pursuant to Section 3922.09 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If OSUHP or the Benefits Appeals Committee relied upon an internal rule, guideline, protocol, or other similar criterion in making the final adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If OSUHP or, if applicable, the Benefits Appeals Committee relied upon a medical necessity or experimental treatment or similar exclusion or limit in making the final adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

URGENT CARE CLAIMS

Consideration of Initial Urgent Care Claim

- Urgent Care Claims must be submitted to OSUHP by mail to: The OSU Health Plan, 700 Ackerman Road, Suite 440, Columbus, Ohio, 43202 or by fax to 614-292-2667. If you submit an Urgent Care Claim, you will receive notice of the benefit determination (in writing or electronically) as soon as possible, taking into account medical exigencies, but not later than 72 hours after OSUHP receives your claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. OSUHP will take into account the seriousness of your condition.
- If you fail to provide sufficient information regarding your Urgent Care Claim, OSUHP will notify you as soon as possible, but not later than 24 hours after receipt of your claim, of the specific information necessary to complete your claim. You will have a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. You will receive a notice of OSUHP's determination no later than 48 hours after the earlier of: (1) the Plan's receipt of the requested specified information; or (2) the end of the 48-hour period within which you were to provide the additional information.
- OSUHP may provide an oral notice of its determination and then follow up with a written or electronic confirmation within three days.

CONTINUED ON PAGE 81

CLAIM DETERMINATION AND APPEAL PROCEDURES

If Your Initial Urgent Care Claim Is Denied

If you receive a notice of an adverse benefit determination, the notice will set forth:

- Information sufficient to identify the claim or health care service involved, including the name of the health care provider, the date of service and claim amount, if applicable;
- The specific reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code and each code's corresponding meaning;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why the material or information is necessary;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A description of the Plan's standard, if any, that was used in making the determination;
- A statement of your right to request an external review and a description of the Plan's internal appeals and external review procedures and the time limits applicable to such procedures, including information about how to initiate an appeal and an external review;
- A statement informing you that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 of the Ohio Revised Code;
- A statement informing you that if the adverse benefit determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 or 3922.10 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If a medical necessity or experimental treatment or a similar exclusion or limit was relied upon in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

Mandatory Internal Appeal

- If your initial claim is denied in whole or in part, you have the right to appeal the adverse benefit determination by sending a written request for review, in a form prescribed by the University, to the Benefits Appeals Committee within 180 days following your receipt of notice of the adverse benefit determination. Your written request should state why you think your claim should not have been denied and should include any adverse benefit determination notice you received and any additional documents, records, information or comments you think may have a bearing on your claim. Upon your request, you will be provided, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim.
- Upon receipt of your request, the Benefits Appeals Committee will conduct a review that takes into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial adverse benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.
- If the adverse benefit determination was based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), the Benefits Appeals Committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who was consulted in connection with the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. Upon request, the Benefits Appeals Committee will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination.
- In the case of a claim involving urgent care, you may submit a request for an expedited internal appeal either in writing or orally. All necessary information for the review, including the benefit determination on review, may be transmitted between the Plan and you by telephone, facsimile, or another similarly expeditious method. To proceed with an expedited internal appeal, you or your authorized representative must contact OSUHP and provide at least the following information:
 - Your name;
 - The date(s) of the medical service;
 - The specific medical condition or symptom;
 - The provider's name;
 - The service or supply for which approval of benefits was sought; and
 - Any reasons why the appeal should be processed on a more expedited basis.

The Benefits Appeals Committee will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 48 hours after receipt of your request for review of an adverse benefit determination. If the Benefits Appeals Committee denies an Urgent Care Claim on review, OSUHP may provide oral notice of that determination, then follow-up with a written or electronic confirmation within three days.

CONTINUED ON PAGE 82

CLAIM DETERMINATION AND APPEAL PROCEDURES

If Your Urgent Care Claim is Denied Upon Mandatory Internal Appeal

If your internal appeal is denied (a “final adverse benefit determination”), you will be notified of the following, in a manner to be understood by you:

- Information sufficient to identify the claim or health care service involved, including the name of the health care provider, the date of service and claim amount, if applicable;
- A discussion of the determination;
- The specific reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code and each code’s corresponding meaning;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A description of the Plan’s standard, if any, that was used in making the determination;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A statement of your right to request an external review within 180 days after the date of the notice of the final adverse benefit determination and a description of the Plan’s internal appeals and external review procedures and the time limits applicable to such procedures, including information about how to initiate an appeal and an external review;
- A statement informing you that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of a standard external review pursuant to Section 3922.08 of the Ohio Revised Code would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may file a request for an expedited external review pursuant to Section 3922.09 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If the Benefits Appeals Committee relied upon an internal rule, guideline, protocol, or other similar criterion in making the final adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Benefits Appeals Committee relied upon a medical necessity or experimental treatment or similar exclusion or limit in making the final adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

CONCURRENT CARE CLAIMS

Consideration of Initial Concurrent Care Claim

- Concurrent Care Claims must be submitted to OSUHP by mail to The OSU Health Plan, 700 Ackerman Road, Suite 440, Columbus, Ohio, 43202 or by fax to 614-292-2667. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, any reduction or termination of those ongoing treatments before the end of that period of time or number of treatments will constitute an adverse benefit determination. OSUHP must notify you of the adverse benefit determination within a reasonable time period prior to the reduction or termination of the ongoing treatments.
- If you request to extend an ongoing course of treatment and your request is an Urgent Care Claim, OSUHP will decide your request and notify you of the determination within 24 hours after it is received, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment the request will be treated as an Urgent Care Claim and decided according to the Urgent Care Claim time frames described above. See Urgent Care Claims beginning on page 80.
- If your request to extend an ongoing course of treatment is not an Urgent Care Claim, your request will be considered a new claim and decided according to the Pre-Service Claim or Post-Service Claim time frames described above, whichever is applicable. See Pre-Service Claims beginning on page 76 or Post-Service Claims beginning on page 78, whichever is applicable.

If Your Initial Concurrent Care Claim Is Denied

If you receive a notice of an adverse benefit determination, the notice will set forth:

- Information sufficient to identify the claim or health care service involved, including the name of the health care provider, the date of service and claim amount, if applicable;
- The specific reason or reasons for the adverse benefit determination, including the denial code, such as the claim adjustment reason code and the remittance advice remark code and each code’s corresponding meaning;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why the material or information is necessary;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A description of the Plan’s standard, if any, that was used in making the determination;
- A statement of your right to request an external review and a description of the Plan’s internal appeals and external review procedures and the time limits applicable to such procedures, including if the Concurrent Care Claim is treated as an Urgent Care Claim, a description of the expedited review process for Urgent Care Claims and including information about how to initiate an appeal and an external review;
- A statement informing you that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 of the Ohio Revised Code;

CONTINUED ON PAGE 83

CLAIM DETERMINATION AND APPEAL PROCEDURES

- A statement informing you that if the adverse benefit determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and your treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 or 3922.10 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If a medical necessity or experimental treatment or a similar exclusion or limit was relied upon in making the adverse benefit determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

Mandatory Internal Appeal(s)

If your initial Concurrent Care Claims is denied in whole or in part, your right to appeal and the process relating to that appeal will be decided under the Urgent Care Claims provisions (beginning on page 80), the Pre-Service Claims provisions (beginning on page 76) or the Post-Service Claims provisions (beginning on page 78), whichever is applicable.

RESCISSIONS OF COVERAGE

If Your Coverage Is Rescinded

If you receive a notice of a rescission of coverage, the notice will set forth:

- Information sufficient to identify the claim or health care service involved;
- The specific reason or reasons for the adverse benefit determination;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why the material or information is necessary;
- Reference to the specific Plan provisions on which the adverse benefit determination is based;
- A description of the Plan's standard, if any, that was used in making the determination;
- A statement of your right to request an external review and a description of the Plan's internal appeals and external review procedures and the time limits applicable to such procedures, including information about how to initiate an appeal and an external review;
- A statement informing you that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to Section 3922.09 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

Mandatory Internal Appeal

- If your coverage under the Plan is rescinded, you have the right to appeal the adverse benefit determination by sending a written request for review, in a form prescribed by the University, to the Office of Human Resources, Benefits Services/Appeals, Suite 300, 1590 North High Street, Columbus, Ohio 43201-2190 or by fax (614-292-7813) within 180 days following your receipt of notice of the adverse benefit determination. Your written request should state why you think your coverage should not have been rescinded and should include any adverse benefit determination notice you received and any additional documents, records, information or comments you think may have a bearing on your claim. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- Upon receipt of your request, the University's Office of Human Resources will conduct a review that takes into account all comments, documents, records and other information submitted by you relating to the rescission of your coverage, without regard to whether such information was submitted or considered in the initial adverse benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual .

If Your Claim Is Denied Upon Mandatory Internal Appeal

If your internal appeal is denied (a "final adverse benefit determination"), you will be notified of the following, in a manner to be understood by you:

- Information sufficient to identify the claim or health care service involved;
- A discussion of the determination;
- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A description of the Plan's standard, if any, that was used in making the determination;

CONTINUED ON PAGE 84

CLAIM DETERMINATION AND APPEAL PROCEDURES

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A statement of your right to request an external review within 180 days after the date of the notice of the final adverse benefit determination and a description of the Plan's internal appeals and external review procedures and the time limits applicable to such procedures, including information about how to initiate an appeal and an external review;
- A statement informing you that if your treating physician certifies in writing that you have a medical condition for which the time frame for completion of a standard external review pursuant to Section 3922.08 of the Ohio Revised Code would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may file a request for an expedited external review pursuant to Section 3922.09 of the Ohio Revised Code; and
- The availability of, and contact information for, the Ohio Department of Insurance, who may assist you with the internal appeals and external review processes.
- If the University's Office of Human Resources relied upon an internal rule, guideline, protocol, or other similar criterion in making the final adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

VOLUNTARY EXTERNAL REVIEW PROCESS

If the Plan makes an adverse benefit determination with respect to all or any portion of your initial claim or your claim on your mandatory internal appeal, you may be entitled to obtain an independent external review pursuant to Ohio law by an accredited independent review organization (IRO) or by the Ohio Department of Insurance.

External Review by an Independent Review Organization

- Generally, External review by an IRO is available only when (1) the adverse benefit determination involves a medical judgment or is based on any medical information, or (2) the adverse benefit determination indicates that the requested service is experimental or investigational (and is not a health care service that is explicitly listed as an excluded benefit under the Plan) and your treating physician certifies that one of the following situations is applicable: (a) standard health care services have not been effective in improving your condition; (b) standard health care services are not medically appropriate for you; or (c) no available standard health care service covered by the Plan is more beneficial than requested health care service. An external review by an IRO may either be standard or expedited.
- Expedited Review. An expedited review is available after an adverse benefit determination only if your treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize your life or health if treated after the time frame of an expedited internal review and you have filed a request for an expedited internal review. An expedited review is available after a final adverse benefit determination if either (1) your treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, if treated after the time frame of a standard external review, or (2) the adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which you received emergency services but have yet to be discharged from the facility. An expedited external review may not be provided for a retrospective final adverse benefit determination.
- Required Exhaustion of Mandatory Internal Appeals for Standard Review. A standard review (including a standard review involving experimental or investigational treatment) is not available unless you have exhausted the Plan's mandatory internal appeal process described previously. However, exhaustion is not required when: (1) the Plan agrees to waive the exhaustion requirement, (2) you did not receive a written decision of your internal appeal within the required time frame, (3) an expedited external review is sought simultaneously with an expedited internal review in accordance with these procedures and applicable state law, or (4) the Plan fails to adhere to all of the requirements of the internal appeal process, except for de minimis violations that do not cause or are not likely to cause you prejudice or harm, are for good cause or due to matters beyond the control of the Plan, occur in the context of an ongoing, good faith exchange of information between the Plan and the covered person and are not reflective of a pattern or practice of non-compliance. Notwithstanding the foregoing, in the case of an adverse benefit determination involving a retrospective review determination made pursuant to a utilization review, you must exhaust the mandatory internal appeals process even if you do not receive a written decision of your internal appeal within the required time frame and even if the Plan fails to adhere to all requirements of the internal appeal process.
- Appeal of Denial of Request for External Review for Failure to Exhaust Mandatory Internal Appeals. If the Plan denies your request for external review on grounds that the mandatory internal appeal process has not been exhausted despite de minimis violations of that process, you may request written explanation from the Plan and the Plan shall provide its explanation within ten days, including a specific description of its basis for asserting that the delay should not cause the internal appeals process to be considered exhausted. You may request review by the Ohio Department of Insurance of this explanation. If the Ohio Department of Insurance affirms the Plan's explanation, you may, within 10 days of receipt of the Ohio Department of Insurance's notice of decision, resubmit and pursue the internal appeal process.

External Review by Ohio Department of Insurance

You may be eligible for external review by the Ohio Department of Insurance of an adverse benefit determination: (1) involving a contractual issue that did not involve a medical judgment or any medical information or (2) in which emergency medical services have been determined to be not medically necessary or appropriate after an external review by an IRO.

Requesting an External Review

You must request an external review of a final adverse benefit determination, in a form prescribed by the Ohio Department of Insurance, within 180 days of the date you received notification of the determination. The request must be in writing, except that a request for an

CONTINUED ON PAGE 85

CLAIM DETERMINATION AND APPEAL PROCEDURES

expedited review may be made electronically or orally, provided that you submit written confirmation of the request to the Plan no later than 5 days after the request is made. When filing a request for an external review, you will be required to authorize the release of your medical records as necessary to conduct the external review.

Evaluation of a Request for External Review

If your request for external review is complete, OSUHP will send you written notice confirming that your request is complete and providing you with the name and contact information of the assigned IRO or the Ohio Department of Insurance (as applicable) and a statement that you may submit additional information for consideration within 10 business days after receipt of the notice, except in connection with a request for an expedited review (including an expedited review involving experimental or investigational treatment).

If your request for external review is not complete, OSUHP will inform you in writing and specify the additional information you need to provide. If the Plan determines that the adverse benefit determination is not eligible for external review, the Plan will send you written notice with the reason for the denial and inform you that you may appeal the denial to the Ohio Department of Insurance. The Ohio Department of Insurance may determine that your request is eligible for external review regardless of the decision by the Plan.

Assignment of Independent Review Organization

If an external review of an adverse benefit determination by an IRO is granted, the Ohio Department of Insurance shall assign an IRO to conduct the external review.

Reconsideration of Adverse Benefit Determination by Plan

Except in the case of an expedited external review, the IRO will forward to the Plan, upon receipt, any additional information it receives from you. The Plan may reconsider its adverse benefit determination and provide coverage for the health care service. Reconsideration will not delay or terminate the external review. If the Plan reverses its previous adverse benefit determination, it will notify you, the assigned IRO and the Ohio Department of Insurance within one day of the decision. The IRO will terminate its review upon receipt of this notice.

Consideration and Determination of External Review by Independent Review Organization

In addition to the documents and information provided by the Plan relating to its adverse benefit determination and any additional information provided by you, the IRO also will consider, if available and appropriate: (1) your medical records, (2) the attending health care professional's recommendation, (3) consulting reports from appropriate health care professionals and other documents submitted by the Plan, you, or the treating provider, (4) the terms of coverage under the Plan to ensure the decision is not contrary to the terms of the Plan and (5) the most appropriate practice guidelines, including evidence-based standards and guidelines. The IRO is not bound by any decisions or conclusions reached by the Plan during its utilization review process or internal appeals process.

The assigned IRO must provide a written notice of its decision within 30 days after receipt by the Plan of a request for standard review (including a standard review involving an experimental or investigational treatment) or within 72 hours of receipt by the Plan of a request for expedited review. This notice will be sent to you, the Plan and the Ohio Department of Insurance. The notice will include the following information: (1) a general description of the reason for the request for the review, (2) the date the IRO was assigned, (3) the dates over which the review was conducted, (4) the date the IRO decision was made, (5) the rationale for the IRO's decision and (6) references to the evidence or documentation that was used to reach the decision. If the IRO overturns the Plan's decision, upon receipt of the notice, the Plan will immediately provide coverage for the health care service.

Any statute of limitations or other defense based upon timeliness is tolled during the time that any properly initiated independent external review is pending. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except to the extent you or the Plan have other remedies available under applicable federal or state law, or unless the Ohio Department of Insurance determines that, due to the facts and circumstances of an external review, a second external review is required. You may not file a subsequent request for external review involving the same adverse benefit determination for which you already received an external review decision, except in the event that new medical or scientific evidence is submitted to the Plan.

IF YOU HAVE QUESTIONS ABOUT YOUR RIGHTS OR NEED ASSISTANCE

YOU MAY CONTACT:

Ohio Department of Insurance

ATTN:

Consumer Affairs

50 West Town Street, Suite 300

Columbus, OH 43215

800-686-1526 / 614-644-2673

614-644-3744 (fax)

614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://gateway.insurance.ohio.gov/UI/ODI.CS.Public.UI/Comment.mvc/DisplayCommentSubmission>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>



THE OHIO STATE UNIVERSITY

HUMAN RESOURCES