GERBER LIFE INSURANCE COMPANY

44 S. Broadway, 8th Floor, White Plains, NY 10601

POLICYHOLDER	BRADFORD EXEMPTED VILLAGE SCHOOL DISTRICT	**POLICY NUMBER**	35-2761-26
ADDRESS	760 RAILROAD AVE BRADFORD, OH 54308	**Effective Date** **Termination Date**	JULY 1, 2026 ACADEMIC YEAR JULY 1, 2027 ACADEMIC YEAR

PREMIUM FOR EACH INSURED PERSON

SEE APPLICATION ATTACHED

LIST OF ENDORSEMENTS ATTACHED TO AND FORMING A PART OF THIS POLICY

COL-03 END (6B)
COL-03 END (5A)
GR-03-OH External
GR-03-OH Internal

GERBER LIFE INSURANCE COMPANY

hereinafter called the Company, agrees, subject to all provisions, conditions, exclusions and limitations of this policy to pay the benefits provided by this policy for loss resulting from a cause covered by this policy. This policy is issued in consideration of the application and payment of the premiums. Premiums as specified above are payable for each Insured Person.

Non-Renewable One Year Term Insurance -- This Policy Will Not Be Renewed

President and CEO

Secretary

Countersigned by _____ **Licensed Resident Agent**

PREMIUMS AND PREMIUM PAYMENT

The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this policy at any time up to the later of 1) two years after the termination of this policy and 2) the date of final adjustment and settlement of all claims under this policy.

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PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy.

Eligible persons may be insured under this policy subject to the following:

1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

1) The Effective Date of the policy; or
2) The date premium is received by the Administrator.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid; or
2) The date the policy terminates.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces. The Named Insured may purchase optional coverages for himself or for himself and all Dependent family members.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury as their liability may appear.

MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

PART III
DEFINITIONS

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply per policy year or per occurrence for each Injury as specified in the Schedule of Benefits.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for an Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confined in a Hospital for at least 18 hours by reason of an Injury for which benefits are payable.

INJURY means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 60 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

INSURED PERSON means the Named Insured. The term "Insured" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1) Progressive care;
2) Sub-acute intensive care;
3) Intermediate care units;
4) Private monitored rooms;
5) Observation units; or
6) Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in:

1) Death;
2) Placement of the Insured's health in jeopardy;
3) Serious impairment of bodily functions;
4) Serious dysfunction of any body organ or part; or
5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries.

MEDICAL NECESSITY means those services or supplies provided or prescribed by a Hospital or Physician which are:

1) Essential for the symptoms and diagnosis or treatment of the Injury;
2) Provided for the diagnosis, or the direct care and treatment of the Injury;
3) In accordance with the standards of good medical practice;
4) Not primarily for the convenience of the Insured, or the Insured's Physician; and,
5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

NAMED INSURED means an eligible, participant of the Policyholder, if: 1) the participant is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

NEGATIVE X-RAY means an X-ray that shows the absence of a fracture; pathology; or disease.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POSITIVE X-RAY means an X-ray that shows the presence of a fracture; pathology; or disease.

PRESCRIPTION DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

PART IV
COVERED LOSS - TIME LIMITS

Covered Medical Expenses will be paid under the Schedule of Benefits for loss due to Injury to an Insured Person provided that treatment by a Physician: a) begins within 60 days after the date of Injury; and, b) is received within 2 years after date of Injury

PART V
SCHEDULE OF BENEFITS
MANDATORY MEDICAL EXPENSE BENEFITS
INJURY ONLY BENEFITS

Mandatory Maximum Benefit	**$25,000**
Deductible	**$0**
Coinsurance	**None**

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

Inpatient

Room & Board:	100% Usual and Customary Charges
Intensive Care:	100% Usual and Customary Charges
Hospital Miscellaneous:	100% Usual and Customary Charges
Surgery:	100% Usual and Customary Charges based on data provided by Ingenix, at the 80th percentile.
Assistant Surgeon:	100% Usual and Customary Charges
Anesthetist:	100% Usual and Customary Charges
Registered Nurse:	100% Usual and Customary Charges
Physician's Visits:	100% Usual and Customary Charges
Pre-admission Testing:	100% Usual and Customary Charges

Outpatient

Surgery:	100% Usual and Customary Charges based on data provided by Ingenix at the 80th percentile.
Day Surgery Miscellaneous:	100% Usual and Customary Charges

(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)

Assistant Surgeon:	100% Usual and Customary Charges
Anesthetist:	100% Usual and Customary Charges
Outpatient Misc. Benefit:	100% Usual and Customary Charges
Physician's Visits:	100% Usual and Customary Charges
Physiotherapy:	100% Usual and Customary Charges to a maximum of $1,250 per non-surgical Injury
Medical Emergency:	100% Usual and Customary Charges
Diagnostic X-Rays:	100% Usual and Customary Charges
Laboratory:	100% Usual and Customary Charges
Tests & Procedures:	100% Usual and Customary Charges
Prescription Drugs:	100% Usual and Customary Charges

Other

Ambulance:	100% Usual and Customary Charges
Durable Medical Equipment:	100% Usual and Customary Charges
Dental:	100% Usual and Customary Charges

(Benefits paid on Injury to Sound, Natural Teeth only.)

*AD&D:	$100,000
Replacement of eyeglasses, hearing aids or contact lenses damaged during a covered Injury, if medical treatment is also received for the covered Injury	100% Usual and Customary Charges

MEDICAL EXPENSE BENEFITS
MAXIMUM BENEFIT

The Maximum Benefit for all benefit coverage afforded under this policy is $25,000 for any one Injury . Covered Medical Expenses shall not include amounts paid by the Insured for coinsurance.

Other Insurance: (X) ***Excess Insurance (Injury Only Plans)** ( ) **Excess Motor Vehicle** ( ) **Primary Insurance**

*If benefit is designated, see endorsement attached.

PART VI
MEDICAL EXPENSE BENEFITS - INJURY

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.

2. **Intensive Care:** If provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

4. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.

5. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.

6. **Anesthetist Services:** professional services administered in connection with inpatient surgery.

7. **Registered Nurse's Services:** 1) while Hospital Confined; 2) ordered by a licensed Physician; and 3) a Medical Necessity.

8. **Physician's Visits:** when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.

9. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit.

10. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. Covered Medical Expenses will be paid under this outpatient surgery benefit; or under the inpatient surgery benefit, but not both. If two or more procedures are performed through the same incision or in immediate succession at the same operative session the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.

11. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies.

12. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.

13. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.

14. **Outpatient Miscellaneous Benefit:** outpatient Hospital and Physician services. Outpatient services payable under this benefit will be designated "Paid under Outpatient Miscellaneous Benefit" in the Schedule of Benefits.

15. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.

16. **Physiotherapy (Outpatient):** See Schedule of Benefits.

17. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the attending Physician's charges, the use of the emergency room and supplies.

18. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits, separate maximums apply to positive and negative X-rays.

19. **Laboratory Procedures (Outpatient):** See Schedule of Benefits

20. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.

21. **Prescription Drugs (Outpatient):** See Schedule of Benefits.

22. **Ambulance Services:** See Schedule of Benefits.

23. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury. No benefits will be paid for rental charges in excess of purchase price.

24. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

25. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

PART VII
EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Dental treatment, except for accidental Injury to Sound, Natural Teeth;

2. Elective Surgery or Elective Treatment;

3. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;

4. Injury caused by, contributed to, or resulting from the addiction to or use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;

5. Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;

6. Motor vehicle Injury in excess of $10,000;

7. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

8. Sickness or disease in any form.

9. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline; or chartered aircraft only while participating in a school sponsored activity;

10. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;

11. Supplies, except as specifically provided in the policy;

12. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all terrain vehicle (ATV); jet ski; ski cycle; or snowmobile, scuba diving, surfing, riding in a rodeo according to the policy provisions;

13. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and

14. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

EXCESS PROVISION

No benefit of this policy is payable for any expense incurred for Injury which is paid or payable by other valid and collectible insurance.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 365 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the "Injury Medical Expense Benefits" provision.

For Loss Of:

Life	$10,000.00
Both Hands, Both Feet, or Sight of Both Eyes	$10,000.00
One Hand and One Foot	$10,000.00
Either One Hand or One Foot and Sight of One Eye	$10,000.00
One Hand or One Foot or Sight of One Eye	$ 5,000.00
Entire Thumb and Index Finger of Either Hand	$10,000.00

Loss shall mean with regard to hands and feet, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

RESOLUTION OF GRIEVANCES

EXTERNAL REVIEW PROCESS

The director of insurance shall establish and maintain a system for receiving and reviewing requests for review from Named Insured's who have been denied coverage of a health care service on the grounds that the service is not a service covered under the terms of the Named Insured's policy or certificate.

On receipt of a written request from a Named Insured or authorized person, the director shall consider whether the health care service is a service covered under the terms of the Named Insured's policy or certificate, except that the director shall not conduct a review under this section unless the Named Insured has exhausted the insurer's internal review process. The insurer and the Named Insured or authorized person shall provide the director with any information required by the director that is in their possession and is germane to the review.

Unless the director is not able to do so because making the determination requires resolution of a medical issue, the director shall determine whether the health care service at issue is a service covered under the terms of the Named Insured's policy or certificate. The director shall notify the Named Insured and the insurer of its determination or that it is not able to make a determination because the determination requires the resolution of a medical issuer.

If the director notifies the insurer that making the determination requires the resolution of a medical issue, the insurer shall afford the Named Insured an opportunity for external review. If the director notifies the insurer that the health care service is not a covered service, the insurer is not required to cover the service or afford the Named Insured an external review.

An insurer shall afford a Named Insured an opportunity for an external review of a coverage denial when requested by the Named Insured or authorized person, if both of the following are the case:

1. The insurer has denied, reduced, or terminated coverage for what would be a covered health care service except that the insurer has determined that the health care service is not medically necessary.

2. Except in the case of expedited review, the proposed service, plus an ancillary services and follow-up care, will cost the Named Insured more than five hundred dollars if the proposed service is not covered by the insurer.

An insurer may deny a request for an external review if it is requested later than sixty days after receipt by the insured of notice from the director of insurance that making a determination requires the resolution of a medical issue. An external review may be requested by the insured, an authorized person, the insured's provider, or a health care facility rendering health care service to the insured. The insured may request a review without the approval of the provider or the health care facility rendering the health care service. The provider or health care facility may not request a review without the prior consent of the insured.

An external review must be requested in writing, except that if the Named Insured has a condition that requires expedited review, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the insurer not later than five days after the request is made.

Except in the case of an expedited review, a request for an external review must be accompanied by written certification from the Named Insured's provider or the health care facility rendering the health care service to the Named Insured that the proposed service, plus any ancillary services and follow-up care, will cost the Named Insured more than five hundred dollars if the proposed service is not covered by the insurer.

For an expedited review, the Named Insured's provider must certify that the Named Insured's condition could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the Named Insured or, with respect to a pregnant woman, the health of the Named Insured or the unborn child in serious jeopardy;

2. Serious impairment to bodily functions;

3. Serious dysfunction of any bodily organ or part;

PROCEDURES USED IN CONDUCTING AN EXTERNAL REVIEW:

The procedures used in conducting an external review shall include all of the following:

1. The review shall be conducted by an independent review organization assigned by the director of insurance.

2. Neither the clinical peer nor any health care facility with which the clinical peer is affiliated shall have any professional, familial, or financial affiliation with any of the following:

    a) The insurer or any officer, director, or managerial employee of the insurer;
    b) The Named Insured, the Named Insured's provider, or the practice group of the Named Insured's provider;
    c) The health care facility at which the health care service requested by the Named Insured would be provided;
    d) The development or manufacture of the principal drug, device, procedure, or therapy proposed for the Named Insured.

3. A Named Insured shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by the insurer.
4. The insurer shall provide the independent review organization conducting the review a copy of those records in its possession that are relevant to the Named Insured's medical condition and the review.

    a) At the request of the independent review organization, the insurer, Named Insured, provider, or health care facility rendering health care services to the Named Insured shall provide any additional information the independent review organization requests to complete the review. A request for additional information may be made in writing, orally, or by electronic means. The independent review organization shall submit the request to the Named Insured and insurer. If a request is submitted orally or by electronic means to a Named Insured or insurer, not later than five days after the request is submitted, the independent review organization shall provide written confirmation of the request. If the review was initiated by a provider or health care facility, a copy of the request shall be submitted to the provider or health care facility.
    b) An independent review organization is not required to make a decision if it has not received any requested information that it considers necessary to complete a review. An independent review organization that does not make a decision for this reason shall notify the Named Insured and the insurer that a decision is not being made. The notice may be made in writing, orally, or by electronic means. An oral or electronic notice shall be confirmed in writing not later than five days after the oral or electronic notice is made. If the review was initiated by a provider or health care facility, a copy of the notice shall be submitted to the provider or health care facility.

5. The insurer may elect to cover the service requested and terminate the review. The insurer shall notify the Named Insured and all other parties involved with the decision by mail, or with the consent or approval of the Named Insured, by electronic means.

6. In making its decision, an independent review organization conducting the review shall take into account all of the following:

    a) Information submitted by the insurer, the Named Insured, the Named Insured's provider, and the health care facility rendering the health care service, including the following:

        i. The Named Insured's medical records;
        ii. The standards, criteria, and clinical rationale used by the insurer to make its decision.

    b) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the national institutes of health or any board recognized by the national institutes of health or any board recognized by the national institutes of health, the national cancer institute, the national academy of sciences, the United States food and drug administration, the health care financing administration of the United States department of health and human services, and the agency for health care policy and research;

c) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical experts, and clinical guidelines adopted by relevant national medical societies.

7. In the case of an expedited review,

a) The independent review organization shall issue a written decision not later than seven days after the filing of the request for review. In all other cases, the independent review organization shall issue a written decision not later than thirty days after the filing of the request. The independent review organization shall send a copy of its decision to the insurer and the Named Insured. If the Named Insured's provider or the health care facility rendering health care services to the Named Insured requested the review, the independent review organization shall also send a copy of its decision to the Named Insured's provider or the health care facility.

b) The independent review organization's decision shall include a description of the Named Insured's condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.

EXTERNAL REVIEW OF DENIAL OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT FOR TERMINAL CONDITIONS:

A. Each insurer shall establish a reasonable external, independent review process to examine the insurer's coverage decisions for Named Insured's who meet all of the following criteria:

(1) The Named Insured has a terminal condition that, according to the current diagnosis of the Named Insured's physician, has a high probability of causing death within two years.

(2) The Named Insured requests a review not later than sixty days after receipt by the Named Insured of notice from the director of insurance that making a determination requires resolution of a medical issue.

(3) The Named Insured's physician certifies that the Named Insured has the condition described in (A)(1) of this section and any of the following situations are applicable:

a) Standard therapies have not been effective in improving the condition of the Named Insured.

b) Standard therapies are not medically appropriate for the Named Insured.

c) There is no standard therapy covered by the insurer that is more beneficial than therapy described in division (A)(4) of this section.

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

(5) The Named Insured has been denied coverage by the insurer for a drug, device, procedure, or other therapy recommended or requested pursuant to division (A)(4) of this section, and has exhausted the insurer's internal review process.

(6) The drug, device, procedure, or other therapy, for which coverage has been denied, would be a covered health care service except for the insurer's determination that the drug, device, procedure, or other therapy is experimental or investigational.

B. A review shall be requested in writing, except that if the Named Insured's physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request shall be submitted to the insurer not later than five days after the oral or written request is submitted.

C. The external, independent review process established by an insurer shall meet all of the following criteria:

(1) Except as provided, the process shall afford all Named Insureds the opportunity to have the insurer's decision to deny coverage of the recommended or requested therapy reviewed under the process.

(2) The review shall be conducted by an independent review organization assigned by the director of insurance. The independent review organization shall select a panel to conduct the review, which panel shall be composed of at least three physicians or other providers who, through clinical experience in the past three years, are experts in the treatment of the Named Insured's medical condition and knowledgeable about the recommended or requested therapy. In either of the following circumstances, an exception may be made to the requirement that the review be conducted by an expert panel composed of a minimum of three physicians or other providers:

a) A review may be conducted by an expert panel composed of only two physicians or other providers if a Named Insured has consented in writing to a review by the smaller panel.

b) A review may be conducted by a single expert physician or other provider if only the expert physician or other provider is available for the review.

(3) Neither the insurer nor the Named Insured shall choose, or control the choice of, the physician or other provider experts.

(4) The selected experts, any health care facility with which an expert is affiliated, and the independent review organization arranging for the experts' review shall not have any professional, familial, or financial affiliation with any of the following:

a) The insurer or any officer, director, or managerial employee of the insurer;

b) The Named Insured, the Named Insured's physician, or the practice group of the Named Insured's Physician;

c) The health care facility at which the recommended or requested therapy would be provided;

d) The development or manufacture of the principal drug, device, procedure, or other therapy involved in the recommended or requested therapy.

However, experts affiliated with academic medical centers who provide health care services to Named Insured's of the insurer may serve as experts on the review panel. Further, experts with staff privileges at a health care facility that provides health care services to Named Insured's of the insurer, as well as experts who have a contractual relationship with the insurer, but who were not involved with the insurer's denial of coverage for the therapy under review, may serve as experts on the review panel. These non-affiliation provisions do not preclude an insurer from paying for experts'review.

(5) Named Insured's shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by the insurer.

(6) The insurer shall provide to the independent review organization arranging for the experts' review a copy of those records in the insurer's possession that are relevant to the Named Insured's medical condition and the review. The records shall be disclosed solely to the expert reviewers and shall be used solely for the purpose of this section. At the request of the expert reviewers, the insurer or the physician requesting the therapy shall provide any additional information that the expert reviewers request to complete the review. An expert reviewer is not required to render an opinion if the reviewer has not received any requested information that the reviewer considers necessary to complete the review.

(7) In the case of an expedited review,

a) The independent review organization shall issue a written decision not later than seven days after the filing of the request for review. In all other cases, the independent review organization shall issue a written decision not later than thirty days after the filing of the request. The independent review organization shall send a copy of its decision to the insurer and the Named insured. If the Named Insured's provider or the health care facility rendering health care services to the Named Insured requested the review, the independent review organization shall also send a copy of its decision to the Named Insured's provider or the health care facility.

b) In conducting the review, the experts on the panel shall take into account all of the following:

i. Information submitted by the insurer, the Named Insured, and the Named Insured's physician, including the Named Insured's medical records and the standards, criteria, and clinical rationale used by the insurer to reach its coverage decision;
ii. Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations;
iii. Relevant findings in peer-reviewed medical or scientific literature and published opinions of nationally recognized medical experts;
iv. Clinical guidelines adopted by relevant national medical societies;
v. Safety, efficacy, appropriateness, and cost effectiveness.

(8) Each expert on the panel shall provide the independent review organization with a professional opinion as to whether there is sufficient evidence to demonstrate that the recommended or requested therapy is likely to be more beneficial to the Named Insured than standard therapies.

(9) Each expert's opinion shall be presented in written form and shall include the following information:

a) A description of the Named Insured's condition;

b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested therapy is more likely than not to be more beneficial to the Named Insured than standard therapies;

c) A description and analysis of any relevant findings published in peer-reviewed medical or scientific literature or the published opinions of medical experts or specialty societies;

d) A description of the Named Insured's suitability to receive the recommended or requested therapy according to a treatment protocol in a clinical trial, if applicable.

(10) The independent review organization shall provide the insurer with the opinions of the experts. The insurer shall make the experts' opinions available to the Named Insured and the Named Insured's physician, upon request.

(11) The opinion of the majority of the experts on the panel is binding on the insurer with respect to that Named Insured. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, the insurer's final decision shall be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, the insurer may, in its discretion, cover the therapy.

(12) The insurer shall have written policies describing the external, independent review process.

D. If an insurer's initial denial of coverage for a therapy is based upon an external, independent review of that therapy, this section shall not be a basis for requiring a second external, independent review of the recommended or requested therapy.

E. At any time during the external, independent review process, the insured may elect to cover the recommended or requested health care service and terminate the review. The insurer shall notify the Named Insured and all other parties involved by mail or, with consent or approval of the Named Insured, by electronic means.

F. The insurer shall annually file a certificate with the director of insurance certifying its compliance with the requirements of this section.

Insured Persons, his/her designated representative, or a Provider may contact WebTPA to request an external review for services denied as not medically necessary, not covered expenses under the policy, or as experimental or investigative in nature by mail or telephone at:

WebTPA
P.O. Box 2415
Grapevine, TX 76099-2415
(866) 975-9468

Also, Insured Persons, his/her designated representative, or a Provider may contact the Ohio Department of Insurance for services denied as not medically necessary, not covered expenses under the policy, or as experimental or investigative in nature by mail or telephone at:

Ohio Department of Insurance
Consumer Services Division
2100 Stella Court
Columbus, OH 43215-1067
(614) 644-2658 or toll free (800) 686-1526

RESOLUTION OF GRIEVANCES

Insured Persons, Providers or their representatives with questions or complaints may call the Customer Service Department at 888-293-9229. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

If not satisfied with the outcome, the Covered Persons, Providers or their representative may contact:

The Ohio Department of Insurance
Consumer Services Division
2100 Stella Court
Columbus, OH 43215-1067
614-644-2673
Toll Free in Ohio
800-686-1526