St. Clairsville, Ohio May 30, 2001

The Board of Commissioners of Belmont County, Ohio, met this day in regular session at the Village of Bethesda at 6:00 P.M. Present: Ryan E. Olexo, Charles R. Probst and Mark A. Thomas, absent Commissioners and Darlene Pempek, Clerk of the Board and Carol Blankenship, Assistant Clerk of the Board. Minutes of the meeting of May 25, 2001, were read, approved and signed.

**EVENING MEETING-BETHESDA**

Robert E. Flanagan, Mayor of the Village of Bethesda, introduced the Board of Commissioners and extended his appreciation to the Board for holding their evening meeting in Bethesda.

Commission President Ryan E. Olexo opened the meeting and explained this was the Board's opportunity to hear from the residents. The Commission takes their evening meetings out to various locations in the County in order to reach the citizens, some of who are unable to attend scheduled meetings at the Courthouse.

Commissioner Olexo thanked those present for attending and stated the Board looked forward to hearing from the residents during the open public forum.

**IN THE MATTER OF THE ALLOWANCE OF BILLS "BILLS ALLOWED"**
**AS CERTIFIED IN THE AUDITOR'S OFFICE.** The following bills having been certified in the Auditor's office, on motion by Mr. Olexo, seconded by Mr. Probst all members present voting YES, each bill was considered and it is hereby ordered that the County Auditor issue his warrant on the County Treasurer in payment of bills allowed.

| Claim of | Purposes | Amount |
|---|---|---|
| ACS Government Records Management | Indexing & Laser paper/Recorders-Gen | 3,283.03 |
| Betty J. Porter, Sandusky Clk of Cts | Summer Conference reg/Clk of Cts-Gen | 150.00 |
| Belmont Veterinary Service | Medical service-Dog & Kennel | 80.00 |
| Administar Federal Inc. | Reimb overpayment, Medicare-County Home | 17,458.00 |
| Ryan Clifford | Contract services, CCap Program-Juv Ct | 60.00 |
| Stanley Galownia | Contract services, CCap Program-Juv Ct | 180.00 |
| Aaron Walker | Contract services, CCap Program-Juv Ct | 60.00 |
| C & C Electric Company | Lloydsville garage-Engineers Bldg Const. | 3,798.00 |
| Power City Plumbing | Lloydsville garage-Engineers Bldg Const. | 4,140.00 |
| Bedway Development, Inc. | Lloydsville garage-Eng. Bldg Const. | 28,219.68 |
| AGX Inc. | Building survey, asbestos/Tacoma-Eng | 500.00 |
| AGX Inc. | Building survey, asbestos/Neffs-Eng | 500.00 |
| Treasurer, State of Ohio | Cooperative purchasing-Sanitary Sewer | 295.00 |
| Eastern Ohio Correction Center | Drug testing-Common Pleas Grant | 2,760.20 |
| Belmont County Commissioners | Reimb auto insurance/E Gorence-Grant | 500.00 |
| Cintas Corporation | Floor mat serv-Clerk of Courts | 361.66 |
| Belmont County Committee On Aging | Dec/Jan Operating exp-In Home Care | 126,635.76 |
| Contingency Fund Replen-GGH | Contingency Fund-Girls Group Home | 100.05 |
| Contingency Fund Replen-BGH | Contingency Fund-Boys Group Home | 125.02 |

**IN THE MATTER OF APPROVING RECAPITULATION OF VOUCHERS FOR THE GENERAL FUND**

Motion made by Mr. Probst, seconded by Mr. Olexo to approve the Recapitulation of Vouchers for the General Fund in the amount of $2,053.82 dated for May 30, 2001.

Upon roll call the vote was as follows:

Mr. Probst Yes
Mr. Olexo Yes

**IN THE MATTER OF APPROVING RECAPITULATION OF VOUCHERS FOR THE LITTER CONTROL FUND**

Motion made by Mr. Probst, seconded by Mr. Olexo to approve the Recapitulation of Vouchers for the Litter Control Fund in the amount of $187.35 dated for May 30, 2001.

Upon roll call the vote was as follows:

Mr. Probst Yes
Mr. Olexo Yes

**IN THE MATTER OF APPROVING**
**RECAPITULATION OF VOUCHERS**
**FOR THE SARGUS CENTER/GROUP HOMES FUND**

Motion made by Mr. Probst, seconded by Mr. Olexo to approve the Recapitulation of Vouchers for the Sargus Center Fund in the amounts of $1,050.00 and $6,232.60 and for the Group Homes Fund in the amounts of $922.59 and $2,263.46 dated for May 30, 2001.

Upon roll call the vote was as follows:

Mr. Probst Yes
Mr. Olexo Yes

**IN THE MATTER OF APPROVING**
**RECAPITULATION OF VOUCHERS**
**FOR THE NORTHERN COURT SPECIAL PROJECTS FUND**

Motion made by Mr. Probst, seconded by Mr. Olexo to approve the Recapitulation of Vouchers for the Northern Court Special Projects Fund in the amount of $2,793.39 dated for May 30, 2001.

Upon roll call the vote was as follows:

Mr. Probst Yes
Mr. Olexo Yes

**IN THE MATTER OF MONTHLY TRANSFER OF**
**FUNDS FOR BELMONT COUNTY SANITARY SEWER**

Motion made by Mr. Probst, seconded by Mr. Olexo to make the following monthly transfer of funds dated for the month of May, 2001 for the Belmont County Sanitary Sewer Department.

| FROM | | TO | | AMOUNT |
|---|---|---|---|---|
| P003-P18 | SUPPLIES | Y090-Y02 | SUPPLIES | 346.12 |
| P003-P19 | EQUIPMENT | Y090-Y03 | EQUIPMENT | 545.53 |
| P003-P20 | LABOR | Y090-Y04 | LABOR | 0.00 |
| P003-P21 | MATERIALS | Y090-Y05 | MATERIALS | 3,509.54 |
| P003-P22 | CONTRACT REP. | Y090-Y06 | CONTRACT REP. | 0.00 |
| P003-P23 | CONTRACT SERV. | Y090-Y07 | CONTRACT SERV. | 0.00 |
| P003-P24 | CONTRACT PROJ. | Y090-Y08 | CONTRACT PROJ. | .00 |
| P003-P25 | PURCHASED H20 | Y090-Y09 | PURCHASED H20 | 50,742.45 |
| P003-P27 | ADV & PRINTING | Y090-Y04 | ADV & PRINTING | 0.00 |
| P003-P28 | TRAVEL & EXP. | Y090-Y11 | TRAVEL & EXP. | 59.75 |
| P003-P29 | PERS | Y090-Y12 | PERS | 0.00 |
| P003-P30 | WORKERS' COMP | Y090-Y13 | WORKERS' COMP | 2,701.67 |
| P003-P31 | OTHER EXPENSES | Y090-Y14 | OTHER EXPENSES | 1,047.71 |
| P003-P32 | TRANSFERS-OUT | Y090-Y17 | TRANSFERS-OUT | 795.89 |
| P003-P35 | MEDICARE | Y090-Y18 | MEDICARE | 243.96 |
| TOTAL | | | | 59,992.62 |
| | | | | |
| P005-P18 | SUPPLIES | Y090-Y02 | SUPPLIES | 640.67 |
| P005-P19 | EQUIPMENT | Y090-Y03 | EQUIPMENT | 2,722.45 |
| P005-P21 | MATERIALS | Y090-Y05 | MATERIALS | 12,779.68 |
| P005-P22 | CONTRACT REP. | Y090-Y06 | CONTRACT REP. | 0.00 |
| P005-P23 | CONTRACT SERV. | Y090-Y07 | CONTRACT SERV. | 26,795.43 |
| P005-P24 | CONTRACT PROJ. | Y090-Y08 | CONTRACT PROJ. | 3,879.50 |
| P005-P25 | PURCHASED H2O | Y090-Y09 | PURCHASED H2O | 818.31 |
| P005-P27 | ADV & PRINTING | Y090-Y10 | ADV & PRINTING | 0.00 |
| P005-P28 | TRAVEL & EXP. | Y090-Y11 | TRAVEL & EXP. | 110.58 |
| P005-P29 | PERS | Y090-Y12 | PERS | 0.00 |
| P005-P30 | WORKERS' COMP | Y090-Y13 | WORKERS'COMP | 7,651.32 |
| P005-P31 | OTHER EXP. | Y090-Y14 | OTHER EXP. | 43,184.22 |
| P005-P34 | TRANSFERS-OUT | Y090-Y17 | TRANSFERS-OUT | 3,135.36 |
| P005-P35 | MEDICARE | Y090-Y18 | MEDICARE | 634.73 |
| TOTAL | | | | 102,352.25 |
| | | | | |
| P051-P02 | SUPPLIES | Y090-Y02 | SUPPLIES | 149.32 |
| P051-P03 | EQUIPMENT | Y090-Y03 | EQUIPMENT | 1,123.47 |
| P051-P05 | MATERIALS | Y090-Y05 | MATERIALS | 517.89 |
| P051-P06 | CONTRACT REP. | Y090-Y06 | CONTRACT REP. | 0.00 |
| P051-P07 | CONTRACT SERV. | Y090-Y07 | CONTRACT SERV. | 0.00 |
| P051-P08 | CONTRACT PROJ | Y090-Y08 | CONTRACT PROJ | 0.00 |
| P051-P09 | SEWAGE DIS. | Y090-Y08 | SEWAGE DIS. | 16,233.23 |
| P051-P11 | ADV & PRINTING | Y090-Y10 | ADV & PRINTING | 0.00 |
| P051-P12 | TRAVEL & EXP | Y090-Y11 | TRAVEL & EXP | 25.77 |
| P051-P13 | PERS | Y090-Y12 | PERS | 0.00 |
| P051-P14 | WORKERS' COMP | Y090-Y13 | WORKERS' COMP | 684.33 |
| P051-P15 | OTHER EXP. | Y090-Y14 | OTHER EXP. | 608.73 |
| P051-P16 | TRANSFERS OUT | Y090-Y17 | TRANSFERS OUT | 0.00 |
| P051-P35 | MEDICARE | Y090-Y18 | MEDICARE | 166.56 |
| TOTAL | | | | 19,509.30 |

| | | | | |
|---|---|---|---|---|
| P053-P02 | SUPPLIES | Y090-Y02 | SUPPLIES | 59.39 |
| P053-P03 | EQUIPMENT | Y090-Y03 | EQUIPMENT | 447.06 |
| PO53-P05 | MATERIALS | Y090-Y05 | MATERIALS | 1,301.12 |
| P053-P06 | CONTRACT REP. | Y090-Y06 | CONTRACT REPAIRS | 0.00 |
| P053-P07 | CONTRACT SERV. | Y090-Y07 | CONTRACT SERV. | 3,616.74 |
| P053-P08 | CONTRACT PROJ | Y090-Y08 | CONTRACT PROJ | 0.00 |
| P053-P09 | SEWAGE DIS. | Y090-Y09 | SEWAGE DIS. | 18,364.45 |
| P053-P11 | ADVER.&PRINTING | Y090-Y10 | ADVER.&PRINTING | 0.00 |
| P053-P12 | TRAVEL & EXP. | Y090-Y11 | TRAVEL & EXP | 10.25 |
| P053-P13 | PERS | Y090-Y12 | PERS | 0.00 |
| P053-P14 | WORKERS' COMP | Y090-Y13 | WORKERS' COMP | 1,502.83 |
| P053-P15 | OTHER EXP. | Y090-Y14 | OTHER EXP. | 10,592.65 |
| P053-P16 | TRANSFERS OUT | Y090-Y17 | TRANSFERS OUT | 10,000.00 |
| P053-P35 | MEDICARE | Y090-Y18 | MEDICARE | 66.30 |
| TOTAL | | | | 45,960.79 |

| | | | | |
|---|---|---|---|---|
| P054-P02 | SUPPLIES | Y090-Y02 | SUPPLIES | 12.32 |
| P054-P03 | EQUIPMENT | Y090-Y03 | EQUIPMENT | 130.69 |
| P054-P05 | MATERIALS | Y090-Y05 | MATERIALS | 41.81 |
| P054-P07 | CONTRACT SERV. | Y090-Y07 | CONTRACT SERV. | 482.70 |
| P054-P12 | TRAVEL & EXP. | Y090-Y11 | TRAVEL & EXP. | 2.99 |
| P054-P13 | PERS | Y090-Y12 | PERS | 0.00 |
| P054-P14 | WORKERS' COMP | Y090-Y13 | WORKERS' COMP | 223.11 |
| P054-P15 | OTHER EXP. | Y090-Y14 | OTHER EXP. | 49.90 |
| P054-P35 | MEDICARE | Y090-Y18 | MEDICARE | 16.97 |
| TOTAL | | | | 960.49 |

| | | | | |
|---|---|---|---|---|
| P055-P02 | SUPPLIES | Y090-Y02 | SUPPLIES | 17.25 |
| P055-P03 | EQUIPMENT | Y090-Y03 | EQUIPMENT | 181.91 |
| P055-P05 | MATERIALS | Y090-Y05 | MATERIALS | 58.54 |
| P055-P07 | CONTRACT SERV. | Y090-Y07 | CONTRACT SERV. | 764.63 |
| P055-P12 | TRAVEL & EXP. | Y090-Y11 | TRAVEL & EXP. | 4.19 |
| P055-P13 | PERS | Y090-Y12 | PERS | 0.00 |
| P055-P14 | WORKERS' COMP | Y090-Y13 | WORKERS' COMP | 240.96 |
| P055-P15 | OTHER EXP. | Y090-Y14 | OTHER EXP. | 349.52 |
| P055-P35 | MEDICARE | Y090-Y18 | MEDICARE | 23.60 |
| TOTAL | | | | 1,640.60 |

| | | | | |
|---|---|---|---|---|
| P056-P02 | SUPPLIES | Y090-Y02 | SUPPLIES | 0.00 |
| P056-P07 | CONTRACT SERV. | Y090-Y07 | CONTRACT SERV. | 3.00 |
| P056-P09 | SEWAGE DISP. | Y190-Y08 | SEWAGE DISP. | 1,191.78 |
| P056-P13 | PERS | Y090-Y12 | PERS | 0.00 |
| P056-P14 | WORKERS' COMP | Y090-Y13 | WORKERS' COMP | 38.51 |
| P056-P15 | OTHER EXP. | Y090-Y14 | OTHER EXP. | 1,477.19 |
| P056-P16 | TRANSFERS OUT | Y090-Y14 | TRANSFERS OUT | 0.00 |
| P056-P35 | MEDICARE | Y090-Y18 | MEDICARE | 9.40 |
| TOTAL | | | | 2,719.88 |

Upon roll call the vote was as follows:

| | |
|---|---|
| Mr. Olexo | Yes |
| Mr. Probst | Yes |

**IN THE MATTER OF GRANTING**
**PERMISSION FOR BCDJFS EMPLOYEES TO TRAVEL**

Motion made by Mr. Olexo, seconded by Mr. Probst granting permission for the following BCDJFS employees to travel.

Name: Lynn Pappas
Destination: Cadiz, Ohio
Date: June 1, 2001
Purpose: FCFC Video Conference
Estimated Cost: $11.73

Name: Jack Cera, and Mike Schlanz
Destination: Steubenville, Ohio
Date: May 29, 2001
Purpose: WIA Meeting
Estimated Cost: $ 43.46

Name: Peggy Graham, Annie Smith, and Kathy Crumbley
Destination: Athens, Ohio
Date: June 5, 2001
Purpose: Overpayment Tracking Meeting
Estimated Cost: $ 109.00

Name: Dwayne Pielech, and Lynn Pappas
Destination: Dellroy, Ohio
Date: June 28-29, 2001
Purpose: Canton District Fiscal Conference
Estimated Cost: $ 232.43

Name: Judy Cilles, Jack Cera and Lynn Pappas
Destination: Athens, Ohio
Date: June 19, 2001
Purpose: Contracting Workshop
Estimated Cost: $ 349.00

Name: Donna Yocum and Mary Eddy
Destination: Cambridge, Ohio
Date: June 28, 2001
Purpose: SETS Training
Estimated Cost: $ 51.05

Upon roll call the vote was as follows:

Mr. Olexo Yes
Mr. Probst Yes

**IN THE MATTER OF GRANTING PERMISSION FOR BOARD OF ELECTION MEMBERS TO TRAVEL**

Motion made by Mr. Olexo, seconded by Mr. Probst granting permission for the Board of Elections members to travel to Columbus, Ohio on May 30, 2001 to attend computer training classes.

Upon roll call the vote was as follows:

Mr. Olexo Yes
Mr. Probst Yes

**IN THE MATTER OF REQUESTS FOR CERTIFICATION OF MONIES**

Motion made by Mr. Probst, seconded by Mr. Olexo to request that the following monies be certified.

May 30, 2001

Budget Commission
Belmont County Courthouse
St. Clairsville, OH 43950

Dear Sirs:

RE: CERTIFICATION OF MONIES/CDBG FUND

Requesting certification of monies for the Commissioners CDBG Fund as follows:

$5,953.00 paid into T011-T01 on May 30, 2001, Grant B-C-99-007-1/Drawdown 239

Upon roll call the vote was as follows:

Mr. Probst Yes
Mr. Olexo Yes

**IN THE MATTER OF AUTHORIZING PURCHASE OF EPSON PROJECTOR/9-1-1**

Motion made by Mr. Probst, seconded by Mr. Olexo to approve the purchase of an Epson Projector under the State-purchasing program at a cost of $4,450.00. The monies for this project are allocated from the Belmont County E911 Fund.

Upon roll call the vote was as follows:

Mr. Probst Yes
Mr. Olexo Yes

**IN THE MATTER OF ADVERTISING FOR BIDS FOR RESURFACING PROJECT 01-5 COUNTY HIGHWAY 4/ENGINEER'S**

Motion made by Mr. Olexo, seconded by Mr. Probst to advertise for the following resurfacing project for the Engineer's Department.

ADVERTISE FOR BIDS

It appearing to the Board that it would be to the best interest of the Public to ask and receive bids for resurfacing County Highway 4, Colerain-Martins Ferry Pike for the Belmont County Engineer's Department, the Clerk is hereby directed to have published in the Martins Ferry Times Leader, a newspaper having general circulation in the County, a "Notice to Bidders" as follows:

**NOTICE TO BIDDERS**

BELMONT COUNTY COMMISSIONERS' OFFICE ST. CLAIRSVILLE, OHIO 43950

Sealed bids will be received by the Belmont County Board of Commissioners at the Commissioners Office, Belmont County Courthouse, St. Clairsville, Ohio until 9:45 A.M. (Local Time), Wednesday, June 20, 2001 for furnishing all labor, materials and equipment to complete for the Belmont County Engineer, the following resurfacing project known as **PROJECT 01-5 RESURFACING COUNTY HIGHWAY 4 COLERAIN – MARTINS FERRY PIKE** and then at said office publicly opened and read aloud.

Copies of specifications and proposals forms may be obtained at the Commissioners office between the hours of 9:00 A.M. and 4:00 P.M. daily, Monday thru Friday.

A bid guaranty shall be provided with the bid in accordance with Section 153.54 of the Ohio Revised Code as follows:

- A Bond in accordance with Section 153.54 (B) O.R.C. for the full amount of the bid OR
- A certified check, cashiers check or letter of credit in accordance with Section 153.54 ( C ) O.R.C. in an amount equal to 10% of the bid. Bid security furnished in Bond form, shall be issued by a Surety Company or Corporation licensed in the State of Ohio to provide said surety.

Each proposal must contain the full name of the party or parties submitting the proposal and all persons interested therein. Each bidder shall be pre-qualified by the Ohio Department of Transportation at the time of the bid opening and shall submit certification of said approval and pre-qualifications with bid. Each bidder must submit evidence of its experiences on projects of similar size and complexity. The owner intends and requires that this project must be completed by August 31, 2001.
All contractors and subcontractors involved with the project will, to the extent practicable use Ohio products, materials, services and labor in the implementation of their project. Additionally, contractor compliance with the equal employment opportunity requirements of Ohio Administrative Code Chapter 123, the Governor's Executive Order of 1972 and Governor's Executive Order 84-9 shall be required.
Bidders must comply with the prevailing wage rates on Public Improvements in Belmont County, Ohio as determined by the Ohio Department of Industrial Relations.

Said Contract will be let to the lowest and best responsible bidder in accordance with **Attachment 1 "Bid Documents Belmont County Commission"**. The County reserves the right to reject any and all proposals and award a contract to that bidder which is in the best interest of the County.

By order of the Board of Commissioners
Of Belmont County, Ohio

Darlene Pempek /s/
Darlene Pempek, Clerk of the Board

Times Leader – Adv. (2) Tuesdays June 5, 2001 and June 12, 2001

Upon roll call the vote was as follows:

Mr. Olexo Yes
Mr. Probst Yes

**IN THE MATTER OF ENTERING INTO AGREEMENT WITH THE HEALTH PLAN OF THE UPPER OHIO VALLEY, INC./GROUP MEDICAL INSURANCE**

Motion made by Mr. Probst, seconded by Mr. Olexo to enter into the following agreement with The Health Plan of the Upper Ohio Valley, Inc. for Group Medical Insurance for county employees.

GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT

THIS AGREEMENT is made and entered into effective the first day of June, 2001, by and between The Health Plan of the Upper Ohio Valley, Inc., a nonprofit corporation organized under the laws of the State of West Virginia and registered as a foreign corporation in the State of Ohio, (herein called "Health Plan"), and Belmont County Commission (hereinafter called "Group" or "Employer").

WHEREAS, The Health Plan operates a comprehensive prepaid program of health care in West Virginia and Ohio (subject to the licensing requirements and operational regulatory standards enforced by the Commissioner of Insurance of West Virginia and the Superintendent of Insurance of Ohio, under respectively, the West Virginia Health Maintenance Organization Act of 1977, and the Ohio Health Maintenance Organization Act of 1977, and the Ohio Uniform Licensure Act) which arranges for the provision of health care services for members in order to protect and promote their health, and which preserves and enhances patient dignity;

AND WHEREAS, Group wishes to participate in the said program;

NOW, THEREFORE, in consideration of the foregoing and of the payment of charges as provided herein and of mutual promises and benefits hereinafter described, the parties hereto agree as follows:

I. GENERAL

The Group engages The Health Plan to arrange for provision of Medical and Hospital Services for members of the group who subscribe for said services, in accordance with the promises and conditions hereinafter provided and in reliance upon the statements of each subscriber in his/her application for health care.

II. INTERPRETATION

In order to provide the advantages of integrated medical and hospital facilities and of coordinated medical practice, as provided for in Public Law 92-222, popularly referred to as the Health Maintenance Organization Act of 1973, 42 U.S. C. § 300e et seq., as amended, and provided for in Ohio Revised Code Annotated § 1751.01 et. seq., as amended, and in West Virginia Code § 33-25A- 1 et seq., as amended, The Health Plan operates on the basis of arranging for services on a fixed prepayment basis rather than an indemnity basis. The interpretation of this Agreement shall be guided by this prepaid service nature of The Health Plan's program.

III. DEFINITIONS

A. ADVERSE DETERMINATION means a determination by the Plan or its designee that an admission, availability of care, continued stay or other health care service covered under this Agreement has been reviewed and based upon the information provided, the health care service does not meet the Plan’s requirements for benefit payment and therefore is denied, reduced or terminated.

B. AFFILIATION PERIOD means a period (not to exceed) which must expire before the health care coverage becomes effective.

C. AGREEMENT means The Health Plan “Group Medical and Hospital Service Agreement”" and other evidence of coverage (Member Handbook, Enrollment Form, or Verification and Confirmation Document and current Provider List).

D. ALTERNATIVE HEALTH BENEFITS PLAN means the health benefits plan or plans which the Group sets as an alternative to the plan set forth in this Agreement.

E. APPROPRIATE PRIOR ARRANGEMENTS means those special billing and eligibility arrangements, if any, agreed to by the Group (i.e. Employer) and the Plan. These affect enrollment eligibility and effective dates of coverage (i.e. probationary periods, etc.).

F. AUTHORIZED PERSON means a parent; guardian or other person authorized to act on behalf of a member with respect to health care decisions.

G. BASIC HEALTH CARE SERVICES means the following services when medically necessary: physician services, inpatient services, outpatient services, emergency health services, urgent care services, diagnostic laboratory and diagnostic therapeutic radiological services and preventive health care services. Basic services do not include supplemental services (i.e., vision, dental or prescription) or experimental services. Please refer to Attachment C, “Hospital and Medical Benefits Schedule” of this Agreement.

H. BENEFITS SCHEDULE means the list of health care benefits or coverage encompassing all medical, hospital and other services under this Agreement. The benefits are attached to or may hereinafter be made a part of this Agreement.

I. CONCURRENT REVIEW means utilization review conducted during a patient’s hospital stay or course of treatment.

J. CONGENITAL means existing and present at birth, referring to certain mental or physical traits, anomalies, malformations, diseases, etc. They may either be hereditary or due to an influence occurring during gestation up to the moment of birth. This does not include that are developmental in nature (not at birth). Examples of congenital defects are cleft lip and cleft palate.

K. CONTRIBUTORY COVERAGE means coverage for which the Group may set up required contributions to be made by the subscriber.

L. COORDINATION OF BENEFITS (COB) means when the subscriber, their spouse, and/or their covered dependents are eligible benefits under more than one group health benefits programs.

M. COPAYMENT means the amount required, if any, to be paid by a member for the services outlined in this Agreement. Copayments shall not be a barrier to the necessary utilization of services by members, copayments paid by a member during a contract year shall not exceed

30% of the total cost (equivalent to negotiated provider fee) of any single basic health care service or 200% of the total annual premium cost. This does not include copays for physician office visits, emergency health services, urgent care services, supplemental health care services or specialty health care services. Members must submit receipts to The Health Plan within 45 days of the end of the contract year. Any such excess shall then be refunded to the subscriber.

N. COVERAGE means the medically necessary and appropriate health benefits coverage under this Agreement.

O. CREDITABLE COVERAGE means coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicaid, military health program, Indian Health Service or tribal health program, a state health benefits risk pool, a Veterans Administration health plan, a public health plan, Medicare, Peace Corps, Cobra or similar plan(s). Prior coverage does not qualify if there was a break in coverage under a prior health plan that was longer than a 63-day period. Generally, plans must give credit for prior health coverage regardless of the specific benefits covered by the prior plan.

The Health Plan will provide to terminated members (or by request) a "Certificate of Creditable Coverage."

P. DEPENDENT means any member of a subscriber's immediate family who meets all applicable requirements of the Article IV and is enrolled hereunder and whose fixed periodic prepayment has been received by the Plan.

Q. DURABLE MEDICAL EQUIPMENT (DME)/Supplies means manufactured equipment/supplies which are medically necessary and appropriate for the treatment of chronic or acute conditions that meets criteria as established by the Health Plan. Examples are crutches, wheelchair, walker, hospital bed, oxygen and mechanical equipment and supplies such as oxygen, nebulizer medications, ostomy bags and urinary catheters (limited to standard models only).

R. EMERGENCY CARE means services provided in or by a hospital emergency facility, available seven days per week, 24 hours a day, to evaluate, treat and stabilize a medical condition manifesting itself by the sudden, and at the time, unexpected onset of symptoms that require immediate medical attention and that failure to provide medical attention would result in the following:

1. Serious jeopardy to the health of the individual (or unborn child).
2. Serious impairment to bodily functions.
3. Serious dysfunction to any bodily organ or part.

When medically appropriate, includes emergency transportation and out-of-area emergency care.

S. EMERGENCY MEDICAL CONDITION means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following.

1. Serious jeopardy to the health of the individual (or unborn child).
2. Serious impairment to bodily functions.
3. Serious dysfunction to any bodily organ or part.

T. ENROLLMENT AREA means the geographical area encompassing the Ohio counties of Belmont, Guernsey, Harrison, Jefferson, Muskingum, Monroe, Noble and Washington. Also, the West Virginia counties of Brooke, Doddridge, Gilmer, Hancock, Harrison, Lewis, Marion, Marshall, Monongalia, Ohio, Pleasants, Tyler, Upshur, Wetzel, Wood counties that may be approved periodically by the Ohio Department of Insurance Commissioner and/or the West Virginia Insurance Commissioner. Enrollment Area may also include any county that borders the approved counties, provided that the subscriber residing in a border county is employed in the Service Area.

U. FEDERALLY ELIGIBLE INDIVIDUAL means an individual is one for whom, as of the date coverage is sought, the aggregate of the periods of creditable coverage is 18 or more months and whose recent prior creditable coverage was under a group health plan, governmental plan or church plan who: is not eligible for coverage under a group health plan, Medicare or Medicaid and does not have other coverage; with respect to whom the most recent coverage was not terminated due to nonpayment of premium or fraud; elected continuation coverage if it was offered and, if such continuation coverage was elected, has exhausted such continuation coverage.

If a member meets eligibility requirements as defined above and submit an application to the Plan within 63 days of his/her loss of coverage, he/she may enroll in the Health Plan Portability Plan. Benefits under The Portability Plan may vary from his/her current group benefits.

V. FIXED PERIODIC PREPAYMENT means the amount established for monthly premium payment, by or for the subscriber, in return for basic and supplemental health care services.

W. HEALTH PLAN PERSONNEL means the personnel employed directly by Health Plan as an employee to assist in carrying out its obligations under this Agreement. They may include, but not limited to, a medical director, nurses, administrative and clerical staff, and other various positions.

X. HOSPICE CARE means a method of caring for the terminally ill that helps those individuals continue their lives with as little disruption as possible. This type of care emphasizes supportive services such as home care and pain control rather than cure oriented services. Hospice care is limited to the home setting and members must have a medical prognosis of six months or less life expectancy.

Y. HOSPITAL means an institution which maintains contractual arrangements with Health Plan for hospital services and is an institution which is operated pursuant to law. It must be primarily engaged in providing, on an inpatient and/or outpatient basis, for the medical care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities. These services must be provided on its premises, under the supervision of a staff of physicians, with 24 hour a day nursing service.

The term “hospital"” does not include a convalescent nursing home or any institution or part thereof, which is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged.

Z. HOSPITAL SERVICES (as outlined in the Benefits Schedule) means those services for registered patients which are as follows:

1. Services that generally and usually are provided by acute care hospitals which contract with Health Plan.

2. Services which are prescribed, directed or authorized by a participating physician and approved by the Plan. True emergency care does not require pre-authorization.

AA. INDIVIDUAL PRACTICE ASSOCIATION (IPA) means The Upper Ohio Valley Individual Practice Association, Inc., a West Virginia corporation made up of physicians who have signed contracts with IPA. The IPA has entered into a written agreement with Health Plan to provide medical services to members under this Agreement.

BB. INTEGRATED PROVIDER NETWORK (IPN) means The Mountaineer Region's Integrated Provider Network, Inc., a West Virginia corporation made up of hospitals and physicians who have signed contracts with the IPN. The IPN has entered into a written agreement with Health Plan to provide medical services to members under this Agreement.

CC. LIFETIME MAXIMUM BENEFIT is a benefit that has a lifetime maximum associated with it regardless of the subscriber/member change in employer group (or non-group) eligibility. Any applicable service obtained while a Health Plan member will be provided one time only per a member's lifetime. This is not applicable to any basic health care services.

DD. MEDICAL SERVICES (as outlined in Attachment C) means professional services of physicians and other medical professionals including medical, surgical, diagnostic, therapeutic and preventive services. These services must be performed, prescribed or directed by the Primary Care, Secondary Care, Specialty Physicians or other health care professionals.

EE. MEDICAID PROGRAMS means state medical assistance programs established pursuant to Title XIX of the Social Security Act and all amendments thereto.

FF. MEDICALLY NECESSARY AND APPROPRIATE when used to describe services or supplies proposed or received means that The Health Plan or its designee has determined that the service or supply meets its standardized criteria for medical necessity. These criteria are derived from recognized accredited national sources, such as national medical specialty societies or widely representative groups of specialists, convened for the purpose and sometimes from regional or local members of the medical community or academic faculties. They are subject to regular review and revision when appropriate and are validated by committees of physicians drawn from The Health Plan’s panels of local and tertiary physicians. It is important to recognize that even though a physician may have recommended a service or supply it may sometimes not qualify as being medically necessary.

GG. MEDICARE ACT means Title XVIII of the Social Security Act and all amendments thereto.

HH. MEMBER means any subscriber or dependent as outlined in Article IV and is enrolled in the Plan.

II. ORTHOTIC means a durable mechanical device meant to correct any defect in form or function of the body. It may include a brace (non-dental), support or splint that is expected to last for more than one year.

JJ. OSTEOTOMY means a surgical procedure to cut through a bone.

KK. OUTPATIENT HOSPITAL OBSERVATION BED means a level of care which allows a patient to remain in a suitable facility of the hospital for extension of emergency/urgent diagnosis

and treatment for a period of 23 hours or less; no admission to an acute care facility occurs.

LL. (1) PARTICIPATING PHYSICIAN means any duly licensed doctor of medicine, osteopathy or podiatry who contract directly/indirectly with the Plan and are part of the Plan’s Provider Network.

(2) PRIMARY CARE PHYSICIAN (PCP) means a participating physician who is the coordinator of care. This physician is primarily responsible for the care of member on a continuing basis.

(3) SECONDARY CARE PHYSICIAN (SCP) means a participating (sub-specialty) physician selected by the member to provide specialty care to the member on a routine basis (as outlined in the Provide List).

(4) SPECIALTY PHYSICIAN means a participating physician who provides specialty care to members. They shall confer with a member's Primary or Secondary Care Physician on any proposed plans of specialty treatment. Referral to and approval by Health Plan is required.

MM. PARTICIPATING PROVIDER means physicians, hospitals, pharmacies and other health care providers who contract directly/indirectly with Health Plan and are part of Plan's Provider Network.

NN. PHYSICIAN OFFICE VISIT means may include, but not limited to, specific medical services of physicians and/or assistants (including nurse practitioners and mid-wives) in an office setting.

OO. PROSTHETIC means a mechanical or other device which replaces all or part of an extremity. These may include an artificial limb, intraocular lens and/or breast prosthesis.

PP. PROSPECTIVE REVIEW means utilization review that is conducted prior to an admission or a course of treatment.

QQ. SERVICE AREA means the geographical area The Health Plan serves. It encompasses the Ohio counties of Belmont, Guernsey, Harrison, Jefferson, Monroe, Muskingum, Noble and Washington. Also, the West Virginia counties of Brooke, Doddrige, Gilmer, Hancock, Harrison, Marshall, Monongalia, Ohio, Pleasants, Tyler, Upshur, Wetzel, Wood counties and any counties that may be approved periodically by Ohio Department of Insurance and/or West Virginia Insurance Commissioner.

RR. SKILLED NURSING FACILITY means a facility that provides services to members requiring 24-hour a day skilled nursing care. This care is provided directly by or requires the supervision of skilled nursing personnel. It may also include other skilled rehabilitative services. The facility must also meet Medicare requirements.

SS. SPECIAL ENROLLMENT PERIOD means an enrollment period outside of the group’s annual open.

TT. SPELL OF ILLNESS means a period/spell which begins the day the beneficiary/member is hospitalized. It ends after the beneficiary/member has been out of the hospital or other facility that primarily provides skilled nursing or rehabilitation services for 60 consecutive days.

UU. STANDING REFERRAL means an ongoing referral to a specialty physician that is medically necessary to continue specialty care, over a short period of time. This care is to resolve a condition that is not life threatening, degenerative or disabling. The Primary Care Physician, in consultation with a Specialist, identifies the need for ongoing specialist care.VV. SUBROGATION means those instances when another person, corporation, insurance company or entity (collectively referred to as “other entity”) may be responsible for payment of medical/hospital and other covered services to a member because of sickness, injury, disease or disability caused by another person or entity.

WW. SUBSCRIBER means a person who is an employee of an enrolled group who meets all applicable eligibility requirements of Article IV. They must enroll hereunder and the fixed periodic prepayment must be received by Plan.

XX. TERTIARY FACILITY means a facility that the Plan has contracted with to provide specialty medical and hospital services which are not normally available through local participating providers in the Health Plan Service Area.

YY. URGENT CARE means health care services that are appropriately provided for an unforeseen medical condition that requires medical attention without delay but that does not pose a threat to the life, limb or permanent health of the injured or ill person.

IV. ELIGIBILITY.

A. Subscriber/Employee

To be eligible to enroll as a subscriber, a person must live in the Enrollment Area and a full-time (as defined by the employer group and agreed to by Health Plan) employee of the Group. The person must also be entitled to participate in the hospital & medical benefits arranged by the Group, or be entitled to coverage under the Consolidated Omnibus Budget Reconciliation Act (C.O.B.R.A.).

Each year before the Group contract anniversary date, The Health Plan is required to hold an open enrollment period. Eligible persons may enroll at this time. Consideration of a member for, or renewal of, Health Plan coverage is not subject to genetic testing or any results therein. The employer's personnel office can advise on the proper procedures. Only newly hired employees are eligible to enroll after the enrollment period during the contract year. Employees who become eligible for benefits after the enrollment period may enroll in the Plan in the month they become eligible for health care benefits.

B. Dependents.

An eligible dependent must be included on a subscriber 's coverage at the initial Group enrollment or at the annual open enrollment period. Newly acquired dependents may enroll during the Groups' contract year. When adding a newly acquired dependent, the Plan must receive a new enrollment form (submitted through the employer) within thirty-one (31) days of the date of event. If not, this dependent may be required to wait until the next annual open enrollment period.

Dependents may include the following:

* Spouse. A legally married spouse may be included on the coverage. To be eligible to enroll as a dependent spouse, the person must live in the Enrollment Area. If the spouse has a different last name from the subscriber, legal documentation (i.e., copy of the marriage certificate) is required to conform the martial relationship.

Legally separated, common law, or a divorced spouse is excluded from eligibility. It is the responsibility of the member (or Group) to notify the Plan if any member fails to continue to meet the eligibility requirements.

- Dependent Children. Dependent children eligible for enrollment may include unmarried dependent children of the subscriber, or children of the subscriber's spouse. Dependent children must live in the Enrollment Area, exceptions being; college/post high school trade school students attending out-of-area accredited schools or if a Qualified Medical Child Support Order (QMCSO) is in effect. Dependent child (ren) status must meet the standards of the U.S. Internal Revenue Code. Specifically, the child receives over 50% of his/her total support from the parent(s) and the child has limited, if any, personal income. See Article VI.

The Health Plan shall not deny enrollment of a dependent child on the basis that any of the following applies.

1. The child was born out of wedlock.
2. The child is not claimed as a dependent on the federal tax r00eturn of the parent.
3. The child does not reside in the household of the parent.
4. The child does not reside in The Health Plan Enrollment Area (college/post high school trade students/QMCSO). Also, they must receive all health care services (while/if in the Service Area) from participating providers as outlined in the Provider List.

An eligible unmarried dependent child of the subscriber, or their spouse, may include the following:

*Natural children of the subscriber or subscriber's spouse. If the subscriber is not married to the natural mother/father legal proof is necessary to confirm the parental relationship.

*Step children. Legal documents are required (i.e. copy of the birth certificate or divorce papers) to establish the parental relationship.

*Legally adopted children. To include assumption and retention by a person of legal obligation for the total or partial support of a child in anticipation of adoption. Legal documents required.

* Legal guardianship/custody. Legal proof of guardianship/custody as determined by the Plan is required. Guardianship/custody will not be accepted for eligibility unless both natural parents are physically or mentally handicapped to the point where they cannot take care of the child in question.

The Health Plan does not provide coverage through guardianship or custody for the child of a dependent child of the subscriber/spouse. This would include the grandchild(ren) or step-grandchild(ren) of the subscriber. The only exception to this is if the subscriber legally adopts the child(ren).

QUALIFIED MEDICAL CHILD SUPPORT ORDER. Pursuant to Ohio Revised Code, Section 1751.59 (B), a "Qualified Medical Child Support Order" (QMCSO) is any court judgment, decree or order that provides for child support related to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan and is ordered under state domestic relations law. These children are not required to live within The Health Plan's Enrollment Area but are required to choose a PCP from a list of physicians participating with the Plan. Also, they must receive all health care services (while/if in the Service Area) from participating providers as outlined in the Provider List. Legal documents required (i.e., copy of court judgment).

C. Newborn Children. A newborn is covered from the moment of birth and remains effective for a 31-day period. To continue coverage beyond the 31-day period, the subscriber must submit a new enrollment form through the employer within (31) days from the date of birth. See letter I of this Article.

If necessary changes are not made, services beyond the 31-day period will not be covered.

D. Handicapped Children. Enrollment of a dependent unmarried child shall terminate on the child's 25th birthday (unless specified differently by the employer and agreed to by Health Plan). However, dependent, unmarried children who live with the subscriber and are both incapable of self-sustaining employment by reason of mental retardation or physical handicap, and are solely dependent upon the subscriber for support and maintenance, are eligible regardless of age. Proof of such incapability and dependency, to be determined by The Health Plan, must be furnished to The Health Plan within thirty (31) days from the child's 25th birthday (unless specified differently by the employer and agreed upon to by the Health Plan) and each year thereafter.

E. Married Dependent Children. Married dependent children are not eligible for coverage. It is the subscriber's/member's responsibility to notify the employer immediately of the date of marriage. Coverage for the dependent will end on the date of marriage (unless specified differently by the employer and agreed to by The Health Plan). If the Plan provides benefits under this Agreement, because of a failure to be notified of the dependent's marriage, The Health Plan may refuse to pay for these benefits. If benefits were paid, the Plan may recover the amount paid for services from the member. See Article VI.

F. Divorce or Legal Separation. Coverage will end for a divorced or legally separated date (unless specified differently and agreed to by the Health Plan). It is the subscriber's/employee's responsibility to notify the employer immediately of the such dates. If the Plan provides benefits under this Agreement because of a failure to be notified of the divorce/legal separation, the Plan may refuse to pay for these benefits. If benefits were paid, the Plan may recover the amount paid for services from the member. See Article VI.

G. Change of Residence. If the member moves, exceptions being: college/post high school trade school student attending out-of-area accredited schools or if a Qualified Medical Child Support Order (QMCSO) is in effect, and the new residence is within the Enrollment Area coverage will continue unchanged. Notify The Health Plan immediately of an address change. If the new residence is outside the Enrollment Area, the individual is no longer eligible to be a member of the Plan. Coverage must be cancelled at the end of the month in which the member became ineligible (unless specified differently by the employer and agreed to by The Health Plan).

H. Death of Subscriber. Dependents should contact the employer's personnel office for a determination of available benefits. See Article VI.

I. Eligibility Dates. The following eligibility dates are applicable to members.

1. Any person who has met the eligibility requirements on the effective date of the Group Contract shall become eligible on such date.

2. Any person who meets the eligibility requirements after the effective date of the Group Contract shall become eligible on the first day of the calendar month following the date of eligibility, unless specified differently by the employer and agreed to by the Plan.

3. A newborn is covered from the moment of birth and remains effective for a 31-day period. To continue coverage beyond the 31-day period, the subscriber must submit a new enrollment form through the employer within 31-days from the date of birth.

If necessary changes are not made, services beyond the 31-day period will not be covered.

4. When a court or administrative order is in effect regarding dependent children, coverage will become effective on the date of the court/administrative order.

J. Effective Dates of Coverage. Subscribers enroll during the initial open-enrollment period by completing a Health Plan enrollment form. Upon receipt by the Plan of

a properly completed enrollment form, coverage for eligible subscribers/dependents will begin on the effective date of the Group Contract.

Employer groups that do not utilize The Health Plan Enrollment Form. The Health Plan requires the employee to sign and return a Verification and Confirmation Document.

Subject to the Group's payment of the monthly premium, coverage for eligible members shall become effective on the earlier of the following dates.

1. On one's eligibility date when a person submits an enrollment form for membership on or before such date.

2. On the first day of the month following his/her eligibility date unless other arrangements have been agreed to between the Group and the Plan.

3. On the first day of the month following the end date of the open enrollment period provided a person submits an enrollment form during the open enrollment period.

4. If an employee/dependent is confined to an inpatient hospital on the effective date of coverage, the health services related to this confinement will be covered under this Plan. These services must be medically necessary and provided by participating providers.

5. A newborn is covered from the moment of birth and remains effective for 31-day period. To continue coverage beyond the 31-day period, the subscriber must submit a new enrollment from through the employer within 31-days from the date of birth.

If necessary changes are not made, services beyond the 31-day period will not be covered.

6. When a court or administrative order is in effect regarding dependent children, coverage will become effective on the date of the court/administrative order.

K. Special Enrollment Periods under the Health Insurance Portability and Accountability Act (HIPAA). HIPPA requires group health plans to offer two special 30-day enrollment periods for employees and dependents, who previously declined coverage to enroll, without waiting for the plan's next regular open enrollment date.

1. Loss of Group Coverage

Plans must allow employees and dependents that lose other coverage to enroll if they have exhausted their COBRA coverage; they cease to be eligible for the other coverage or employer contributions for the other coverage cease, legal separation, divorce, death, termination of employment or reduction in hours.

The effective date of coverage will be the first of the following month upon Health Plan's receipt of the enrollment information.

2. Change in Family Status.

Plans that offer dependent coverage must provide a special enrollment period when an employee gains dependents by reason of marriage, birth, adoption or placement for adoption.

The effective date of coverage will be the date of event.

In some instances, the enrollee will be required to provide The Health Plan with a "Certificate of Creditable Coverage."

L. Other Rules of Eligibility. No person is eligible to re-enroll hereunder who has had coverage terminated under Articles V., VIII.B.,IX., or XVII. If coverage is contributory, the subscriber must agree to make the required contributions. In addition, subscribers and dependents who meet the eligibility requirements (of Article IV.) may enroll by submitting, within (30) days from the Qualifying Event, a completed enrollment form provided by The Health Plan to the Group. If the Group has a probationary or waiting period during which a new employee may not enroll, the enrollment form for such employee and his/her dependent(s) must be submitted to Health Plan within two (2) weeks upon completion of the probationary or waiting period.

M. Change of Group Eligibility Rules. The composition of the Group and requirements determining eligibility for membership in the Group which exist at the effective date of this Agreement are material to the execution of this Agreement by The Health Plan. During the term of this Agreement, no change in the Group's eligibility or participation requirements shall be permitted to effect eligibility or enrollment under this agreement unless such change is agreed to by The Health Plan.

N. Condition of Group's Offering. The Group will offer coverage under this Agreement to all eligible persons on conditions no less favorable than those for any alternative health benefit plan available through the Group.

O. Plan Administrator. The employer is the plan administrator under this Agreement. The plan administrator is solely responsible for administering this Agreement for the Group Health Plan members. This would include (but not be limited to) complying with any federal, state, or local law or regulation which may apply to the Group under this Agreement such as the Employee Retirement Income Security Act of 1974 (ERISA), providing notices and documents and applying the eligibility requirements.

FINAL DETERMINATION FOR ALL ELIGIBILITY AND COVERAGE WILL BE MADE BY THE HEALTH PLAN.

No person will be refused enrollment/re-enrollment based on health status, health care needs, or age (excepting dependency requirements) and is not subject to genetic testing or any results therein.

The Health Plan has the sole and absolute discretion to construe and interpret the provisions of this coverage. Included but not limited to, eligibility to become or remain a member under this Agreement, entitlement to covered services, all claims and/or benefit determinations, and operating the Grievance Procedure/Appeal Process.

V. TERMINATION OF COVERAGE.

Member

Coverage under the contract for a member will terminate immediately with written notice as indicated below.

1. Failure of the member to pay, or to have paid on the subscriber's/member's behalf, the required premium when due.

2. The member commits fraud or forgery.

3. The subscriber/member makes any material misrepresentation on the enrollment application or other Health Plan forms.

4. If the member allows an ineligible member to use their Health Plan ID card.

5. If the member resides out side of the Enrollment Area (exceptions being college/post high school trade school students attending out-of-area accredited schools or if a Qualified Medical Child Support Order (QMCSO) is in effect) for three continuous months.

6. If the member no longer meets the eligibility requirements in Article IV. Members may be eligible for continuation of coverage in some cases.

**All benefits will cease at 11:59 p.m. on the effective date of termination, unless specified differently by the employer group and agreed to by the Health Plan.**

The member may appeal any action pursuant to the Grievance Procedure/Appeal Process outlined in this Article XV.

Group

Coverage under the contract for a Group and their affected members will terminate on not less than 30 days written notice for any of the following.

1. Nonpayment of Premiums. If the Group fails to pay the premiums or contributions in accordance with the terms of the coverage or fails to pay premiums in a timely manner.

2. Group Medical and Hospital Service Agreement Termination. If the Group terminates the Group Medical and Health Service Agreement with proper notification.

3. Fraud. If the Group performs an act or practice that constitutes fraud or makes intentional misrepresentations of material facts under the terms of the coverage.

4. Violation of Participation or Contribution Rules. If the Group fails to comply with material plan provisions relating to employer contribution or group participation rules.

5. Termination of Coverage. If Health Plan ceases to do business in the employer market with required-proper notification (not less than 90 days) to all applicable parties.

6. Movement Outside Service Area. If the Group no longer has eligible enrollees in the Enrollment Area.

All terminated-eligible members will be given an option to convert to a non-group policy.

**All benefits will cease at 11:59 p.m. on the effective date of termination, unless specified differently by the employer group and agreed to by The Health Plan.**

After termination, neither The Health Plan nor Health Plan Providers have any further liability or responsibility under this Agreement.

It is the responsibility of the member (or Group) to notify the Plan if any member fails to continue to meet the eligibility requirements. If Health Plan provides benefits under this Agreement because of a failure to be notified, the Plan may refuse to pay for these benefits. If benefits were paid, the Plan may recover the amount paid for services from the member.

**NOTICE:** Health Plan will honor a request made by the Group to retroactively terminate an employee's and/or dependent's coverage provided the termination date is not beyond 60 days of Health Plan's receipt of the request and Health Plan has not paid claims.

Members who are confined to a hospital, skilled nursing facility or other approved medical facility on the day their health coverage is to end shall not have coverage until the earliest occurrence of any of the following.

1. The member's discharge from the hospital.

2. Determination by the member's attending physician that inpatient care is no longer medically indicated.

3. The member's reaching the limit for contractual benefits.

4. The member's new coverage becomes effective.

Any person obligated for any part of a prepayment (premium) may cancel this Agreement within 72 hours after they have signed the enrollment form.

Coverage may be terminated by a member if the member gives 30 days prior written notice to The Health Plan. The member should also notify their employer of this action.

VI. CONTINUATION OF COVERAGE

As a member of The Health Plan members may have certain options for continuation of coverage.

**1. Continuation of Group Coverage Upon Termination of Employment.**

Ohio and Federal laws require that employees in certain situations and/or their dependents have the right to continue their group health coverage.

Pursuant to divisions (A) and (B) of Section 1751.53 of the Ohio Revised Code, eligible employees may continue their coverage for themselves and any eligible dependents for six months after the date the group coverage would otherwise terminate.

Eligible employee means the following:

The employee had continuous coverage during the entire three-month period preceding the employee's termination, the terminated employee is entitled to Unemployment Compensation, the terminated employee is not entitled to or become entitled to Medicare or the terminated employee is not, and does not become covered or eligible for group coverage under which the employee was not immediately covered prior to termination. A person eligible for continuation of coverage under division (A) of Section 1751.53 and eligible for coverage under Section 3923.123 of the Ohio Revised Code may elect either coverage, but not both.

It is the employer's responsibility to notify the employee of the right of continuation under this Article.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies only to employer Groups with 20 or more employees. The Health Plan will acknowledge COBRA qualified Groups with 20 or more eligible employees, those with fewer than 20 are not COBRA qualified or eligible for COBRA benefits through The Health Plan. The Employer assumes responsibility for determining whether the employee is subject to COBRA; however in consent with the COBRA Law.

**2. Continuation of Coverage in the event if Insolvency.**

Although it is not a member of any Guaranty Fund, The Health Plan maintains insolvency insurance. In the event the Plan became insolvent, this insurance would provide health care coverage (including necessary inpatient care) to members until the expiration of their contract with the Plan. Participating providers, or health care facilities, will continue to provide covered services to members as needed to complete medically necessary services commenced but not finished. However, the member is protected only to the extent of the hold harmless provision outlined in participating provider and facility contracts.
In the event of insolvency, the member may be financially responsible for health care services rendered by a provider or facility that is not under contract with the Plan, whether or not Health Plan authorized the use of the provider or facility.

**3. Under COBRA.**

Subscriber/Employee. If a member losses his/her Health Plan coverage because of a reduction in hours of employment or the termination of his/her employment (for reasons other than for gross misconduct on member's part) member and/or his/her dependents may be able to continue their coverage which was in effect at the time of the Qualifying Event. His/her coverage may be continued for a period of 18 months from the date of the Qualifying Event. This 18 month COBRA period may be extended to 29 months for individuals who are disabled as of the date of the initial termination or reduction in hours of employment.

If a subscriber's employment is terminated due to permanent disability under Title II or XVI of the Social Security Act, coverage may be continued for the subscriber and/or family dependents for a maximum period of 29 months.

Legal Spouse of Employee. If a member is a covered spouse of an employee he/she has the right to continue their coverage for a period of 18 months from the date of the Qualifying Event if, group health coverage is lost for either of the following.

A) The termination of spouse's employment (for reasons other than gross misconduct).

B) A reduction in spouse's hours of employment.

Coverage may be continued for a period of 36 months from the date of the Qualifying Event if, group health coverage ends for the following.

A) The death of an employee.
B) The employee's Medicare Entitlement.
C) A divorce or legal separation.

Dependent Child of Employee or Employee's Spouse. If a covered dependent child of an employee or of the employee's spouse or if a child born to, or placed for adoption with, a covered employee during the period of COBRA coverage, the dependent has the right to continue coverage for a period of 18 months from the date of Qualifying Event if, group health coverage ends for the following.

A) The termination of parent's employment (for reasons other than gross misconduct).

B) A reduction of the parent's hours of employment.

Coverage may continue for a period of 36 months from the date of the Qualifying Event for the following.

A) The death of the employee/subscriber.

B) The divorce or legal separation of parents.

C) The employee's Medicare Entitlement.

D) The loss of eligibility as a dependent child.

Employee's Responsibility.

The employee or a family member has the responsibility to inform the employer or employer's health benefits administrator of a divorce, legal separation, or a child losing dependent eligibility status. The employer has the responsibility to notify the plan administrator (i.e. employer or other entity) of the employee's death, termination of employment, reduction in hours or Medicare entitlement for COBRA participants.

When the health benefits plan administrator learns that one of these events has happened, he/she should let the member know that he/she has the right to continue their coverage.

Employee and/or employee's family members will have 60 days to elect COBRA Continuation Coverage. The 60 days must be allowed from the latter of the following.

A) The date of notice

B) or the date of Qualifying Event.

COBRA coverage must be effective on the day immediately following the date of the Qualifying Event. There can be no break in coverage.

If a subscriber and/or subscriber's dependents choose to continue the coverage, the employer must give coverage similar to that of similarly situated active employees.

The member will be responsible for paying the cost of the coverage received. Also, there may be an additional administrative charge.

Continuation of COBRA coverage may be cut short for any of the following.

* Employer no longer provides group health coverage for any of its employees.

* Member does not pay the required monthly payment for coverage within the month due.

* Member becomes an employee of another employer and is not covered by the employer's group plan.

* Member becomes eligible for Medicare after he/she has elected COBRA continuation coverage.

* Member divorces a covered employee, later remarries and new spouse covers him/her under his/her group health plan.

* Member no longer lives within The Health Plan's Enrollment Area. The Health Plan will provide emergency care (only) out of the Service Area for no longer than three months. Coverage will be canceled on the last day of the third month.

At the end of the 18 or 36 months of continued coverage, member may be eligible to enroll in the Plan Conversion Direct Pay Coverage.

Health Plan's obligation to provide continuation of coverage under COBRA or other similar law ceases upon termination of this Agreement for any reason. It is the employer's responsibility to provide for continuation of coverage for employees whose rights under COBRA or any similar law, are beyond the termination of this Agreement.

Health Plan policy is: Although COBRA eligibles have independent election rights, it does not imply they have individual enrollment rights (i.e., if enrollment through the employer group is family coverage and electing COBRA as family, the COBRA enrollment will be family with the applicable premium charged).

**WARNING:** Groups should not make a practice of paying COBRA premiums for individuals in anticipation of receiving payment from the individuals. Health Plan will honor a request made by the Group to retroactively terminate these individuals' and/or dependents' COBRA coverage due to non-payment provided the termination date is not beyond 60 days of the Health Plan's receipt of the request and Health Plan has not paid claims.

**4. Health Plan Non-Group Direct Pay Conversion Coverage**

Pursuant to Section 1751.16 of the Ohio Revised Code, if a member ceases to be eligible under group coverage, as outlined in Articles IV and V, The Health Plan will send a letter to affected members outlining their non-group direct pay conversion rights including monthly premium amounts and schedules of benefits. The member may convert, without furnishing evidence of insurability, if deemed eligible to do so by the Plan and provided such notice is given to Health Plan within 30 days from the date of the letter. The member may convert his/her membership in accordance with such rules and regulations governing the Conversion/Direct-Pay Agreement. The coverage thereunder, the initial payment, the form of such agreement, and all terms and conditions as the Plan may have in effect at the time of his/her application for conversion shall apply.

If a member is eligible for other employer sponsored health coverage, such member may not be eligible for the Direct Pay Conversion Coverage.

The Non-Group/Direct Pay Conversion Coverage may not provide the same copay plan offered through the employer group coverage.

**5. Continuation of Coverage During Military Service**

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of anyone absent from work due to uniformed services. The USERRA applies to all group health benefit plans.

Special rules apply to health benefits under the USERRA. First, employees (subscriber) must be given COBRA like rights under USERRA with respect to health care benefits. This means the subscriber and eligible dependents can elect up to 18 months worth of coverage under the employer's health plan if, their coverage was in effect at the time the reservist was called or ordered to active duty.

An eligible person may extend the 18 month period of continuation to a 36 month period of continuation if any of the following occurs during the 18 month period.

A) The death of the reservist.

B) The divorce or separation of a reservist from the reservist's spouse.

C) The cessation of dependency of a child pursuant to the terms of the contract.

An eligible person must file a written election of continuation of coverage with their employer, and pay their employer the first month's applicable premium no later than, 31 days after the date on which the subscriber's coverage would have otherwise ended. If the employer notified the subscriber of their right to continue after the date on which the eligible subscriber's coverage would otherwise terminate, the written election and payment must be received by the employer no later than 31 days after the notification date.

The subscriber's/member's rights to continuation of coverage on extension ceases on the date on which any of the following occur.

) The subscriber/member becomes covered by another group health plan that does not contain any exclusion or limitation of any pre-existing condition of that eligible member. This does not include the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

B) The 18 month or applicable 36 month period of coverage is exhausted.

C) The subscriber fails to make timely payment of monthly payments whereby, coverage ends on last day for which premiums were paid.

D) The group contract is terminated and is replaced by similar coverage under another group health plan or arrangement.

**6. Health Insurance Portability and Accountability Act (HIPAA)**

Pursuant to Section 1751.16 (B) (1) (b) of the Ohio Revised Code, and in conjunction with Federal HIPPA requirements, The Health Plan has available to certain “Federally Eligible Individuals" the Basic or Standard Portability Plan. The Plan does not impose any pre-existing condition exclusions to those that are eligible. See Articles III.U and IV.K.

The Health Plan will provide to terminated members (or by request) a “Certificate of Creditable Coverage”. See Article III.O.

**WARNING: The member will be responsible for repayment for any claims incurred and paid by The Health Plan after member’s date of termination, unless member elects to continue coverage as defined in this Article.**

**VII. INDEPENDENT CONTRACTORS/REFUSAL TO ACCEPT TREATMENT**

1. 1(A). The relationship between Health Plan and the IPA/IPN is an independent contractor relationship. The contracted physicians of the IPA/IPN are not employees or agents of Health Plan, nor is Health Plan an employee or agent of the IPA/IPN:

1(B). The relationship between Health Plan and non-IPA/IPN physicians and other health care providers contracting directly or indirectly with Health Plan is an independent contractor relationship(s). These providers are not employees or agents of Health Plan, nor is Health Plan an employee or agent of these providers.

1(C). The relationship between Health Plan and hospital(s) is an independent relationship. The hospital is not an employee or agent of Health Plan, nor is Health Plan an employee or agent of the hospital.

2. Participating Physicians maintain the physician-patient relationship with members and are solely responsible to members for all medical services.

3. Neither the Group nor any member is the agent or representative of The Health Plan, and neither shall be liable for any acts or omissions of The Health Plan, its agents or employees, or IPA/IPN, or hospital(s) or any other person or organization with which The Health Plan has contracted or hereafter shall make arrangements for the performance of health care services under this Agreement

**VIII. THIRD PARTY PAYMENTS; COORDINATION OF BENEFITS; SUBROGATION; ASSIGNABILITY**

A. The benefits under this Agreement for members aged 65 or older or for the members otherwise eligible for Medicare, Medicaid or Workers' Compensation payments, are not designed to duplicate any benefit under these programs. All sums payable for services provided pursuant to these programs shall be retained for and payable to Health Plan. Member agrees to submit such paperwork and/or claim(s) to obtain or assure Medicaid, Medicare or Workers' Compensation reimbursement. In certain cases, and if requested by The Health Plan, a member shall complete and submit to The Health Plan such consents, releases, assignments and other documents reasonably requested by The Health Plan in order to obtain or assure Medicaid or Medicare reimbursements or reimbursement under the applicable Workers' Compensation Law.

B. COORDINATION OF BENEFITS (COB) is the procedure used to pay health care expenses when a person is covered by more than one plan. The Health Plan follows rules established by Ohio and West Virginia law to decide which plan pays first and how much the other plan must pay.

The objective is to make sure the combined payments of all plans are no more than actual bills.

When a member is covered by another health care plan in addition to this one (or has coverage from other insurance plans including medical benefits coverage in automobile "fault" or "no-fault" type contracts). The Health Plan will follow Ohio/West Virginia coordination of benefit rules to determine which plan is primary and which is secondary. The member must submit all bills first to the primary plan. The primary plan must pay its full benefits as if the member had no other coverage. If the primary plan denies the claim or does not pay the full bull, the member may then submit the balance to the secondary pan.

The Health Plan pays for health care only when the member follows Health Plan rules and procedures. If Health Plan rules conflict with those of another plan, it may be impossible to receive benefits from both plans and the member will be forced to choose which plan to use.

**Plans that do not Coordinate.**

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

- Individual (not group) policies or contracts.
- Medicaid.
- Group hospital indemnity plans which pay less than $100.00 per day.
- School accident coverage.
- Some supplemental sickness and accident policies.

**How The Health Plan Pays as Primary Plan.**

- When Health Plan is primary, Health Plan will pay the full benefit allowed by this Agreement as if the member had no other coverage.

**How The Health Plan Pays as Secondary Plan.**

- When The Health Plan is secondary, Plan payments will be based on the balance left after the primary plan has paid. Health Plan will pay no more than that balance. In no event will Health Plan pay more than Health Plan would have paid had Health Plan been primary.
- Health Plan will pay only for health care expenses that are covered by the Plan.
- Health Plan will pay only if the member has followed all of the Plan procedural requirements, including care obtained from or arranged by the Primary Care Physician, precertification, etc.
- Health Plan will pay no more than the "allowable expenses" for the health care involved. If the Plan allowable expense is lower than the primary plan's, Health Plan will use the primary plan's allowable expense. That may be less than the actual bill.

**Which Plan is Primary ?**

To decide which plan is primary, The Health Plan has to consider both the coordination provisions of the other plan and which member of the family is involved in a claim. The primary plan will be determined by the first of the following which applies.

1. Non-coordinating Plan.

If the member has another group plan which does not coordinate benefits, it will always be primary.

2. Employee.

The plan which covers the member as an employee (neither laid off nor retired) is always primary.

3. Children (Parents Divorced or Separated).

If the court decree makes one parent responsible for health care expenses, that parent's plan is primary.

If the court decree gives joint custody and does not mention health care, Health Plan will follow the birthday rule.

If neither of those rules applies, the order will be determined in accordance with the Ohio Department of Insurance Department/West Virginia Insurance Commission rules on Coordination of Benefits.

4. Children and the Birthday Rule.

When a dependent child's health care expenses are involved, Health Plan follows the "Birthday Rule". The plan of the parent with the first birthday in a calendar year is always primary for the children. If the subscriber's birthday is in January and the spouse's birthday is in March, the subscriber's plan will be primary for all of the children.

However, if the spouse's plan has some other coordination rule (i.e., "gender rule" which says the father's plan is always primary), Health Plan will follow the rules of that plan.

5. Other Situations.

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Department of Insurance/West Virginia Insurance Commission on Coordination of Benefits.

Coordination Disputes.

If a member believes that Health Plan has not paid a claim properly, he/she should first attempt to resolve the problem by contacting The Health Plan. Please refer to Section XV "Grievance Procedure/Appeal Process". If the member is still not satisfied, he/she may call or write the State Insurance Department, in the state he/she resides, for instructions on filing a consumer complaint.

| | |
|---|---|
| Ohio Department of Insurance | West Virginia Insurance Commission |
| Consumer Services Division | PO Box 50540 |
| 2100 Stella Court | Charleston, WV 25305-0540 |
| Columbus, Ohio 43215-1067 | 1-800-642-9004 |
| 1-304-558-3386 | |
| 1-614-644-2673 | |

The Health Plan is prohibited from coordinating benefits with any supplemental individual or family direct pay insurance policies or other supplemental individual health benefit policies.

C. SUBROGATION refers to those instances when another person, corporation, insurance company or any entity (collectively referred to as "other entity") may be responsible for medical/hospital and other covered services to a member because of sickness, injury, disease or disability caused by another person or entity. The Health Plan or a third party contracting with the Plan will pay for these services to which the member is entitled under this Agreement. The Health Plan has the right to recover for services it pays directly or for services paid by a third party which contracts with the Plan. This includes filing suit in the member's name. The Health Plan will recover the amount paid for these services or in the instance of capitated services, it will recover utilizing Health Plan's fee-for service rates (as opposed to the capitation payments themselves). If services are paid by a third party, the amount recovered is their fee-for-service rates. The Health Plan shall not recover in subrogation or reimbursement, more than the amounts paid for services rendered to the member. By accepting payment for these services, the member assigns to The Health Plan all of his/her rights to recovery against the other entity to recover for these services.

The member has the obligation to help Health Plan in all possible ways including signing documents that may be needed for the Plan to enforce its rights. The member may not impair or damage these subrogation rights in any way.

If the member makes a claim or files suit against the other entity mentioned above, The Health Plan must be immediately notified in writing. If a member receives money from the other entity responsible for the sickness, injury, disease or disability of the member, the member must pay The Health Plan for services covered by the Plan in the manner described above. This payment to The Health Plan includes, but is not limited to settlement proceeds, whether or not the recovery by the member specifies that monies he/she is receiving include monies for medical/hospital services. In instances where a member or his/her attorney fails to notify The Health Plan of a potential subrogation claim or otherwise fails to cooperate with the Plan in subrogation or reimbursement, the Plan will be entitled to recover payment it made for medical/hospital services from any monies obtained by or awarded to the member. Again, this is whether or not the recovery by the member specifies that monies he/she is receiving include monies for medical/hospital services. Subrogation, and/or reimbursement also applies to insurance coverage such as medical payments coverage, uninsured and/or under-insured motorist coverage. However, it would not include the medical services not covered by the Plan.

The member may receive a questionnaire or telephone call from The Health Plan or from a company that the Plan has contracted with to recover subrogation claims, asking for information regarding medical claims that may have been related to an accident or injury. The member is required to respond. Coverage for the subscriber and his/her dependents may be terminated if they, or their legal representative, refuse to cooperate or carry through, in any manner with the requirements of the subrogation terms of this Agreement.

The subrogation company also has a toll-free telephone number if there is a need to contact them to discuss the specifics of an accident or injury which can be obtained by contracting The Health Plan Funds Recovery Department (or the toll-free number listed on the correspondence sent to the member). If a member receives a questionnaire from the subrogation company, it means that they are attempting to decide if a claim may be the responsibility of another entity in a case as auto liability, homeowner's liability, no-fault medical coverage, product's liability, Workers' Compensation, etc.

The Health Plan reserves the right to change the subrogation company at any time.

D. ASSIGNABILITY. A member may not assign his/her interest or rights to or payment for hospital and medical services under this Agreement without prior written consent of Health Plan.

IX. FIXED PERIODIC PREPAYMENT

A. The Group or its designated agent shall remit to The Health Plan on behalf of each subscriber and his/her dependent/members on the first business day of each month the amount specified in the (fixed periodic prepayments) schedule of monthly payments listed in Attachment B. If the States of Ohio or West Virginia or any other taxing authority impose upon The Health Plan a tax or license fee which is levied upon or measured by the monthly amount listed in Attachment B, or by The Health Plan's gross receipts or any portions of either, then commencing upon the effective date of such tax or license fee, the Group or its designated agent shall remit to The Health Plan with the appropriate monthly payment, a pro rata amount sufficient to cover all such taxes and license fees rounded to the nearest cent.

Only members for whom the stipulated payment is actually received by The Health Plan shall be entitled to hospital and medical services covered hereunder and then only for the period for which such payment has been received. If any required payment has not been received by the time specified above, all rights of the member under this Agreement shall terminate and may be reinstated only by the approval of The Health Plan.

B. Health Plan shall have the right to change the fixed periodic prepayments as of any date the extent or nature of the risk under this Agreement changes by amendment or by reason of any provision of law or any governmental program or regulation. The group will be given 30 days prior notice before a change in the fixed periodic prepayment is to become effective.

X. SERVICES AND BENEFITS

A. Benefits within the Service Area:

Within the Service Area subscribers and dependents shall be entitled to receive all hospital, medical and other services specified in the Benefits Schedule(s) attached hereto. Within the Service Area, except in cases of emergencies defined at Article III R, services are available only from Participating Providers listed on the Health Plan Provider List. Such list can and may be changed from time to time. Health Plan shall not have any liability or obligation whatsoever on account of any service or benefit sought or received by any member from any other doctor, hospital or extended care facility, or other person, institution or organization, unless prior authorization is given by The Health Plan.

B. Emergency Benefits:

Members who are outside the Service Area, or who require emergency care within the Service Area, may receive the emergency benefits as defined in Attachment A. Members shall be liable for charges incurred by any emergency room visit when such visit was neither due to any emergency, as defined herein, nor authorized by The Health Plan or a participating physician. Whenever practical, the member should attempt to go to a participating hospital, even in an emergency situation.

C. Tertiary Services:

If The Health Plan determines hospital and medical services are not available through in service area providers, the member must obtain services through a tertiary provider as authorized and approved by The Health Plan.

D. At renewal, the hospital and medical services covered by this Agreement can, and may be changed without the consent or concurrence of the Group or member.

XI. EXCLUSIONS AND LIMITATIONS

Certain services as set forth in Attachment C shall be excluded (or limited, as stated from the coverage of this Agreement).

XII. FORCE MAJEURE/EXCUSES FOR LIMITED OR NON-PERFROMANCE

The rights of members and obligations of Health Plan are subject to the following limitations:

A. In the event of any major disaster or epidemic, The Health Plan providers shall render hospital and medical services provided under this Agreement insofar as practical, according to its best judgement, within the limitations of such facilities and personnel as are then available, but The Health Plan and participating providers shall have no liability or obligation for delay or failure to provide or arrange for such services due to lack of available facilities or personnel if such lack is the result of such disaster or epidemic.

B. In the event that due to circumstances not reasonably within the control of The Health Plan, such as complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant part of participating providers personnel or similar causes, the rendition of services provided under this Agreement is delayed or rendered impractical neither, The Health Plan nor participating providers shall have any liability or obligation on account of such delay or such failure to provide services, but The Health Plan and participating providers shall make a good faith effort to provide or arrange for medical services, the obligation of The Health Plan shall be a good faith effort to arrange for alternative method of receiving hospital or medical care.

XIII. TERMINATION OF AGREEMENT.

This Agreement shall continue in effect for one year from the effective date hereof, and may be renewed from year to year thereafter subject to the following:

A. Upon default of the fixed periodic prepayment in accordance with the provisions of Article IX, and subsequent written notification of such default by The Health Plan, all rights and benefits hereunder shall terminate for the affected members from the last prepaid date.

B. This Agreement may be terminated by the Group by giving 30 days prior written notice to The Health Plan. In such event, all rights to benefits hereunder shall terminate for all members as of the date of termination stated in said notice. The Health Plan will cooperate with the Group in attempting to make equitable arrangements for continuing care of members who are confined inpatients on the date of termination.

C. The Health Plan may terminate this Agreement by giving 30 days prior written notice to the Group. In such event, any member who is confined inpatient at the effective date of termination shall receive all benefits otherwise available hereunder to hospitalized patients for the conditions under treatment during the remainder of the particular episode of confinement, until the earliest occurrence of either (1) the member's discharge, (2) determination by the member's attending physician that inpatient care is no longer medically indicated, or (3) the member's reaching the limit for contractual benefits, (4) the member’s new coverage becomes effective. Except as expressly provided in this paragraph, all rights to benefits shall cease as of the effective date of termination.

D. The Health Plan may terminate this Agreement if the Group performs an act or practice that constitutes fraud or makes misrepresentations of material facts under the terms of the coverage.

E. The Health Plan may terminate this Agreement for Violation of Participation or Contribution Rules-if the Group fails to comply with material Plan provisions relating to employer contribution or group participation rules.

F. If The Health Plan ceases to do business in the employer market with required-proper notification (not less than 90 days) to all applicable parties.

G. Movement Outside Service Area. If the Group no longer has eligible enrollees in the Enrollment Area.

**All benefits will cease at 11:59 p.m. on the effective date of termination, unless specified differently by the employer group and agreed to by The Health Plan.**

XIV. CONFIDENTIALITY

All information concerning a Health Plan member’s medical history and enrollment file is confidential. The member has a right to approve or refuse the release of personal information by The Health Plan except when the release is required by law or the Plan. Information regarding confidentiality is discussed on the Enrollment Form or Verification and Confirmation Document.

Upon a subscriber’s signature on a Health Plan Enrollment Form or Verification and Confirmation Document, the subscriber authorizes any provider to release medical records for themselves and their family to The Health Plan or its designee. The Health Plan can also release this information to individuals who are conducting a review of the cost, quality and/or the appropriateness of service rendered to members or are handling matters of wrongful payment, double payment or subrogation.

XV. GRIEVANCE PROCEDURE/APPEAL PROCESS

Health Plan members have the right to appeal decisions of the Plan that they believe do not provide them, or limit, health care benefits they believe should receive under the Plan. The appeal rights are explained below.

The Health Plan has designated a "Grievance Coordinator". This assures that individual members, employer groups, and authorized persons and providers, have a meaningful voice in the Health Plan. The Grievance Coordinator can be contacted by calling (740) 695-3585 or 1-800-624-6961, TDD (740) 695-7919 or 1-800-622-3925. Our fax number is (740) 695-5297 and e-mail from website at www.healthplan.org. Also, you may write or contract us in person at: Grievance Coordinator, The Health Plan, 52160 National Road East, St. Clairsville, Ohio 43950. Grievances will be processed in accordance with state laws.

The Health Plan Appeals and Grievance Procedure are designed to do the following:

1. Be prompt and responsive.
2. Be flexible enough to manage both complicated and uncomplicated grievances without delay.
3. Provide the ability to modify the Plan's operations in ways that address emergent problems from patterns of grievances.
4. Provide that feedback from both members and providers be established which will improve the Plan's operations.

These objectives will guide The Health Plan in resolving complaints/concerns and/or grievances. These include, but are not limited to the following.

1. Non-authorization, limitation or reduction of the coverage of health care services.
2. Administrative complaints such as cancellation/non-renewal of coverage and eligibility determinations.

Each level of the Grievance Procedure will involve a Health Plan employee with problem solving authority. They will participate in each step of the Grievance Procedure. Medically related grievances will have a physician involved in the review process.

The following describes the Grievance Procedure process.

**1. Internal Review.**

When a member receives an "adverse determination" (see Article III.A) in relation to any of the reasons above, the member or authorized person may request the following reviews. When there is a prospective or concurrent review determination (see Article III.PP and III.I), a member's provider or health care facility (rendering the service) with consent of member ("authorized provider") may also request the reviews.

**A. Informal Review.**

The member (or authorized person or authorized provider) may request The Health Plan to reconsider the issue for informal review. The informal appeal may be written or oral (by phone or in person). The appeal will be documented by the Plan. If the issue is not resolved, The Health Plan employee assisting the member will advise them of the next step in the process.

**B. Formal Review.**

If the member (or authorized person or authorized provider) continues to receive an adverse determination in the informal review (or wishes to go directly to a formal appeal), they may submit a written formal appeal (formal grievance). This is done on The Health Plan's grievance form. This must be filed within one year of the date of the occurrence leading to the grievance.

The formal grievance is handled internally by The Health Plan Appeals Committee. A Plan member may, if they wish, meet with representatives of the Plan to review the situation. If The Health Plan Appeals Committee continues an adverse determination, a physician (of the same or similar specialty who provides or treats the requested service) will then review the adverse determination if it involves medical appropriateness. If the physician determines the service is not medically necessary and appropriate, the Plan will continue not to authorize coverage for the service.

If the physician determines that the service is medically necessary and appropriate, the Plan may cover the service. If not, the member will be afforded an independent external review by an independent review organization (IRO). However, such request must be made, in writing, within 180 days after notification. The formal grievance will be processed in a reasonable length of time. This will not exceed 60 days. The total process including informal review will not exceed 60 days. Any member grievance in which time is of the essence will be handled quickly so that the specific situation. It will be reasonable in respect to the situation, and no more than three days after the review of the internal review decision within 60 days, or of the expedited review within three days, this shall be deemed a denial. Then the member (or authorized person or authorized provider) may request an external review in writing within 180 days after the non-determination.

**2. Non-authorization Because the Services are Determined by The Health Plan Not to be Covered Benefit or Member's Coverage has been Cancelled (Administrative Complaints).**

The Health Plan, after formal review, does not authorize coverage of the service because it has been determined by the Plan that a certain service is not a covered benefit or coverage has been terminated. In such cases the member, authorized person, authorized provider, or employer group (when applicable) may request a review from the State Insurance Department in the state where they reside. Also included for appeal would be other administrative complaints such as eligibility determinations, etc. This review to the State Insurance Department is available only after a formal review has been completed.

Ohio Department of Insurance
Consumer Services Division
2100 Stella Court
Columbus, Ohio 43215-1067
1-304-558-3386
1-614-644-2673

West Virginia Insurance Commission
PO Box 50540
Charleston, WV 25305-0540
1-800-642-9004
1-304-558-3386

For example, the appropriate State Insurance Department will review the Plan's contract benefits and the service requested. If the Insurance Department determines that the service is not a covered benefit, the Plan does not have to cover/pay for the service. If the Insurance Department determines that the service is a covered benefit, the Plan must either cover/pay for the service or give the member a chance for a review by an independent review organization (IRO). However, the cost of the service would be more than $500.

**1. External Independent Review.**

**A. Non-authorization Because Services are Not Medically Necessary and Appropriate.**

**The Health Plan may not authorize a service because the Plan**
Deems the service is not medically necessary and appropriate. If so, the member, or authorized person or authorized provider, may request an external review. This is done by an independent review organization (IRO). The service and related expenses must cost you more than $500 if it is not covered by the Plan. The $500 does not apply in cases of expedited reviews. The IRO will not be professionally or financially affiliated with The Health Plan.

The request for review must be made within 180 days of date of letter notifying the member's, authorized person's, or authorized provider's request was not granted in the formal review process. This request must be in writing and include a certification from the provider that the services will cost more than $500.

The IRO will review the member's medical records, Health Plan medical review criteria, Health Plan's clinical rationale and standards it used. The IRO will review any other information required by law to make its determination. If the IRO determines that the service is medically necessary and appropriate, the Plan will pay for the service according to the terms of the contract. If the IRO determines that the service is not medically necessary and appropriate, the Plan does not have to cover/pay for the service.

**B. Non-authorization Because Services Deemed Experimental/Investigational by The Health Plan.**

Experimental or investigative drugs, devices, procedures or other therapies ("services") generally are not covered by the Plan. However, a member or authorized person or authorized provider, may request an external review if The Health Plan does not authorize coverage of these types of healthcare services, in the formal review, which would be covered if it were not considered by The Health Plan to be experimental/investigative.

If the member has a terminal illness, the member may also request an external review when services have not been approved for coverage because they are deemed experimental or investigative. To qualify for this review the member must meet all of the following criteria.

1. The member has a terminal condition that according to the current diagnosis has a high probability of causing death within two years.
2. The member or authorized person requests an external review not later than 180 days after receipt of notice of the result of the formal review.
3. The member's physician certifies that one of the following situations applies to member's condition:
    - Standard therapies have not been effective in improving the member's condition.
    - Standard therapies are not medically appropriate for the member.
    - There is no standard therapy covered by The Health Plan that will benefit the member more than therapy requested by either the member or their physician.

4. The member's physician has recommended a drug, device, procedure or other therapy that he/she certifies in writing is likely to benefit the member more than standard therapies or the member has requested a therapy that has been found in preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.

If the IRO finds the health care service is not experimental/investigational, The Health Plan will cover the service. If the IRO finds the service is experimental/investigational, the service will not be covered. However, if it is found that it should be covered, the Plan will cover the service(s).

**C. Instructions for requesting an independent review/external review.**

This external independent review process is available for A and B above and only after the member, authorized person, or authorized provider has exhausted the formal appeal offered by The Health Plan. Then the request for an external review must be made, in writing, within 180 days of receiving notice of the result of the Plan's formal review. The member, authorized person, or authorized provider is not required to pay for the review, since the review is paid for by the Plan. The request for the external review may be sent to the Plan and it will be forwarded to the IRO.

The IRO must provide the member or authorized person (or authorized provider if applicable) and The Health Plan with a response within 30 calendar days of receipt of the review. The decision generally would include the following.

- A description of the member's condition.
- The principal reasons for the decision.
- An explanation of the clinical rationale for the decision.

**D. Expedited Reviews.**

When the review must be completed quickly because of the member's medical condition the member, authorized person, or authorized provider (when applicable) may request an expedited-external review by phone, fax or email. However, the member must follow up this request with a written confirmation within five days of the phone, fax or email request. The IRO must provide the requesting party a response to an expedited review within seven calendar days of receipt of the request for expedited review (if no additional information is needed by the IRO).

The expedited review may be requested if the member's provider certifies that, in the absence of immediate medical attention, the following could happen.

- The health of the member (or unborn child) could be in serious jeopardy.
- Serious impairment to bodily functions could occur.
- Serious dysfunction of any body organ or part could occur.

**E. Complaints/Concerns on Quality Care.**

The member may submit a written complain relating to the quality of care (rendered by health care providers) to: The Health Plan Quality Improvement Department, 52160 National Rd. East, St. Clairsville, Ohio 43950. The Quality Improvement Department will investigate the complaint and take appropriate action.

## XVI. CLAIM PROVISIONS

A. It is not anticipated that a member will make payment to any provider providing benefits under this Agreement. However, if the member furnishes evidence satisfactory to The Health Plan that he/she has made payments to such provider with respect to charges for benefits under this Agreement, payment with respect to those charges will be paid to the subscriber. Written proof covering the occurrence, character and extent of the event for which a claim is made shall constitute satisfactory evidence.

B. If a charge is made to a member for any service with respect to benefits under this Agreement, written proof of such charge must be furnished to The Health Plan within 90 days after the delivery of the service.

C. Failure to furnish such proof within the required time shall not invalidate nor reduce any claim if it was not feasible to give proof within such time, provided such proof is furnished as soon as reasonably possible. All such charges will be paid to the subscriber upon receipt of the satisfactory evidence described above.

## XVII. RECORDS

A. The Health Plan shall keep a record of members. The Group shall forward the information periodically required by The Health Plan in connection with the administration of this Agreement. The Health Plan's liability for the fulfillment of any obligation dependent upon information to be furnished by the Group shall not arise prior to receipt of that information in the form requested by The Health Plan. Nor shall The Health Plan be liable for any obligations due to information incorrectly supplied by the Group or not supplied by the Group. All records of the Group which have a bearing on eligibility shall be open for inspection by The Health Plan at any reasonable time.

B. Members or applicants for membership shall complete and submit to The Health Plan such enrollment forms, health assessment forms, questionnaires, or other forms or statements as Health Plan may reasonably request. Members warrant that all information contained in such applications, forms or statements submitted to The Health Plan incident to enrollment under this Agreement or the administration thereof shall be true, correct and complete and all rights to benefits hereunder are subject to the condition that all such information shall be true, correct and complete. Any violation of this provision may give rise to immediate termination of member's right to coverage with no right to coverage with no right of re-enrollment.

C. The Health Plan is entitled to receive from any provider of services to member, information reasonably necessary in connection with the administration of this Agreement, but subject to all applicable confidentiality requirements. By acceptance of coverage under this Agreement, the member authorizes every provider rendering services hereunder to disclose all facts pertaining to such care and treatment, and physical condition of the member to The Health Plan upon request.

D. Required Insurance Fraud Warning: Pursuant to Ohio Revised Code Section 3999.21, "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

XVIII. MISCELLANEOUS

A. By this Agreement, the Group makes The Health Plan coverage available only to persons who are eligible under Article IV. However, this Agreement shall be subject to amendment, modification or termination in accordance with any provision hereof or by mutual agreement between The Health Plan and the Group without the consent or concurrence of the members. By electing medical and hospital coverage pursuant to this Agreement, or accepting benefits hereunder, all members legally capable of contracting, and the legal representatives of all members incapable of contracting, agree to all terms, conditions and provisions hereof.

B. Any member who fails to submit the documents requested under Article VIII, A, pertaining to reimbursement under Medicare or Medicaid programs or a Workers' Compensation Law, must pay for services received.

C. Cards issued by The Health Plan to members pursuant to this Agreement are for identification only. Possession of a Health Plan identification card confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits the holder of the card must, in fact, be a member on whose behalf fixed periodic prepayment under this Agreement have actually been paid. Any person receiving services or other benefits to which he/she is not then entitled pursuant to the provisions of this Agreement shall be responsible for charges. If any member permits the use of his/her Health Plan identification card by any other person, such card may be retained by The Health Plan and all rights of the member of his/her family covered pursuant to this Agreement shall be immediately terminated at the will of The Health Plan as provided for in Article V.

D. The Health Plan may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.

E. This Agreement, Member Handbook, Enrollment Forms or Verification and Confirmation Document of the members covered hereunder, and Provider List constitutes the entire contract between the parties and, as of the effective date hereof, supersedes all other agreements between the parties.

F. No agent or other person, except an officer of The Health Plan, has authority to waive any conditions or restrictions of this Agreement; to extent the time for making a payment; or to bind The Health Plan by making any promise or representation or by giving or receiving any information. No change in this agreement shall be valid unless evidence by an endorsement on it signed by one of the aforesaid officers or by an amendment to it signed by the Group and by one of the aforesaid officers.

G. Certain members may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Physicians or physicians authorized by The Health Plan. These physicians may regard such refusal to accept their recommendations as incompatible with the continuance of the physician-patient relationship and as obstructing the provision of proper medical care. If a member refuses to accept such a recommended treatment or procedure, than neither the participating or authorized physician, hospital, nor The Health Plan shall have any further responsibility to provide care for the condition under treatment.

H. Any notice under this Agreement may be given by United States Mail, first class, postage prepaid, addressed as follows:

If to Health Plan: The Health Plan of the Upper Ohio Valley, Inc.
52160 National Road, East
St. Clairsville, Ohio 43950

If to a member: Last known address

If to a Group: Belmont County Commission
101 W. Main Street, Courthouse
St. Clairsville, Ohio 43950

I. The Health Plan shall provide annually, before the first day of May, to each Group, and make available to each subscriber upon request, The Health Plan's most recent audited annual financial statements including a balance sheet and statement of receipts and disbursements.

J. The Health Plan shall provide annually to each subscriber a summary of the following:

1. A description of The Health Plan including the health care benefits offered and the facilities and personnel from whom such benefits may be obtained, including any material changes therein since the last report;
2. the current Evidence of Coverage (Member Handbook); and
3. a clear and understandable description of the Grievance Procedure/Appeal Process.

XIX. MEDICARE AND EMPLOYER GROUP HEALTH PLANS (EGHP).

If an active employee and/or dependents are covered by The Health Plan (through their employer) and Medicare, The Health Plan is generally primary and Medicare secondary in the following situations:

**Working Aged.**

When all of the following criteria are met, Medicare will pay as secondary.

- The beneficiary is age 65 or older and entitled to Part A of Medicare.
- The beneficiary is either of the following.
    1. Actively employed and covered by an EGHP with 20 or more employees.
    2. The spouse of an active employed person and covered by EGHP with 20 or more employees. This is regardless of the employee's age.

Employers with 20 or more employees must offer their active employees and employees' spouses of any age the same coverage they offer to employees under age 65. This coverage is primary to Medicare.

Employer groups, with less than 20 employees that have actively-employed Medicare beneficiaries or dependents with Medicare entitlement, are mandated by The Health Plan to enroll these individuals in one of the Health Plan Medicare+Choice options.

**End Stage Renal Disease (ESRD).**

When the following is met, Medicare will pay as secondary **for a period of up to 30 months.**

- The beneficiary is entitled to Medicare solely due to ESRD and is covered by an EGHP of any size.

This applies to all persons entitled to Medicare due to ESRD and covered by an EGHP. There is no minimum size for the EGHP under the ESRD.

**Disability.**

When all of the following is met, Medicare will pay secondary.

- The beneficiary is under age 65.
- The beneficiary is entitled to Medicare due solely to a disability other than ESRD.
- The beneficiary is covered by a Large Group Health Plan (LGHP) with 100 or more employees.

Medicare will pay primary benefits when the employee is not an active employee and is receiving disability benefits from the employer.

NOTE: IF A MEDICARE ENTITLED PERSON DECLINES EGHP, NOTICE MUST BE GIVEN TO MEDICARE.

Should a Medicare entitled individual decline the EGHP, the employer plan cannot offer to pay for Medicare covered services. However, the employer can offer to pay for health care services that are not covered by Medicare such as hearing aids or routine dental care.

Medicare uses IRS and Social Security information to learn whether Medicare beneficiaries or their spouses are working. This information is used to determine whether the EGHP is primary to Medicare. Medicare will contact the employer to confirm such information. Medicare will request reimbursement form the employer for any services they paid primary in error.

XX. EFFECTIVE DATE

This Agreement shall become effective on the first day of June, 2001 and continue through the last day of May, 2002

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by duly authorized representatives this 28th day of May, 2001

| | |
|---|---|
| THE HEALTH PLAN OF THE UPPER OHIO VALLEY, INC | GROUP #0129 BELMONT COUNTY COMMISSIONERS |
| BY: Phyllis D. Wright /S/ | BY: Ryan E. Olexo /S/ |
| Title: President | |
| By: ? | Charles R. Probst, Jr /S/ |
| Title: Vice President Marketing | Title: Commissioners |

Upon roll call the vote was as follows:

| | |
|---|---|
| Mr. Probst | Yes |
| Mr. Olexo | Yes |

**IN THE MATTER OF ACCEPTING HEALTH ASSURANCE RENEWAL RATES FOR FOR COUNTY EMPLOYEES**

Motion made by Mr. Olexo, seconded by Mr. Probst to accept the Health Assurance Renewal rates for health coverage for Belmont County employees as follows:

Effective June 1, 2001 through May 31, 2002

| TIER | PPO #2082010001 | HMO #2030680001 |
|---|---|---|
| Individual | $228.32 | $203.75 |
| Parent/Child | 570.91 | 509.33 |
| Parent/Children | 570.91 | 509.33 |
| Couple | 570.91 | 509.33 |
| Family | 570.91 | 509.33 |

Upon roll call the vote was as follows:

| | |
|---|---|
| Mr. Olexo | Yes |
| Mr. Probst | Yes |

**IN THE MATTER OF ENTERING INTO AGREEMENT WITH COUNTY COMMISSIONERS ASSOCIATION OF OHIO FOR WORKERS' COMPENSATION GROUP RATING PLAN**

Motion made by Mr. Probst, seconded by Mr. Olexo to enter the following agreement with the County Commissioners Association of Ohio for the county employees Workers' Compensation Group Rating Plan Agreement.

**COUNTY COMMISSIONERS ASSOCIATION OF OHIO**
**WORKERS' COMPENSATION GROUP RATING PLAN AGREEMENT**

THIS AGREEMENT, dated as of July 1, 2001, is between CCAO Service Corporation ("CCAOSC"), an Ohio corporation, and the County of Belmont ("Participant"), a political subdivision of the State of Ohio.

**Section I: INTRODUCTION**

Section 4123.29 of the Ohio Revised Code (ORC), and the rules promulgated thereunder, permit the establishment of employer group rating plans in order to group the experience of employers for workers' compensation rating purposes. The County Commissioners, Association of Ohio ("CCAO") acting through CCAOSC, its Service Corporation, as sponsoring organization within the meaning of Section 4123.29 and the regulations associated with same, hereby establishes a group for the benefit of its membership for the purpose of obtaining a group rating pursuant to Section 4123.29, ORC. The terms and conditions for participation in the CCAO group rating plan are herein established.

A participating employer is hereafter referred to individually as a "Participant". Participating employers are collectively referred to as the "Group".

**Section II: NAME**

The name of the plan shall be the CCAO Workers' Compensation Group Rating Plan, hereafter referred to as the "CCAO Group Rating Plan or the "Plan". The principal office of the CCAO Group Rating Plan shall be located at 37 W. Broad Street, Suite 650, Columbus, Ohio 43215.

**Section III: PURPOSE OF GROUP PLAN**

The CCAO Group Rating Plan is intended to: (1) achieve lower workers' compensation rates for the Group, and (2) result in the establishment of safer working conditions and environments for each Participant.

**Section IV: REPRESENTATIONS AND WARRANTIES CONCERNING ELIGIBILITY**

A. CCAOSC, for itself and on behalf of CCAO, represents and warrants as follows:

1. CCAO was created more than two years prior to the date of application for Group coverage.

2. CCAO was formed for purposes other than obtaining Group workers' compensation under Section 4123.29, ORC; rather, it was formed for the purpose of, among other things, uniting the county commissioners of Ohio into an association to promote the best practices and policies in the administration of county government for the benefit of the people of the State of Ohio.

3. The business of the Group is substantially similar such that the risks which are grouped are substantially homogeneous.

4. The aggregate workers' compensation premiums of the Group members are expected to exceed $150,000 during the rating period covered by this Agreement.

B. The Participant represents and warrants as follows:

1. It has an Ohio Bureau of Workers' Compensation ("OBWC") policy number for counties and its account with OBWC is in good standing such that no outstanding premiums, penalties or assessments are due from it.

2. It is not a member of any other group for the purpose of obtaining workers' compensation coverage under Section 4123.29, ORC.

3. That its 1998 calendar year payroll does not exceed $40,000,000. Counties with a 1998 calendar year payroll of $40,000,000 or more will not be eligible for membership in the Rating Plan. The maximum annual payroll amount shall be established annually by the CCAO Workers' Compensation Group Rating Plan Executive Committee, to reflect inflation and prevailing Ohio county payroll trends.

**Section V. BASIC OBLIGATIONS OF PARTIES**

Pursuant to Section I hereof, CCAO, acting through CCAOSC, has established the CCAO Group Rating Plan.

1. CCAOSC shall:
   (1) coordinate and administer the CCAO Group Rating Plan in accordance with this agreement.
   (2) file or cause to be filed all necessary applications with OBWC to obtain membership for the Participants in the CCAO Group Rating Plan; and
   (3) perform such additional duties as are required of it by this Agreement.

2. The Participant shall:
   (1) join and participate in the CCAO Group Rating Plan; and
   (2) perform such additional duties and pay such fees and expenses as are required of it by this Agreement.

**Section VI: PENALTY RATED PARTICIPANTS**

Additionally, the participant recognizes that the inclusion of group members with a penalty modification detrimentally affects the group rate. Each year, CCAOSC, in cooperation with the administrator, shall analyze the projected experience modification of all prior year plan members. CCAOSC, in its sole discretion, may determine that a plan participant is not eligible for any subsequent year group plan and not renew said participant. Alternatively, CCAOSC, in its sole discretion, may create additional allocations or contributions of such participants, including the formation of a "Premium Discount Pool".

Effective June 1, 1999, a penalty rated county that has not previously participated in the Plan will not be eligible for membership in the Plan.

**Section VII: PREMIUM DISCOUNT POOL PARTICIPANTS**

Effective for the policy year commencing January 1, 1998, CCAOSC has created a Premium Discount Pool. Prior year participants projected to be in a penalty rating **must participate** in the CCAOSC Premium Discount Pool in order to remain in the Group Rating Plan. CCAOSC Premium Discount Pool participants are required to implement the **CCAO 10 Step Safety Plan for County Government**, and must submit an annual progress report to CCAOSC. However, enrollment in the Bureau of Workers' Compensation Premium Discount Program (PDP) shall be at the discretion of the Participant. To enroll in the BWC's PDP, the Participant shall complete a "UA-5 Application For Premium Discount Program", and shall meet all requirements of the Bureau of Workers' Compensation for continued participation in the PDP.

CCAOSC shall include the calculated PDP savings (derived as if the member is participating in PDP) for each participant in the calculation of the rate contribution and rebate (Section VIII) such that the PDP participant will receive or contribute the amount determined as if the participant was included in the group program.

A penalty rated Participant who became penalty rated prior to January 1, 2002, and is no longer eligible for the PDP due to the number of years of PDP participation (as specified in the BWC PDP guidelines) will not be eligible for Plan membership. A penalty rated Participant who became penalty rated after January 1, 2002, may remain in the Group for not more than three years during which they remain penalty rated.

**Section VIII: RATE CONTRIBUTION AND REBATES**

The participant understands that the group rate must be estimated in advance of the experience period and is based upon the most recent experience period, and that the actual group rate will vary depending upon multiple factors. The participant is solely responsible for any assessments of premiums owed to the OBWC. In no event shall CCAO, CCAOSC, the third party administrator, or other group members be held liable for premiums owed by the participant to the OBWC.

The participant understands the group rate is subject to change during and subsequent to the policy period, and all debit and credit adjustments processed by the OBWC will be the premium responsibility of the individual participant. In no event will CCAO, CCAOSC, the third party administrator, or the other group members be held liable for premiums owed by the participant to the OBWC resulting from subsequent rate revisions.

It is understood that in forming a group the OBWC will calculate a group rate for the CCAO Group Rating Plan which shall be applied uniformly to the members of the Group regardless of each Participant's individual rate. It is further understood that OBWC shall calculate premiums, as provided by law, multiplying the group rate (as described above) times each Participant's individual payroll.

In order to allocate the savings derived by formation of the Group, and to maximize the number of Participants in the Group, it is hereby agreed that annually the CCAOSC shall estimate the total savings which shall accrue to the Group through its formation which shall include the amount of savings for participants in the Premium Discount Program. The CCAOSC shall notify each Participant of the estimated savings as well as the estimated rebates and/or additional billings required so that yearly budgeting may be facilitated on a timely basis for the Participants.

Upon receipt of the actual year-end payroll figures from each Participant, the CCAOSC shall calculate the total realized savings which shall accrue to the Group through its formation and collect rate contributions from and pay rate equalization rebates to the Group's various Participants. The Participants determined to be eligible for the group filing shall receive the share of the group savings which shall be equal to the total savings of all group members less Premium Discount reimbursements multiplied by the percentage found by dividing the Participants individual payroll by the total payroll of all participating group members.

Premium Discount Program participants shall receive a share of plan savings which shall be the amount determined as if the participant was included in the group program filed with the Ohio Bureau of Workers' Compensation. Individual payroll divided by the payroll of all plan members will be applied to the plan savings as if the participants were included in the group filing.

CCAOSC shall bill any rate contributions due from individual Participants no later than sixty (60) days following receipt by CCAOSC of the payroll report submitted by Participants to the OBWC. Bills for contributions are due and payable to CCAOSC within thirty (30) days of receipt. All rebate checks shall be paid to those Participants due rebates no later than ten (10) days from the date of receipt of all contributions due from individual Participants.

**Section IX: ADMINISTRATIVE SERVICES**

CAOSC, with the approval of the Group Executive Committee, shall retain the services of a third party administrator ("TPA") specializing in the administration of workers' compensation claims. Such designated TPA shall assist CCAOSC staff in the day to day management of the Plan, prepare and file necessary reports for both OBWC and members, assist with loss control programs, and other duties (**excluding** claims-related matters, which shall be the responsibility of each individual Participant, as provided in the second paragraph of this Section IX) relating to the Plan's activities. The cost of these services shall be borne by the Participant in proportion of its workers' compensation premiums plus its contribution, or minus its rebate, as the case may be. CCAOSC shall bill the Participant for such services at such times as are determined by the Group Executive Committee, and the Participant shall remit payment to CCAOSC within thirty 30 days of its receipt of such bill.

Each Participant may at its sole expense, engage the services of an attorney, or other qualified TPA, or representative for claims-related matters, such as hearings before the respective state agencies.

In any event, the Participant agrees to inform CCAOSC, the Group, and the Group's TPA, at all times, of all claims which will affect the rating of the Group.

**Section X: RISK MANAGEMENT SERVICES**

The Participant acknowledges that one of the statutory requirements for a group rating program is a substantial improvement in accident prevention and safety training by the Group. The Participant shall make a good faith effort to maintain a safe working environment for its employees and to implement the Group's model safety and claims management program, which is hereto attached as Exhibit A. In addition, each participant shall participate in and comply with any safety program or claims management procedure adopted by the Group Executive Committee. The costs for risk management services shall be allocated, billed and paid in the same manner as described in Section IX, above. The Participant may provide supplementary training and risk management consulting services to its employees at the Participant's sole expense.

CCAOSC reserves the right to require the Participant to undergo an occupational safety and health audit of its premises. For such audits, the Participant shall have the option of (1) using a qualified private safety consultant of the Participant's choice, subject to CCAOSC's approval; or (2) requesting CCAOSC to arrange for an audit performed by the Ohio Division of Safety and Hygiene ("ODSH") . It is understood that the ODSH will perform an audit at no additional cost. However, if the Participant chooses to utilize a private safety consultant it shall do so at its own cost. A copy of the audit results and safety

recommendations shall be provided to CCAOSC upon CCAOSC's request. The Participant and CCAOSC agree that if a private consultant is engaged by the Participant to perform an audit, the consultant will act as an independent agent, not subject to the direction and control of CCAOSC.

**Section XI: GENERAL MANAGEMENT FEES**

The Participant agrees to pay anticipated general management fees during the term of the Agreement, if any, as described and in the manner specified in Section IX, above.

**Section XII: GROUP EXECUTIVE COMMITTEE**

There is hereby established a Group Executive Committee, which shall consist of nine members. Two of said members shall be the President and the Treasurer of CCAOSC; the remaining seven members shall be representatives of the Participants, elected for the ensuing year by the Participants. No Participant shall have more than one member of the Group Executive Committee in any year, and each elected member shall be a county commissioner. However, any member may by written instrument appoint a designee, who need not be a county commissioner but shall be an officer or employee of the member's county. A designee shall have the same powers as the appointing member.

The duties of the Group Executive Committee shall be:

1) to approve the selection of a TPA, as provided in Section IX hereof;
2) to review and approve proposed TPA fees, fees for risk management services, and general management fees, and to provide for the billing and collection thereof;
3) to determine ongoing eligibility of each Participant for continued participation in the Group; and
4)
5) to perform such other acts and functions as may be delegated to it from time to time by the Group.

**Section XIII: TERM OF AGREEMENT**

Subject to the approval of the CCAO Group Rating Plan by the OBWC, the term of this Agreement shall commence on the date of execution hereof and shall be continuing and shall be applicable to all rating periods beginning January 1, 2002, and thereafter. CCAOSC may terminate this Agreement upon sixty(60)days written notice to the Participant. The Participant may terminate this Agreement so as not to be included in the CCAO Group Rating Plan for the next annual rating period provided sixty (60) days written notice of intent to withdraw from the CCAO Group Rating Plan is given to CCAOSC prior to the prescribed application deadline of OBWC, currently June 30 of the year prior to the applicable annual rating period. In any event, a Participant shall not be relieved of the obligation to pay any amounts owed for participation in the CCAO Group Rating Plan prior to withdrawal therefrom.

**Section XIV: APPLICATION BY PARTICIPANT**

Initial application of a Participant shall include: (1) properly signed and authorized copy of this Agreement; (2) properly executed and notarized OBWC Form AC-26, allowing CCAOSC or its TPA to represent the CCAO Group Rating Plan before OBWC. A Participant's initial application shall also include a one-time membership fee in the amount of $2,000. In order to remain in good standing, a Participant shall provide to CCAOSC annually prior to June 30 of each year: (1) a properly executed and notarized OBWC From AC-26 and (2) an authorization letter for TPA/Risk Management Services (unless written exception has been obtained pursuant to Section IX and X, above), allowing CCAOSC or its TPA to represent the CCAO Group Rating Plan.

**Section XV: GENERAL PROVISIONS**

CCAOSC shall strictly account for all funds collected and disbursed relating to the Group Rating Plan. All Group Rating Plan funds shall be strictly segregated from all CCAOSC activities relating to the operations and activities of CCAO's property/casualty insurance pool or pools.

The Participant is solely responsible for any assessment of premiums levied by OBWC against it. Neither the CCAO Group Rating Plan nor its TPA shall be liable for any such charges.

If the Participant leaves the group, it will allow representatives of the Group to access its loss experience for a period of three (3) years following the last year of participation.

The Participant acknowledges that Group rate setting is solely the function of the OBWC. It is understood that such considerations as the "TM Calculation", "Credibility Factor", and "Loss Value Limitation", shall be assigned by OBWC at the group, rather than the individual, level.

The Participant hereby acknowledges receipt of the complete Agreement.

**IN WITNESS THEREOF**, the parties hereby enter into this Agreement on the date given below.

**CCAO SERVICE CORPORATION**

By: David W. Brooks? /s/

Date

**COUNTY OF BELMONT**

By: Charles R. Probst, Jr. /s/, Ryan E. Olexo /s/

Date Signature of Authorized Official

County Name: Belmont County
Address: Courthouse, 101 W. Main Street
City, State, Zip: St. Clairsville, Ohio 43950
OBWC Number: 30700001-0

Name of Participant's TPA for claim related matters: Comp Management, Inc.

APPROVED AS TO FORM
Robert Quirk /s/
Prosecuting Attorney

Upon roll call the vote was as follows:
Mr. Probst Yes
Mr. Olexo Yes

**IN THE MATTER OF APPROVING AMENDMENT TO IV-D CONTRACT BETWEEN CSEA AND BELMONT COUNTY COMMON PLEAS COURT/BCDJFS**

Motion made by Mr. Olexo, seconded by Mr. Probst to approve the following amendment to the IV-D Contract between Belmont County Child Support Enforcement Agency and Common Pleas Court that was entered into on the 10th day of January 2001 and numbered 0701041, effective May 1, 2001.

Article 4-Total Contract Value: $104,166.20
Article 5-Cost and Delivery of Purchased Services: adjusts the per unit rate from $232.63 to $168.01.

Upon roll call the vote was as follows:
Mr. Olexo Yes
Mr. Probst Yes

**IN THE MATTER OF DISCUSSION HELD RE: ANGELA MONTAG, BETHESDA, REQUEST FOR COUNTY WATER**

Angela Montag, Rafter M Rodeo, presented to the Board her need for county water. Ms. Montag explained that her family operates the Rafter M. Rodeo and has plans to expand. Ms. Montag stated, "This means economic development for Belmont County, we have a chance to do something unique, county water will help us grow and provide jobs to residents, without county water we can't grow." Angela explained the current situation at the rodeo and how they have the fire department haul in water.

Ms. Montag told the Commissioners she was trying to prevent the problem before it occurred, she does not want to shut down her business. She stated, "I want to create jobs, stay here in the area, I am asking you personally for help - help our business grown. We are willing to meet you halfway and will do what ever it takes. Our business is only five tenths of a mile from the road. I am asking the Board to please take this under consideration. If it is feasible, proceed – the sooner, the better. My goal is to have county water before the next rodeo season."

Commissioner Olexo explained, "The Board has received the final study for the waterline extension project from Hammontree and Associates. That is the first step; the second step is securing the funding. We have initiated that process, we are attempting to bring in federal funds, an outside source to subsidize our funds. The Board is making every effort To complete all areas included in the study. Our goal is to have county water to every citizen in this county. Monetarily, we can not do every water project at once, we are proceeding."

Commissioner Olexo informed Ms. Montag that when the Board has any further course relevant to her area, they would contact her. He continued, "We understand this is the number one priority of our citizens and the Board will make every effort we can to do all these projects."

Commissioner Probst stated, "The area in question, Ault Road, is one of the target areas of the waterline extension project. In looking over everything, it does appear to be feasible." Mr. Probst explained the Board would be meeting soon with the County Auditor to discuss the financing of these projects. He stated the Commission would soon release which areas will be included in Phase I of the waterline extension projects.

Ms. Montag stated, "We want to be able to install restroom facilities, we are not able to do so. I have put in four wells in the last seven years; there are only two presently working. I want to prevent a situation from happening – our not having any water."

Commissioner Olexo explained, "There is one and a half million dollars generated per year from the permissive sales tax, out of that amount - $250,000.00 is allocated to the Belmont County Engineer Department for road paving. The previous board of Commissioners established that and it is the intent of this Board to continue that practice. The prior board committed to two sewage projects, which total almost four million dollars. That is part of the infrastructure funding. The Board will need to determine what is available for the waterline extension projects; we will have more information after meeting with the County Auditor. Our priority, as always, is the health and safety of our residents."

**IN THE MATTER OF DISCUSSION HELD**
**RE: BELMONT COUNTY JOB AND FAMILY SERVICES**
**PRESS RELEASE – HEALTHY START/HEALTHY FAMILIES CAMPAIGN**

Dwayne Pielech, Director Belmont County Department of Job and Family Services, and Jack Cera, Deputy Director, presented the following information to the Board:

Contact: Dwayne Pielech
Department of Job & Family Services
(740) 695-1075 ext. 100

**FOR IMMEDIATE RELEASE**
**BELMONT COUNTY HEALTHY START/HEALTHY FAMILIES CAMPAIGN BEGINS**

**Belmont County, OH**—The Belmont County Commissioners in coordination with the Department of Job & Family Services, and the Belmont County Commissioners announced at Wednesday's evening meeting in Bethesda that the Belmont County Healthy Start/Healthy Families Program will be launching an informational advertising blitz beginning on June 1st.

This "educational/awareness" campaign will include newspaper, television, radio and outdoor advertising mediums; along with a full-length promotional video that will be available for viewing or check-out at local libraries, doctor and dentist offices and at the Belmont County Department of Job & Family Services facilities.

"The Healthy Start/Healthy Families Program is offered to our Belmont County residents who may qualify for heath coverage for their children—free of charge," Pielech explained. "We hope that our campaign will educate those parents who meet the required income guidelines so that their children will be awarded full health benefits. With the rising cost of groceries, gasoline and clothing nowadays, many hard-working parents find it hard to make ends meet; but Healthy Start/Healthy Families can lift the burden of paying for their children's benefits," he added.

The Healthy Start/Healthy Families Program is not a welfare program. Many of the families who participate in this project are full-time employees who are either not offered benefits at their jobs; or do not meet specific income guidelines (see supplement to this press release).

Those individuals who are interested in applying for the Healthy Start/Healthy Families Program can do so easily and confidentially. A simple, two-page application is all that is required to fill out—and can even be mailed in to the Belmont County Department of Job & Family Services. No long lines or list of questions to answer. Families who are accepted into the Healthy Start/Healthy Families Program will receive health benefits for their children at little or no cost.

"The working family is the group who will benefit from this program," Pielech explained. "Individuals who care about their children and want to make sure that they are receiving the best healthcare possible are being rewarded for their dedication and work ethic," he added. "The employees who work at the local mall, retail stores, mom and pop establishments or do not work forty hours per week are potential candidates to receive 'free health coverage' through Healthy Start/Healthy Families for their children," Pielech concluded.

For more information on the Healthy Start/Healthy Families Program, call the local Department of Job & Family Services in your home county. For this specific campaign, Belmont County residents are encouraged to call the Belmont County Department of Job and Family Services at (740) 695-1074 ext. 6.

| FAMILY SIZE | ANNUAL INCOME | MONTHLY INCOME | HOURLY WAGE |
|---|---|---|---|
| 1 | $17,184 | $1432 | $8.32 |
| 2 | $23,220 | $1935 | $11.25 |
| 3 | $29,268 | $2439 | $14.18 |
| 4 | $35,304 | $2942 | $17.10 |
| 5 | $41,340 | $3445 | $20.02 |

Note: Families with incomes slightly higher than these figures should still apply.

**IN THE MATTER OF DISCUSSIONS HELD**
**RE: PUBLIC FORUM**

**WATER HYDRANT ISSUES**
Mayor Flanagan informed the Board that the Village has an ongoing problem with the fire hydrants in their vicinity. Council members feel a pump would help the situation. Dave Green, council member and also a member of the volunteer fire department, stated that a

flow test on the hydrants in town had been completed in 1999 and 2000. The difference between them was quite considerable. Residents are concerned that if there would be a large structure fire, it would become a real problem. Mr. Green explained that when the Village required flow testing, the county made certain the water tank was full. He stated, "the difference between our test and the county's test – it is not a water pressure problem, it is a flow problem. There is not adequate water coming into the Village."

Commissioner Olexo stated, "The Board is aware of the problem, we have done some research. The recommendation is to install a water station, which would cost $100,000.00. We will be in contact with you to see if we can make this a joint effort. The other option would call for looping systems and we are researching this also. We cannot expand a system if a system is not currently adequate to meet the resident's needs. The safety and health of our residents is the number one concern."

**REQUEST FOR COUNTY WATER**

John Drewitt, Lashley Hill resident, requested an update on the water line extension project. Mr. Drewitt questioned if Lashley Hill was included in the study.

Commissioner Olexo stated, "Specifically, I don't know. You are on our list of areas without water. The study came back in a five year stage. The engineer's recommendations don't always match what we feel are the direct needs of our citizens. The projects that will become part of Phase I, hinge on the county's finances."

**VILLAGE ISSUES**

Ms. Ruth Saffell, council member, questioned if the lift station is the county's problem or the village's.

Commissioner Olexo stated, "I am not sure. Technically, it is the county's line which is why I commented that we would be in contact with the Village. The total cost of the water line extension project would be 12.9 million; this does not include any upgrades, such as a lift station for Bethesda. What funds can be secured will determine where we start."

Mr. Melvin Jenewein, resident of Clover Ridge, informed the Board that there were two miles of County Road 5 that were in very bad shape and in need of blacktop. Mr. Jenewein questioned if something could be done. Commissioner Olexo stated he would check with County Engineer Fred Bennett and get back to Mr. Jenewein.

Mr. Jenewein then requested an explanation on the Committee on Aging court action. The Commissioners explained the Board was asking the Courts for a declaratory judgment - to define what the levy monies can legally be used for.

**IN THE MATTER OF AWARDING**
**CDBG PROJECTS FOR FY 2001**

Motion made by Mr. Probst, seconded by Mr. Olexo to award the following CDBG projects in the amount of $221,500.00 for FY 2001.

| ACTIVITY | CDBG FUNDS |
|---|---|
| VILLAGE OF BARNESVILLE | |
| Fire Hydrant replacement OR sidewalk installation | $38,700.00 |
| VILLAGE OF BELMONT | |
| Street resurfacing | 38,982.00 |
| RICHLAND TOWNSHIP | |
| Street resurfacing | 33,575.00 |
| SOMERSET TOWNSHIP | |
| Park improvements and culvert replacements | 30,200.00 |
| LAFFERTY V.F.D. | |
| Purchase of fire brush truck | 43,550.00 |
| POWHATAN POINT V.F.D. | |
| Fire equipment | 36,493.00 |

Upon roll call the vote was as follows:

| | |
|---|---|
| Mr. Probst | Yes |
| Mr. Olexo | Yes |

**IN THE MATTER OF ADJOURNING COMMISSIONERS MEETING AT 7:25 P.M.**

Motion made by Mr. Olexo, seconded by Mr. Probst to adjourn the meeting at 7:25 P.M.

Upon roll call the vote was as follows:

| | |
|---|---|
| Mr. Probst | Yes |
| Mr. Olexo | Yes |

Meeting adjourned.

Read, approved and signed this 1st day of June A.D., 2001.

_____

_____ COUNTY COMMISSIONERS

Mark A. Thomas, absent

We, Ryan E. Olexo and Darlene Pempek, President and Clerk respectively of the Board of Commissioners of Belmont County, Ohio, do hereby certify the foregoing minutes of the proceedings of said Board have been read, approved and signed as provided for by Sec. 305.11 of the Revised Code of Ohio.

_____ PRESIDENT

_____ CLERK