Summary Plan Description – January 1, 2024

City of Greensburg Employee Benefit Plan

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General Information

NAME OF PLAN: City of Greensburg Employee Benefit Plan
PLAN ID NUMBER: 35-6001049
PLAN NUMBER: 501
PLAN EFFECTIVE DATE: January 1, 2017
PLAN REVISION DATE: January 1, 2024

Participants Include: This Summary Plan Description is for all eligible full-time Employees of the City of Greensburg.

Name & address of Employer/Plan Sponsor/Plan Administrator:
City of Greensburg
314 W Washington St.
Greensburg, IN 47240
Phone: (812) 663-8582
Fax: (812) 663-6314

The Plan Administrator is responsible for compliance with the provisions of state and federal requirements relating to such position.

Agent for Service of Legal Process:
The Plan Administrator named above.

Plan Supervisor:
Dunn and Associates Benefit Administrators, Inc.
4550 Middle Road; Suite A
PO Box 2369
Columbus, IN 47202
Phone: (812) 378-9960
Fax: (812) 378-9967
Web: www.dunnbenefit.com (includes *Dunn Online*)
Dunn Online is a service that provides plan participants with the ability to view their own eligibility and claims data plus more.

Plan Year/Calendar Year: The financial records of the Plan are kept on a Plan Year basis beginning each January 1 and ending on each December 31. Deductible and coinsurance information is kept on a calendar year basis beginning each January 1.

Type of Administration: The Plan is administered by the Employer with the following coverages:

a. Basic Life, basic accidental death and dismemberment, and dependent life benefits are fully insured. The premiums for this coverage are paid by the Plan.
b. Medical benefits are self-insured by the Employer. Reinsurance policies have been obtained for aggregate coverage on behalf of the Employer. The reinsurance premiums are paid by the Trust.

Excess loss policies are on file in the office of the Plan Administrator and are open to inspection at any time during regular business hours.

Plan Benefits: Other Summary Plan Descriptions may have been prepared for additional benefits for Employees of the Employer. This Plan covers only those benefits shown below:

For Covered Employees:
Basic Life
Basic Accidental Death and Dismemberment Benefits
Voluntary Term Life

For Covered Dependents:
Dependent Life

For Covered Employees and Dependents:
Comprehensive Medical Benefits

This Plan is not the result of any collective bargaining agreement.

Funding: The Plan is funded by directed contributions from the Employee and this Employer. Any Employee contributions toward the cost of the coverages provided by this Plan will be deducted from his pay, and they are subject to change.

Trustees:
Mayor
City of Greensburg
314 W Washington St.
Greensburg, IN 47240

Personnel Administrator
City of Greensburg
314 W Washington St.
Greensburg, IN 47240

Clerk Treasurer
City of Greensburg
314 W Washington St.
Greensburg, IN 47240

Accounting Specialist
City of Greensburg
314 W Washington St.
Greensburg, IN 47240

Claims Procedures

When to File a Claim - Report claims promptly. *Claims should be filed with the Plan Supervisor within 30 days of the date charges were incurred* by you or through an authorized representative. Claims filed later than that day will not be covered unless:

a. it is not reasonably possible to report the claim in that time and
b. the claim is reported no later than March 31 of the year following the year the claim was incurred (this period will not apply when the person is not legally capable of reporting the claim).

Supporting Documentation - The Plan Supervisor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested. Verification of facts or assertions pertaining to any claim, including (but not limited to) accident related information, submission of x-ray and other appropriate diagnostic information may be necessary to make a benefit determination. Keep in mind:

Claim Form - If your healthcare provider will not file claim on your behalf, obtain a claim form from your Employer. All sections of the claim form should be completed each time a claim is submitted. If a section is not applicable, write "N/A." The claimant must sign the claim form authorizing it to be processed. If payment is to be made to the provider, the claimant must also sign this authorization. If any of this information is missing, it could take longer to process the claim.

In some cases, the attending doctor may provide the Employee with a fully itemized bill. If the Employee has this bill, simply attach it to the claim form without having the doctor complete Physician or Supplier Information. The bills and/or claim form should show:

a. name of patient
b. period of time covered by the charges
c. date and charge for the visit
d. complete and accurate diagnosis
e. current Procedural Terminology (CPT) if charge is for surgery or anesthesia
f. provider's federal I.D. number or Social Security Number
g. complete current address of provider including zip code

Canceled checks and balance due statements typically ***do not*** provide enough information for the Plan Supervisor to process a claim and could delay processing of the claim. Attach originals of itemized bills and keep copies for Employee records.

Prescription Drug Claim - When a Network Pharmacy is used, the cost of drugs will be filed with the Plan Supervisor by the pharmacy. If the Employee has other coverage/insurance and it is primary to this Plan or a pharmacy not in the Network is used, drug claims will need to be filed by the Employee. Claims filed by the Employee should show:

a. name of person for whom drug was prescribed
b. prescription number and name of drug
c. cost of the drug and date of purchase--cash register receipts, canceled checks or charge card receipts cannot be accepted for consideration
d. if the drug is a generic drug; the prescription receipt must be marked GENERIC by the pharmacist

Second Surgical Opinion Claims - Although a second opinion is not required, if a covered person is considering surgery and obtains a second opinion from another surgeon, please be sure that it is clearly stated on the bill that the charge was for a second surgical opinion.

Claims for Dependent Students - When a claim is submitted for a dependent enrolled in an accredited college or university, the Employee must submit proof of enrollment. This may include a paid tuition receipt or letter from the registrar. Proof of enrollment must be submitted upon request.

Primary Coverage/Insurance Involved - An Explanation of Benefits (EOB) must be submitted with all claims when the charges have or should be considered by another primary plan first. To determine if a claim should be considered by another primary plan prior to being submitted under this Plan, please see the "Coordination with Other Plans" section in this document.

Notification of Benefit Determination - The Plan Administrator, through the Plan Supervisor shall approve or deny (in whole or in part) each claim. Payment of a benefit is considered approval of a claim. If your claim is denied in whole or in part, you will receive a written notice of the denial. The notice will include:

a. the specific reason(s) for the adverse claim decision;
b. a reference to pertinent Plan provision, internal rules, guidelines, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
c. if the denial is based on medical necessity or experimental treatment, an explanation of the scientific of clinical judgment used in making the decision (or a statement that an explanation will be provided free of charge upon request);
d. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access, and copies of all other relevant documents;
e. a description of any additional information needed from the covered person and an explanation of why such information is necessary, when applicable;
f. an explanation of the Plan's claim review procedure and time limits; and
g. a statement informing the claimant about the right to bring a civil action under state and federal requirements.

You may appeal adverse claim decisions as explained in the "Claims Appeal and Review Procedure" section of this booklet either yourself or through an authorized representative.

Urgent Care Claims - If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable (which this Plan does – see "The Pre-utilization Program" section), and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received. If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 24 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service) - If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable (which this Plan does – see "The Pre-utilization Program" section), a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim. For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of claim. For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15- or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier). For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment - If you are receiving an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Claims Payment to an Estate or Minor - If any benefits of the Plan shall be payable to the estate of a covered person or to a minor or individual who is incompetent to give a valid release, the Plan may pay such benefits to any relative or other person either whom the Plan determines to have accepted competent responsibility for the care of such individual or otherwise required by law. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and Employer to the extent of such payment.

Preferred Provider Organization (PPO)

Preferred Provider Organizations (PPO's) are networks of health care professionals that are contracted to accept a negotiated reasonable and customary fee as the covered amount for specific services. These preferred providers will file claims directly with the Plan Supervisor and have agreed not to "balance bill" an eligible insured for the amount of the charge above the negotiated fee schedule. The Primary PPO for this Plan is **Encore Combined Health Network**.

All providers contracted with Encore Combined Health Network or directly with Dunn and Associates will be considered "In-Network" Providers. Covered expenses incurred by an "In-Network" provider (i.e. hospital or physician) will be covered at a higher rate than "Out-of-Network" Providers (providers **not** listed as a participating provider of the Encore Network). See the Schedule of Benefit within this Summary Plan Description booklet for additional information and exceptions to this payment process.

An updated list of Encore Combined Health Network providers can be obtained from the Human Resources Department of this Employer, the Plan Supervisor, or by visiting Encore's web site at **www.encorehealthnetwork.com**. Encore can also be reached by phone **at 888-446-5844**.

Referrals - Referrals to an Out-of-Network provider are covered as Out-of-Network services, supplies and treatment. It is the responsibility of the covered person to assure services to be rendered are performed by In-Network providers in order to receive the In-Network provider level of benefits.

Exceptions - The following listing of exceptions represents services, supplies or treatments rendered by an Out-of-Network provider where covered expenses shall be payable at the In-Network level of benefits:

a. While confined to an In-Network provider hospital, the In-Network provider physician requests a consultation from an Out-of-Network provider.

b. Covered person is outside of the state of Indiana for business or personal reasons when expenses were incurred. *Since it is not always possible to determine this situation by looking at a claim submitted by the provider, it is the covered person's responsibility to notify the Plan Supervisor.*

c. When a covered dependent resides outside the service area of the Preferred Provider Organization, for example a full-time student, covered expenses shall be payable at the In-Network provider level of benefits.

Additional Preferred Provider Organizations may be utilized in order to optimize coverage areas; When this occurs, the covered charges will be paid at the "In-Network" rate. It should not be assumed that covered expenses incurred by these providers will always be paid at the "In-Network" rate since providers could be free to become non-participating providers at any time.

Out-of-network claims will be reimbursed at the negotiated rate through direct contract if mutually agreed upon by the plan and the provider or reimbursed by a percentage of Medicare allowed rate. For confirmation of the allowed rates, contact the Plan Supervisor.

Note - that providers are free to become non-participating providers at any time; therefore, it is the covered person's responsibility to ensure providers are still in the Encore network prior to having services rendered.

Services received at Columbus Specialty Surgery Center, Tax ID# 45-4115316 located at 2425 North Park Dr. Suite 20 Columbus, Indiana will be considered non-covered benefits under this plan. Payment for all expenses billed by this facility will be the responsibility of the participant.

If a claim is processed utilizing a designated PPO fee schedule, Reasonable and Customary (R&C) limits will not be applied to the claim. The PPO Fee schedule will override the R&C fee schedule.

Pre-Utilization Program

Pre-Utilization in Indiana - Employees and dependents are under a pre-utilization review program coordinated by Clinix, a utilization review/case management company. Pre-utilization review includes utilization review, concurrent stay review, and discharge planning.

Services Requiring Pre-Utilization Review - Hospital Admissions – All inpatient hospital admissions over 18 hours require pre-utilized review. Maternity stays are excluded from this requirement unless the mother or baby remains in the Hospital for more than 48 hours following a normal delivery or for more than 96 hours following a cesarean section. Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. *However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).* In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- **Outpatient Surgical Procedures** – Any outpatient surgical procedure that takes place in an operating room or surgery center has a pre-utilization review prior to the procedure. In addition, the following outpatient procedures also require pre-utilization review:
  Outpatient Chemotherapy
  Outpatient Radiation Therapy
  Outpatient Dialysis
- **Cancer Care** – Cancer care includes but is not limited to chemotherapy, radiation, and surgical removal.
- **Dialysis** – Home and Facility Outpatient Dialysis.
- **Durable Medical Equipment (DME)** – Medical equipment which is not disposable (i.e., is used repeatedly and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth.
- **Home Health Care** – Items and services provided as needed in patients' homes by a home health agency (HHA) or by other arrangement made by a Home Health Agency.
- **Hospice Care** – Services provided by a health care facility or program providing medical care and support services, such as counseling, to terminally ill persons and their families.
- **Infusions** – Home and Facility Infusions.
- **MRI's** (outpatient only) – Outpatient Magnetic Resonance Imaging (MRI) procedures.
- **Outpatient Surgical Procedures** – Any outpatient procedures requiring the use of an operating room or surgery center.
- **Pregnancies** – Clinix should be notified when you become pregnant. Inpatient maternity stays of no more than 48 hours following a vaginal delivery or 96 hours following a cesarean section are excluded as mentioned above.
- **Scans (outpatient only)** – Outpatient Positron Emission Tomography (PET) scans and CT scans or computed tomography scans;
- **Skilled Nursing Care –** Around-the-clock nursing and rehabilitative care, that can only be provided by, or under the supervision of, skilled medical personnel.
- **Sleep Studies** – Contact Clinix prior to scheduling sleep study procedures.
- **Therapy** – Physical, Occupational and Speech Therapy (outpatient basis only).

How to obtain pre-utilization review - Call Clinix 1-800-227-2298 and provide the following information to the case manager:

a. name of the covered person being treated
b. social security number or other identifying number of the Employee
c. recommended procedure
d. proposed date of procedure

For planned (elective) inpatient admissions, call at least 7 days prior to admission, for emergency admissions, call within 48 hours following admission, and for obstetrical care, call during the 1st trimester. For all other services requiring pre-utilization review, call prior to scheduling the procedure/care or obtaining equipment. Confidential voice mail is available 24 hours per day. If voice mail is left, remember to leave information above. If the covered person believes this request is "urgent" (see "Urgent Claim" in Definitions section), he should indicate this to the case manager. A health care provider may call on behalf of the covered person, and the provider also may indicate urgency to the case manager. A covered person (or the parent or guardian of a covered person who is a minor or otherwise legally incapacitated) may designate an authorized representative for purposes of requesting pre-utilization review of

services or appealing a denial involving Care Management in writing. Except that in the case of a claim involving urgent care, a health care professional with knowledge of the condition may always act as an authorized representative.

Notification of Pre-utilization determination - If a request for pre-utilization review is "urgent", the case manager will advise whether the request is approved or denied within 72 hours. If a request for pre-utilization review is not "urgent", the case manager will advise whether the request is approved or denied within 15 days. The case manager will approve a requested procedure, service, or supply only if it finds it to be medically necessary and medically appropriate, based on the severity and complexity of the covered person's illness or injury, the covered person's age and general health, and medical necessity/appropriateness guideline. *However, a determination by the case manager that a requested procedure, service, or supply is medically necessary and/or medically appropriate does NOT mean that the procedure, service, or supply is a covered expense under this Plan.*

Continued Confinement - If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already certified, the Employee, the physician, or the hospital may get more days certified by calling Clinix. This must be done no later than on the last day that has already been certified. Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to the Employee and to the physician.

Concurrent Review - The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extended beyond the initial pre-utilization will require concurrent review.

Discharge Planning - Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during pre-utilization or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

Case Management - Clinix will review the medical care provided to covered persons and may recommend alternative, cost-efficient programs of treatment. Such programs will be implemented only with the consent of the covered person, his physician, and the Plan Supervisor and may, in appropriate cases, provide for payment of benefits that would not otherwise be covered by the Plan if payment of such benefits is expected to accelerate recovery or reduce overall expenses. If the identified individual refuses to cooperate with the Case Management services, future claims for illness or injury may not be covered under the Plan. If a claim is identified as a potential large claim expense by Case Management and Dunn & Associates, the individual identified is expected to cooperate with the Plan's Case Management efforts.

Disease Management - This Plan includes a disease management program. This is a program that targets Covered Persons identified as needing assistance with the management of their chronic illness. The identified Covered Persons are assigned to a Nurse Educator who will work with them in the areas of participation education, medication compliance, targeting risk factors, potential complication identification, specialist physician follow-up, disease triggers, and appropriate medical follow-up care. Disease management participants are also educated about modifying certain lifestyle factors in order to improve their overall health.

If there is a disagreement/appeal - The decision to hospitalize, perform a procedure or use a particular vendor at all times rest with the covered person and his physician. A covered person (or the authorized representative of the covered person) may appeal any whole or partial denial of pre-utilization review of services as described under the "Claims Appeal and Review Procedure" section of this booklet. Note that since pre-utilization review is performed by Clinix and not the Plan Supervisor, appeals related to adverse pre-utilization review decisions should be directed to Clinix and **not** Dunn and Associates.

Benefit Reduction - If the procedures for Pre-utilization Review of Hospital Admissions are not followed, covered charges will be subject to a $500 per admission penalty. This penalty will not count toward any deductible or co-insurance maximums.

Remember -

- ✓ *Call* Clinix *BEFORE receiving the care mentioned above.*
- ✓ *In emergencies, the Employee still needs to let* Clinix *know that a covered person has been admitted to the hospital within 48 hours of the admittance.*
- ✓ *An Employee should check his coverage under this Plan.* Clinix *reviews and approves the hospitalization. It does not approve Employee or dependent eligibility or that all charges are covered. An Employee must check his Plan for eligible procedures and charges.*
- ✓ *If the Employee does not follow procedures as required for hospital admissions, a $500 per admission penalty will apply to the covered charges.*

Eligibility

Eligibility for Employees - Employees - All full-time salaried and hourly employees will be eligible for coverage. Full-time is defined as employees who are scheduled to work at least 30 hours per week at the usual place of business or the location which you are required to travel.

Elected Officials - All elected officials employed by this Employer will be eligible for coverage, except the following: City Council Members, City Attorney, persons appointed to City Boards or Commissions are not eligible for coverage. Elected Officials are covered regardless of hours worked and are not required to report hours worked (IC 36-4-7-2).

Variable Hour employees not regularly scheduled to work more than 30 hours per week are not eligible for coverage under this plan.

No person may be covered both as an Employee and a dependent of this plan.

Waiting Period - Employees - All eligible employees will commence coverage on the first day of the month following the hire date for this Employer. All coverage will commence on these dates if the Employee has agreed to make any required contributions for coverage (but not until an enrollment card has been completed and signed).

If an employee is unable to work due to illness or injury and returns to work within 180 days of losing coverage, they may be reinstated with no waiting period.

Elected Officials - Elected Officials are covered on the first day of employment.

Effective Date for Coverage - All eligible employees shall become effective after the stated waiting period provided written application for such coverage is made on or within 30 days of such date. If application is made after the 30-day period (other than during a special enrollment period available to special enrollees), the Employee shall be considered a Late Enrollee and, coverage for the eligible employee shall not become effective until the end of the next Open-Enrollment period.

Eligibility for Dependents - An Employee may request coverage for his/her eligible dependents. The cost of the premium for this coverage is the Employee's responsibility. All dependents must meet the criteria listed in the Definitions section to be eligible for coverage. All eligible dependents will commence coverage on the day the Employee does if written application has been made within 30 days of the effective date. If the Employee makes a written request for coverage more than 30 days after the effective date for which he is eligible for dependent coverage, those persons who are his dependents shall be considered "Late Enrollees" and, coverage shall not become effective until the next Open-Enrollment period.

Compliance with Health Insurance Portability and Accountability Act of 1996 - In 1996 the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was passed by Congress. Pursuant to HIPAA, the Plan will at no time take into consideration any health status-related factors (including both physical and mental illnesses, prior receipt of health care, prior medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence, or disability) which exists in relation to a person who is eligible for coverage under the Plan for purposes of determining the initial or continued eligibility of that person for coverage under the Plan, for determining the level of contribution of the person to Plan funding, or to determine the level of benefits which will be made available to a person.

Special Enrollment Period (other coverage) **-** An Employee or Dependent who did not enroll for coverage under this Plan because he or she was covered under other group coverage or had health insurance coverage at the time he or she was initially eligible for coverage under this Plan, may request a special enrollment period if he or she is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

a. termination of the other coverage (including exhaustion of COBRA benefits)
b. cessation of employer contributions toward the other coverage
c. legal separation or divorce
d. termination of other employment or reduction in number of hours of other employment
e. death of Covered Person

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility. However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.) The Employee or Dependent must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage. The effective date of coverage as the result of a special enrollment shall be the first day following the loss of coverage if proper enrollment procedures are completed within thirty (30) days of the loss of coverage.

Special Enrollment Period (Dependent Acquisition) **-** All Employees currently covered or not, who acquire a new Dependent may request a special enrollment period. For the purpose of this provision, the acquisition of a new Dependent includes marriage, birth of a dependent child, or adoption or placement for adoption of a dependent child. The Employee must request the special enrollment within thirty (30) days of the acquisition of the Dependent.

The effective date of coverage as the result of a special enrollment shall be:

a. in the case of marriage, the date of marriage
b. in the case of a Dependent's birth, the date of such birth
c. in the case of adoption or placement for adoption, the date of such adoption or placement for adoption

Special Enrollment Period (CHIP) - Effective April 1, 2009, when an employee or eligible dependent is covered under a Medicaid plan or states children's health insurance program (CHIP) and loses eligibility under that plan; or becomes eligible under a CHIP or Medicaid plan for premium assistance that could be used toward the cost an employer health plan, may be able to enroll within 60 days of losing coverage.

Open Enrollment - An open enrollment period shall be held annually during the month of November and/or December. During this open enrollment period, Employees who have not previously elected coverage under the Plan and who do not qualify for a Special Enrollment Period as described herein, may enroll for coverage for themselves and/or any eligible Dependents. Coverage shall be effective on January 1 for Employees or Dependents who enroll during an open enrollment period. All Plan provisions, s shall apply to an Employee or Dependent who enrolls in the Plan during an open enrollment period.

Working Spouse Rule - If the spouse of the Employee is employed and eligible for coverage under their own employer (regardless of cost), that spouse will NOT be eligible for coverage through this plan. The Working Spouse Rule does not require a spouse to enroll in his/her employer's plan. However, if the spouse is eligible to enroll, there will be no coverage under this plan.

Exception: If the spouse of the employee is employed and eligible for coverage under their own employer (regardless of cost), that spouse may be covered as secondary under this plan if the employer plan of the spouse does NOT meet the ACA's minimum value requirements. The spouse must be enrolled in their employer's plan and that plan will pay as primary to this plan. This exception does not apply if the employer of the spouse offers multiple plan options and at least one of the options meets ACA minimum value requirements.

No person may be an employee and a dependent of this Plan.

It is the responsibility of the employee to notify the Human Resources Department if the spouse's eligibility changes anytime during the year. The employee has 30 days to notify the Human Resources Department. Failure to notify the Human Resources Department of other coverage available to a spouse may be considered insurance fraud and will result in immediate loss of coverage for the spouse. The employee will be responsible for all applicable premiums and any claims paid on the ineligible spouse. Furthermore, additional disciplinary action may be taken against the employee including possible termination of employment, subject to this employer's personnel policy.

Reinstatement - If an employee is unable to work due to illness or injury and returns to work within 180 days of losing coverage, they may be reinstated with no waiting period.

Schedule of Benefits

This Schedule of Benefits includes the benefits available; coverage amounts and maximum amounts that apply under the Plan. However, Plan payment is not based solely on the Schedule of Benefits. For a complete understanding of whether a particular charge will be paid and at what level, all provisions outlined in this document must be reviewed.

Life Benefits		
Basic Life Benefit		See life benefit certificate for benefit reduction schedule.
Class I-Elected/Appointed Officials	$25,000	
Class II-All Other Eligible Employees	$25,000	
Basic Accidental Death & Dismemberment Benefit		
Class I-Elected/Appointed Officials	$25,000	
Class II-All Other Eligible Employees	$25,000	
Dependent Life		
Spouse (under age 70)	the lesser of $5,000 or 50% of the Employees amount.	
Child (less than 6 months)	$1,000	
Child (more than 6 months to age 26)	the lesser of $2,500 or 50% of the Employee's amount.	
Voluntary Term Life		
Employee	Minimum $10,000 up to a maximum of $500,000 in increments of $1,000 not to exceed five times annual base salary.	Guarantee issue $150,000. Employee must elect coverage to cover dependents. See life benefit certificate for benefit reduction schedule.
Spouse (under age 70)	Minimum of $10,000 up to a maximum of $250,000 in increments of $500 not to exceed 100% of the employees elected amount.	Guarantee issue $25,000.
Child (less than 6 months)	$1,000	Guarantee issue $1,000.
Child (more than 6 months to age 26)	Minimum of $2,500 up to a maximum of $10,000.	Guarantee issue $10,000.

COMPREHENSIVE MEDICAL BENEFITS

Medical Benefits				
Benefit Description	**DCMH**	**In-Network**	**Out-of-Network**	**Plan Limitations**
Annual Maximum	Unlimited	Unlimited	Unlimited	Per Individual
Pre-Utilization	See pre-utilization section	See pre-utilization section	See pre-utilization section	A reduction in benefits may apply if pre-utilization requirements are not met.
Deductible	EE/$0 FAM/$0	EE/$750 FAM/$1,750	EE/$1,500 FAM/$3,500	In & Out-of-network deductibles do not apply toward each other. Deductible applies to all covered expenses unless otherwise stated under Special Conditions
Covered Expenses	80% no deductible	80% after deductible	60% after deductible	Unless otherwise stated under Special Conditions or elsewhere in this document.

Medical Benefits				
Benefit Description	**DCMH**	**In-Network**	**Out-of-Network**	**Plan Limitations**
Coinsurance Limit Medical Rx	EE/$1,250 FAM/$1,750 EE/$500 FAM/$1,000		EE/$2,500 FAM/$4,000 EE/$500 FAM/$1,000	In-network limits include DCMH charges. In- and out-of-network coinsurance limits do not apply toward each other and are per calendar year. After the coinsurance limit has been met, covered expenses are payable at 100% of reasonable and customary for the remainder of that calendar year.
Maximum Out of Pocket	EE/$2,500 FAM/$4,500		EE/$4,500 FAM/$8,500	In-network limits include DCMH charges. In- and out-of-network limits do not apply toward each other and are per calendar year. *Deductible + Copays + Coinsurance + Rx Copays.*
Special Conditions				
AccuDoc Facilities		100% no deductible visits and labs. 80% after deductible all other services.	n/a	Additional services are available at AccuDoc Facility locations only - $20 xray copay
Allergy Injection	$5 copay	$5 copay	60% after deductible	
Ambulance	80% no deductible	80% after deductible	60% after deductible	
Cardiovascular Care	80% no deductible	80% after deductible	60% after deductible	Call Dunn & Associates for information on designated facilities in your area.
DCMH Well Clinic Physician/Lab services	100% no deductible	n/a	n/a	Services provided by Decatur County Memorial Hospital Well Clinic only.
Dialysis (outpatient)	80% no deductible	80% after deductible	60% after deductible	Limited to 200% of Medicare fee schedule. Limited to 50 treatments per episode of care. Treatment will be considered a separate episode of care if more than 180 days have lapsed since the last treatment.
Emergency Room Facility Physician	$150 copay then 80% no deductible 80% no deductible	$250 copay then 80% no deductible 80% after deductible	$250 copay then 80% no deductible 80% after deductible	
Extended Care/Skilled Nursing	80% no deductible	80% after deductible	60% after deductible	Limited to an annual individual maximum of 30 days per convalescent period.
Home Health Care	80% no deductible	80% after deductible	60% after deductible	Limited to an annual individual maximum of 100 visits within any calendar year, maximum of 4 hours per visit.
Hospice Care	80% no deductible	80% after deductible	60% after deductible	
Hospital Room/Board	80% no deductible	80% after deductible	60% after deductible	Limited to semi-private room rate.
Intensive Care	80% no deductible	80% after deductible	60% after deductible	Limited to 4x semi-private room rate.

Medical Benefits				
Benefit Description	**DCMH**	**In-Network**	**Out-of-Network**	**Plan Limitations**
Laboratory Expenses	100% no deductible	Designated facilities 100% no deductible All other facilities 80% after deductible	60% after deductible	Designated draw sites include all Quest/LabOne sites, AccuDoc Urgent Care sites, MidAmerica Labs and CRH Labs.
Medical Aids	80% no deductible	80% after deductible	60% after deductible	
Mental Health & Substance Abuse Care Outpatient Inpatient	 $20 copay then 100% no deductible 80% no deductible	 $25 copay then 100% no deductible 80% after deductible	 60% after deductible 60% after deductible	
Organ Transplant	See fully insured policy.			Pre-utilization requirements must be followed and met or penalties may apply.
Outpatient Surgery	80% no deductible	80% after deductible	60% after deductible	
Physician Office Visit	$20 copay then 100% no deductible.	$25 copay then 100% no deductible	60% after deductible	
Physiotherapy	80% no deductible	80% after deductible	60% after deductible	Limited to an annual individual maximum of: ABA Therapy: 20 visits/yr Physical Therapy: 20 visits/yr Occupational Therapy: 20 visits/yr Manipulative Therapy: 20 visits/yr Speech Therapy: 20 visits/yr Cardiac Rehab: 36 sessions/yr Pulmonary Rehab: 20 visits/yr
Pre-Admission Testing	80% no deductible	80% after deductible	60% after deductible	
Preventative Health Care	100% no deductible	100% no deductible	100% no deductible	
Preventative health care services include: ✓ Evidence-based items or services that have a rating of "A" or "B" and are currently recommended by the U.S. Preventive Services Task Force ✓ Immunizations that are currently recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (CDCP) ✓ Evidence-informed preventive care and screenings (as provided for in the comprehensive guidelines supported by the Health Resources and Services ✓ Administration (HRSA) for infants, children and adolescents ✓ Additional preventative care and screenings (as provided for in the comprehensive guidelines supported by the HRSA) for women ✓ Pediatric oral and vision exams will be covered under the preventative benefit in accordance to the recommendation in the PPACA.				
Specialist	$20 copay then 100% no deductible DCMH owned physician.	$25 copay then 100% no deductible	60% after deductible	
Telemedicine	n/a	100% no deductible	100% no deductible	There is no cost to the patient for Telemedicine services received by SwiftMD.
Temporomandibular Joint Disorder	80% no deductible	80% after deductible	60% after deductible	
Urgent Care	n/a	80% after deductible	60% after deductible	
Voluntary Second Surgical Opinion	100% no deductible	100% no deductible	100% no deductible	
X-Rays Outpatient	 $20 copay	 $25 copay	 60% after deductible	

Prescription Drug Benefit		
Benefit Description		**Plan Limitations**
Prescription Drug (30-day supply)	Generic - $4 copay Preferred - $35 copay Non-Preferred - $75 copay	* If an insured elects not to purchase a generic drug when available and approved by the physician, the employee will be responsible for the brand copay plus the difference in the cost of the generic and the brand name drug purchased. Discounts are available through participating pharmacies in the preferred network. Only the copay will need to be paid by the covered person up front.
Prescription Drug (90-day supply)	Generic - $10 copay Preferred - $70 copay Non-Preferred - $150 copay	
Specialty Rx (30-day supply)	Specialty drugs are not covered under this Plan. Please contact the Pharmacy Benefit Manager for guidance and additional information.	

Definitions

ABA Therapy - Per Indiana regulation, applied behavioral analysis therapy services, or ABA therapy services, means the design, implementation and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. The diagnosis should be made by a qualified provider such as a Licensed Physician; Licensed Health Service Provider in Psychology (HSPP); Other Behavioral Health Specialist with training and experience in the diagnosis and treatment of ASD and acting within the scope of licensure and expertise.

Accident - "Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

Accidental Injury – An injury is a condition caused by accidental means which results in damage to the covered person's body from an external force. Shall mean an injury sustained as the result of an accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

Active Work, Actively Working, Actively at Work – A requirement that an Employee be actively at work on a full–time basis at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

ADA - shall mean the American Dental Association.

Affordable Care Act (ACA) - The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

AHA - shall mean the American Hospital Association.

Adverse Benefit Determination – Denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit. It includes a decision to deny benefits based on(a) the individual being ineligible to participate in the Plan, (b) utilization review and (c) a treatment being characterized as experimental or investigational or not medically necessary or appropriate. It also includes a concurrent care decision (other than a reduction in coverage due to Plan amendment or termination).

Alternative Treatment – Medical treatment or care that is provided in lieu of the benefits specified in this Plan, because it may be provided in a less comprehensive setting or because it is less expensive. Alternate Treatment must be (a) recommended by the Case Manager for a covered person; (b) Medically Necessary; and (c) approved by the Plan Administrator. If the Plan Administrator determines that medical treatment or care is Alternate Treatment for a covered person in one instance, it shall not be obligated to determine that the same medical treatment or care is Alternate Treatment for other covered persons under this Plan in any other instance.

Ambulatory Surgical Facility – A facility licensed by the state in which it operates for outpatient surgical procedures. If the state does not issue such licenses, it means a facility with an organized staff of physicians which:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
b. provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;
c. does not provide inpatient accommodations;
d. is not, other than incidentally, a facility used as an office or clinic for private practice of an individual provider; **and**
e. has appropriate government planning approval, if required by its state laws

Ambulatory Surgical Center shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

Approved Clinical Trial - means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services (CMS), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required). The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").
A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate. "Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device, or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out of network benefits are otherwise provided under the Plan.

Assignment of Benefits - shall mean an arrangement whereby the Participant, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less Deductibles, co-payments, and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Participant and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and Deductibles, co-payments and the coinsurance percentage that is the responsibility of the Participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Participant as the sole beneficiary.

Authorized Representative – An "authorized representative" means a person authorized, in writing by the covered person, to act on the covered person's behalf. The parent or guardian of a covered person who is a minor or otherwise legally incapacitated may appoint an authorized representative for the covered person. The Plan will also recognize a court order giving a person authority to submit claims on covered person's behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of condition may always act as an authorized representative.

Balance Billing - In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over non-Network Providers that engage in balance billing practices. In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider. The Participant is responsible for any applicable payment of co-insurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Birthing Center - A legally licensed, public, or private establishment for the performance of prenatal care, delivery, and post-partum care, with an organized medical staff. Charges for its services must be made. The Birthing Center must be under the direction of a Physician specializing in obstetrics and gynecology. A Physician or Nurse-Midwife must be present at all births and during the immediate post-partum period. Nursing services, under the direction of a registered graduate, professional nurse (R.N.) or Nurse-Midwife, must be provided in the recovery room. Medical records for each patient must be kept.

Brand Non-Preferred – Brand Non-Preferred drugs are those drugs <u>not</u> on the Preferred Drug Listing. The Preferred Drug Listing is compiled by a committee of clinical pharmacists and practicing physicians for their safety, quality, and effectiveness.

Brand Preferred – Brand Preferred drugs are those drugs on the Preferred Drug Listing. The Preferred Drug Listing is compiled by a committee of clinical pharmacists and practicing physicians for their safety, quality, and effectiveness.

Cardiac Care Unit - shall mean a separate, clearly designated service area which is maintained within a Hospital, and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.
2. It provides within such an area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such an area.
4. It contains at least two beds for the accommodation of critically ill patients.
5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

Case Manager – An entity that reviews the cost effectiveness or prescribed courses of treatment for the covered person and evaluates and recommends more cost-effective alternative courses of treatment, under the terms of an agreement with the Employer.

CDC - shall mean Centers for Disease Control and Prevention.

Centers of Excellence - shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used. Any Participant in need of an organ transplant may contact the Third-Party Administrator to initiate the Pre-Certification process resulting in a referral to a Center of Excellence. The Third-Party Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admissions taking place at a Center of Excellence. If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence. Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

Certified Nurse Midwife – A registered nurse who meets the following requirements:

a. has graduated from an accredited School of Nursing Midwifery;
b. is licensed by the State Board of Nursing and the American College of Nurse-Midwives; and
c. provides care in accordance with all state requirements.

Child and/or Child(ren) - shall mean the Employee's natural Child, any stepchild, legally adopted Child, or any other Child for whom the Employee has been named legal guardian, or any other Child for whom the Employee has been named legal guardian, or an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

CHIP - refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA - refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Chiropractic or Chiropractic Services – Chiropractic or Chiropractic Services means the diagnosis and analysis of any interference with normal nerve transmission and expression, the procedure preparatory to and complementary to the correction thereof by an adjustment of the articulations of the vertebral column, its immediate articulation, and includes other incidental means of adjustments of the spinal column and the practice of drugless therapeutics. However, chiropractic does not include any of the following:

a. prescription or administration of legend drugs or other controlled substances;
b. performing of incisive surgery or internal or external cauterization;
c. penetration of the skin with a needle or other instrument for any purpose except for the purpose of blood analysis;
d. use of colonic irrigations, plasmatic, ionizing radionoics;
e. conducting invasive diagnostic tests or analysis of body fluids except for urinalysis;
f. the taking of x-rays of any organ other than the vertebral column and extremities; and
g. the treatment or attempt to treat infectious diseases, endocrine disorders, or atypical or abnormal histology.

Claims Audit - In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit. The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records. Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document. Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

Close Relative – The spouse, parent, brother, sister, or child of you or your spouse. For the purpose of this Plan, close relative will also mean any health care provider residing in the same household with the covered person or anyone related by blood, marriage, or legal adoption to the covered person or the spouse of the covered person.

Coinsurance – Coinsurance describes how the cost of health expenses is shared between the Employer and the Employee.

Community Mental Health Center – This is a facility which:

a. offers a program of services approved by the state Department of Mental Health;
b. is organized for the purposes of providing multiple services of persons with mental illness, including substance abuse; **and**
c. is licensed by the state in which it operates

Concurrent Care – An ongoing course of treatment to be provided over a period of time or for a specified number of treatments.

Concurrent Care Decision – Occurs when the Plan previously approved an ongoing course of treatment provided over a period of time, or the Plan approved a specific number of treatments, and the Plan subsequently reduces or terminates coverage for the treatments.

Concurrent Stay Review – A review by the utilization review/case management company which occurs during the covered person's hospital confinement to determine if continued inpatient care is a covered service.

Confinement – A period of time when an individual becomes confined in a hospital or Convalescent Nursing Facility due to an Illness or Injury.

Convalescent Facility – An institution or a distinct part of an institution meeting all of the following tests:

a. it is licensed to provide and is engaged in providing, on an inpatient basis, for persons convalescing from injury or disease, professional nursing services rendered by a registered graduate nurse or by a licensed practical nurse under the direction of a registered graduate nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
b. its services are provided for compensation from its patients and which patients are under the full-time supervision of a physician or registered graduate nurse;
c. it provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered graduate nurse;
d. it maintains a complete medical record on each patient;
e. it has an effective utilization review plan; and
f. it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the mentally handicapped, custodial, or educational care or care of mental disorders.

Coordination of Benefits (COB) – Coordination of Benefits, also called COB, describes how expenses covered by two separate health programs are shared. When an individual is covered for health benefits under two separate plans, coordination of benefits rules defines the order in which the plans will make payment. More information, including the order of benefit payments for dependents, is provided under the section called "Coordination with Other Plans."

Copayment/Copay – A cost sharing arrangement whereby a covered person pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery – Surgery is cosmetic if it is intended to change:

a. the texture or appearance of the texture, shape, or structure of any part of the human body considered normal, allowing for age and ethnic origin; or
b. the relative size or position of any part of the body; when such surgery is not needed to correct or improve a bodily function.

Cosmetic surgery includes surgery performed to treat a mental or nervous disorder through a change in appearance.

Covered – When describing "employee" or "dependent," this means entitled to receive benefit payments under the terms of the Plan. When describing "charges," "expenses," "illness," or "injury" it means occurring after the effective date of coverage and not excluded from coverage.

Covered Expense – Covered expenses are those which are eligible for payment under the plan, if all plan requirements are met.

Covered Person – Any person meeting the eligibility requirements for coverage as specified in this document and properly enrolled in the Plan.

Creditable Coverage – Creditable Coverage includes coverage of an individual under a group health plan (including COBRA), individual health insurance coverages, Medicare, Medicaid, military sponsored health care, a program of the Indiana Health Service, a state health benefits risk pool, the Federal Employees Health Benefit Program, a public health plan as defined in regulations and any health benefit plan of the Peace Corps Act. Creditable Coverage also includes short term, limited coverage.

Custodial Care – Care is custodial if it is comprised of services and supplies, including room and board and other institutional services, which are provided to an individual whether disabled or not, primarily to assist this patient in the activities of daily living.
Such services and supplies are custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended, or performed. Such care includes, but is not limited to, helping a patient walk, get into or out of a bed and take normally self-administered medicine. The Plan Supervisor will determine, based on reasonable medical evidence, whether care is custodial.

Deductible – A specified dollar amount of covered expenses that must be incurred during a year before any other covered expenses can be considered for payment at the percentages stated in the Schedule of Benefits and this Plan.

Basic Embedded Deductible Explanation
A health plan with an embedded deductible actually has two deductible amounts. In a family plan, for example, the embedded deductibles may start meeting expenses for an individual after the individual has met the individual deductible, and for the entire family after the family deductible has been met. The individual does not have to wait for the family to reach the family deductible before he sees the plan paying for their portion of the claims.

Dependents – Shall be any of the following:
a. an employee's spouse (who is not divorced or legally separated) living in the same household. Evidence of marriage in the form of official documents or notarized statements may be required before coverage can commence;
b. An employee's children up to 26 years of age; regardless of whether they are eligible for other health coverage (employer-sponsored or otherwise);
c. a child who is the subject of a Qualified Medical Child Support Order (QMCSO).

The term "children" will include:
a. an Employee's own natural children;
b. an Employee's legally adopted child (or one for whom legal adoption proceedings have been initiated)
c. all stepchildren (parent is currently married to the Employee)

Michelle's Law - If a dependent child withdraws from school due to accident or illness as certified by the attending physician of the dependent child involved, coverage may be extended through the date that is one year after the first day of the medically necessary leave of absence or the date which coverage would otherwise terminate under the terms of this plan. Documentation from the institution must be provided. Graduating students will be covered through the end of the month in which they graduate.

Mentally or Physically Handicapped Dependents - The term "dependent" shall also mean an unmarried child, who, if on such child's termination date, is incapable of self-sustaining employment by reason of mental or physical handicap and such child is chiefly dependent upon the Employee for support and maintenance. Proof of incapability must be submitted to the Plan Supervisor within

120 days of the child's 19th birthday. The child must have been incapacitated prior to age 19 and covered as a dependent under this Plan. The Plan Supervisor also has the right to require, at reasonable intervals, proof that an Employee's child has been fully handicapped continuously since the last proof was submitted. After a child's coverage has been continued under this section for two years, the Plan Supervisor will not require this proof more often than once a year. If an Employee fails to submit any required proof, or refuses to permit a medical examination of the child as requested, he/she will be considered no longer fully handicapped. No person may be covered as a dependent of more than one Employee of this Employer. No person who is a full-time member of the Armed Forces may be considered a Dependent, except as otherwise required under USERRA.

Diagnostic Services – The following procedures ordered by a qualified physician because of specific symptoms, in order to determine a definite condition or illness:

a. radiology, ultrasound, and nuclear medicine
b. laboratory and pathology
c. EKG, EEG, and other electronic diagnostic medical procedures
d. psychological testing
e. neuropsychological testing
f. testing for attention deficit disorder & ADHD (up to the point of diagnosis)

Donor – A donor is the person who provides the organ for the recipient in connection with organ transplant surgery. A donor may or may not be an Employee or Dependent covered under the provisions of this Plan. Charges for donor expenses may or may not be covered by the Plan depending on the benefits set out in the Plan.

Drug Screening – a qualitative drug screening followed by confirmation with a second method, when necessary, may detect the presence of certain drugs and classes of drugs. Commonly screened for include amphetamines, cocaine, opiates, barbiturates, benzodiazepines, cannabinoids, and ethanol. Drugs may also be detected using an assay specific to a single class of drugs. A routine drug screening is a test repeatedly performed for a participant one or more times weekly over a period of time.

Durable Medical Equipment – Equipment that is customarily used to serve a medical purpose, appropriate for use in the home, is able to withstand repeated use and is not generally useful to a person in the absence of injury or illness.

Emergency – A sudden and unexpected life-threatening illness/injury of sufficient severity that in the absence of immediate medical attention could reasonably be expected to result in death or total and permanent disability or cause serious damage to a bodily function of the patient, as determined by the Plan Administrator or its designee.

Emergency Care – Emergency care is the first treatment given in a hospital's emergency room or emergency care facility after the sudden and unexpected onset of symptoms or an accident-causing injuries which are severe enough to require immediate hospital level care. Hospital level care will be deemed to be required only if care could not safely and adequately have been provided other than in a hospital or adequate care was not available elsewhere in the area at the time and place it was needed.

Employee – An Employee is a person employed by this Employer and assigned to, and regularly working for, the required number of hours, and who is included in a class or group of employees to which the Plan has been and continues to be extended. For the purposes of brevity and clarity in this document, any references to the Employee will be in the male pronoun, his, which will in no way exclude any female Employee.

Employer – The Company and any entity that is affiliated with the Company within the meaning of Section 414(b) or (m) of the Internal Revenue Code of 1986, that adopts this Plan for the benefit of its Employees, whose participation in the Plan is approved by the President (or any other duly authorized officer) of the Company. An employer may withdraw from the Plan by delivering to the applicable Plan Supervisor written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

Experimental or Investigational - Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments, or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    a) maximum tolerated dose;
    b) toxicity;
    c) safety;
    d) efficacy; and
    e) efficacy as compared with the standard means of treatment or diagnosis; or
3. if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a) maximum tolerated dose;
    b) toxicity;
    c) safety;
    d) efficacy; and
    e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the FDA but is used as a non-approved treatment (off label use) shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug; provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
4. A clinical study or review article in a reviewed professional journal.

Routine patient care costs for clinical trials include:

1. Covered health services for which benefits are typically provided absent a clinical trial;
2. Covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Covered health services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for clinical trials do not include:

1. The experimental or investigational service or item;
2. Items and services provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient; and
3. Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

Explanation of Benefits (EOB) - "Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

Extended Care/Skilled Nursing facility – An extended care/skilled nursing facility is a legally operated institution which:

a. for a fee provides convalescents with room, board and 24-hour care by one or more professional nurses and other nursing personnel needed to provide adequate medical care;
b. is under full-time supervision of a doctor or registered graduate nurse (RN);

c. keeps complete medical records on each patient;
d. if not operated by a doctor, has the services of one available under an established agreement;
e. is not an institution, or part of one, used mainly as a rest facility, a facility for the aged, drug addicts, alcoholics, the mentally handicapped, or custodial or educational care or care of mental disorders; and
f. has an effective utilization review plan.

Family Member – A family member is an Employee or a Dependent of the Employee. A "covered family member" is a family member with respect to whom coverage under this Plan is in force.

Generic Drug – A Prescription Drug, which has the equivalency of the brand name drug, with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information – Information about genes, gene products, and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Genetic testing for susceptibility to malignant diseases is considered medically necessary when the following criteria are met:
1. The genetic disorder is associated with a potentially significant cancer; and
2. The risk of the significant cancer from the genetic disorder cannot be identified through biochemical or other testing, and
3. A specific mutation, or set of mutations, has been established in the scientific literature to be reliably associated with the risk of developing malignancy; and
4. The results of the genetic test may impact the medical management of the individual; and
5. The use of the genetic test in directing therapy decisions will likely result in an improvement in net health outcomes; and
6. Genetic counseling, which encompasses all of the following components, has been performed:
    a. Interpretation of family and medical histories to assess the probability of disease occurrence or recurrence; and
    b. Education about inheritance, genetic testing, disease management, prevention, and resources; and
    c. Counseling to promote informed choices and adaptation to the risk or presence of a genetic condition; and
    d. Counseling for the psychological aspects of genetic testing

Investigational and Not Medically Necessary: Genetic testing for cancer susceptibility is considered investigational and not medically necessary in individuals not meeting any of the criteria above. Genetic testing for cancer susceptibility using panels of genes (with or without next generation sequencing), including, but not limited to CancerNext™, is considered investigational and not medically necessary unless all components of the panel have been determined to be medically necessary based on the criteria above. However, individual components of a panel may be considered medically necessary when criteria above are met.

Home Health Care Agency – An agency that fulfills the following requirements: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located if licensing is required.

Home Health Care Plan – A Home Health Care Plan must meet the following requirements: it must be a formal written plan made by the patient's attending physician which is reviewed at least every 30 days; it must state the diagnosis; certify that the home health care is in place of Hospital confinement; and it must specify the type and extent of home health care required for the treatment of the patient.

Hospice – A health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for covered persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician or one Registered Nurse, and it must maintain standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospice Care Program – A formal program directed by a Physician to help care for a Terminally Ill person that meets the standards set by the National Hospice Organization and has been approved by the Plan Supervisor. If the Hospice Care Program is required by a state to be licensed, certified, or registered, the program must also meet such requirements to be considered an eligible Hospice Care Program.

Hospital – An institution is a hospital if it meets fully every one of the following tests:

a. it maintains on the premises an inpatient basis diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and
b. it continually provides on the premises 24 hour a day registered graduate nurse services; and
c. it is recognized as a hospital by the Joint Commission on Accreditation of Hospitals or Medicare; and
d. it makes charges for its services.

For the services covered under this Plan and for no other purpose, inpatient services for treatment of mental illness or substance abuse that are provided by a community mental health center or by a psychiatric hospital licensed by the state Board of Health or the Department of Mental Health will be considered services rendered in a hospital as defined above. The term "hospital" will not include, nor will the term "covered charges" include charges incurred in connection with confinement to any institution or part thereof used principally as a rest or nursing facility or a facility for the care of mental disorders, the aged, chronically ill, convalescents, drug addicts or alcoholics, or as a facility providing primarily custodial, educational, or rehabilitative care.

Illness – An illness is a sickness, bodily disorder, or disease and mental or functional nervous disorder. For the purposes of the Plan, the following conditions are also considered as illnesses:

a. sterilization including vasectomy and tubal ligation
b. alcoholism and drug addiction (substance abuse); and
c. the condition of being pregnant and all conditions and/or complications resulting from the pregnancy
    1. pregnancy is covered the same as any other illness for female employees and covered dependents.
    2. elective abortions - coverage is limited to abortions performed upon recommendation of a physician due to medical complications or woman becomes pregnant through an act of rape or incest.

Some illnesses may be subject to limited coverage or maximums as shown in the Schedule of Benefits.

Incurred or Incurred Date – With respect to a covered expense, the date the services, supplies or treatment are provided.

Incurred Expense – An expense will be considered to be incurred at the time the service or supply is actually provided.

Injury – A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include illness or infection of a cut or wound, or self-inflicted injury.

Inpatient – The term “Inpatient” refers to the classification of a covered person when the person is admitted to a Hospital, Hospice, or Convalescent Nursing Facility for treatment, and charges are made for Room and Board to the covered person as a result of such admission.

Intensive Care Unit – A section, ward, or wing within the Hospital which is separated from the other facilities and:

a. is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
b. has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
c. provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

Incurred Expense – An expense will be considered to be incurred at the time the service or supply is actually provided.

Late Enrollee – An individual who is enrolled for coverage after the initial eligibility date. Note, however, a special enrollee will not be considered a late enrollee.

Layoff – A period of time during which the employee, at the employer’s request, does not work for the employer, but which is of a stated or limited duration and after which time the employee is expected to return to full-time, active work. Layoffs will otherwise be in accordance with the employer’s standard personnel practices and policies.

Licensed Practical Nurse – An individual who has received specialized nursing training and practical nursing experience and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Lifetime – Wherever the word "Lifetime" appears in this plan document in reference to benefit maximums and limitations, it is understood to mean "while covered under this Plan". A new Plan Supervisor for this Plan does not constitute a new Plan. Under no circumstances does "Lifetime" mean "during the lifetime of the covered person".

Manipulation Therapy - Osteopathic/Chiropractic manipulation therapy used for treating problems associated with bones, joints and the back. Manipulation services rendered in the home as part of home care services are not covered.

Medically Necessary – Care and treatment is "medically necessary" only if the Plan Supervisor determines that it meets **all** of the following conditions:

a. The care and treatment are appropriate given the symptoms, and is consistent with the diagnosis, if any. "Appropriate" means that the type, level and length of services, and setting are needed to provide safe and adequate care and treatment;
b. it is rendered in accordance with generally accepted medical practice and professionally recognized standards;
c. it is not treatment that is generally regarded as experimental, investigational, or unproven;
d. it is specifically allowed by the licensing statutes which apply to the provider who renders the service;
e. it is ordered by a doctor and documented in a timely fashion in the covered person's medical record;
f. it is necessary in combination with other care or treatment and is likely to provide a doctor with additional information when used repeatedly; and
g. it is not performed while the covered person is hospital confined when it could have been adequately performed in an outpatient facility.

Medicare – This is Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

Mental Health Parity – Pursuant to the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Mental or Nervous Disorder – Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional illness or disorder of any kind. This would also include clinical dependency on drugs or alcohol. Conditions for which state or local law requires treatment in a public or private facility (court-ordered confinements) are not covered. It does not include learning disabilities, behavioral or conduct disorder conditions.

Minor or Emergency Medical Clinic – A free-standing facility, regardless of its name, including an ambulatory surgical center, that is engaged primarily in providing minor emergency and episodic medical care. A Physician, a Registered Nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system.

Newborn – An infant from the date of birth until the initial Hospital discharge or until the infant is fourteen (14) days old, whichever occurs first.

Non-Occupational Illness or Injury – An illness is non-occupational if it does not arise out of (or in the course of) any work for pay or profit, nor in any way results from such occupation. An illness will be deemed to be "non-occupational" regardless of cause if proof is furnished that the person:

a. is covered under any type of workers' compensation law; and
b. is not covered for that illness under such law.

An injury is considered non-occupational only if it is an accidental bodily injury and does not arise out of (or in the course of) any work for pay or profit nor, in any way results from an injury which does.

Non-Participating Provider – Provider who does not hold a participating provider agreement with the preferred provider organization contracted by this Employer. Also referred to as "Out-of-Network" providers.

No Surprise Act – Protection from Surprise Medical Bills *(https://www.in.gov/healthcarereform/no-surprises-act)*
What is balance billing? Balance billing occurs when a health care provider bills a patient after the patient's health insurance company has paid its portion. The balance bill is for the difference between the amount the provider charges and the price the insurance company sets, after the patient pays any co-pay, co-insurance, or deductible. Balance billing can occur when a consumer

receives health care services from an out-of-network provider or an out-of-network facility. In-network providers agree with an insurance company to accept the insurance payment in full. In-network providers agree not to balance bill. Out-of-network providers do not have this agreement with the insurance company. Therefore, in the past they sometimes billed the patient for the amount not covered by insurance. Some health plans, such as Preferred Provider Organization (PPO) or Point of Service (POS) plans, offer some coverage for out-of-network care, but the provider can still balance bill the patient. Other plans offer no coverage for out-of-network providers and leave the financial responsibility entirely on the consumer. Balance billing is prohibited in both Medicare and Medicaid.

What is surprise billing? Surprise billing occurs when a patient receives a balance bill after unknowingly receiving care from an out-of-network provider or an out-of-network facility, such as a hospital. This can occur in emergency and non-emergency situations. Some states have enacted protections for consumers against surprise billing. However, state laws do not apply to self-insured health plans, which account for the majority of people who get coverage through an employer. Now, federal law adds additional protections. What protections are in place?
A new federal law, the No Surprises Act, protects you from:

- emergency out-of-network medical bills including air ambulances, and
- non-emergency services at an in-network facility.

The federal law applies to plans starting in 2022 and will be enforced by the federal government in Indiana. It applies to self-insured health plans offered by employers as well as health insurance companies.

A facility (such as a hospital or freestanding emergency room (ER)) or a provider (such as a doctor) may not bill you more than your in-network cost sharing amount for emergency services. This is true even if the emergency services you received were at an out-of-network facility or performed by an out-of-network provider.

- Under your health plan, you are still responsible for cost sharing amounts that may include copays, coinsurance, and deductibles.
- You are also protected when you receive non-emergency services from out-of-network providers at in-network facilities. An out-of-network provider may not bill you more than your in-network co-pay, co-insurance, or deductible for services performed at an in-network facility.
- You can still consent in advance to receive care from an out-of-network provider in some situations and agree to pay the provider amounts above your in-network co-pay, co-insurance, or deductible.

What else should I know? You must receive notice of your rights under the new law from your health plan and from the facilities and providers that serve you. If you think the protections have not been applied correctly, you can file an appeal with your insurance company or request external review of the company's decision.

You also can file a complaint with the federal Department of Health and Human Services.

Open Enrollment – The open enrollment period shall be held during the month of November/December of each year.

Opioid Drug - Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others.

Orphan Disease - An orphan disease is defined as a condition that affects fewer than 200,000 people nationwide. This includes diseases as familiar as cystic fibrosis, Lou Gehrig's disease and Tourette's syndrome, and as unfamiliar as Hamburger disease, Job Syndrome and acromegaly or "gigantism". Orphan drugs and biologics are defined as those intended for the safe and effective treatment, diagnosis, or prevention of rare diseases/disorders.

Orphan Drugs - An orphan drug is a pharmaceutical agent that has been developed specifically to treat a rare medical condition. The condition itself being referred to as an orphan disease. The FDA keeps a list of orphan drugs on their website at www.accessdata.fda.gov/scripts/opdlisting/oopd.

Orthotic Appliance – An external device intended to correct any defect in the form or function of the human body.

Orthotic Device(s) – Medically necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb. Covered devices include but are not limited to cervical collars; ankle foot orthosis; corsets (back and special surgical); splints (extremity); trusses; slings; wristlets; build up shoe and custom made shoe inserts.

Outpatient Substance Abuse Facility – This means an institution which:

a. provides a program for diagnosis, evaluation, and effective treatment of substance abuse;
b. provides detoxification services need with its effective treatment program;
c. provides infirmary-level medical services or arranges with a hospital in the area for any other medical services that may be required;
d. is at all times supervised by a staff of physicians;
e. provides at all times skilled nursing care by licensed nurses who are directed by a full-time registered graduate nurse; and
f. prepares and maintains a written plan of treatment for each patient based on medical, psychological, and social needs which is supervised by a physician and meets licensing standards.

Paperwork Reduction Act Statement According to the Paperwork Reduction Act of 1995
No person is required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 3.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Participating Provider – A designated institution, Physician or other provider who holds a participating provider agreement with the preferred provider organization contracted by this Employer. Also referred to as "In-Network" providers. *Note that providers are free to become non-participating providers at any time; therefore, it is the Covered Person's responsibility to ensure providers are still in the appointed network prior to having services rendered.*

Physician - A physician or person acting within the scope of applicable state licensure/certification requirements and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Medicine (D.M.D), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Optometrist (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychiatrist or Psychologist(Ph.D., Ed.D., Psy.D.), Master of Social Work (M.S.W.), Licensed Professional Counselor (L.P.C.),Audiologist, Physiotherapist, Occupational Therapist, Physician's Assistant, Nurse Practitioner, or Registered Respiratory Therapist, or Speech Language Pathologist. In the case of mental health services, the term "physician" shall also include and be limited to a Psychiatrist, a holder of a doctoral degree who is licensed to practice psychology in the state of Indiana and a C.C.S.W. social worker.

Physiotherapy - Physiotherapy is any treatment of an illness or injury by the use of physical means such as air, heat, cold, light, water, electricity, or active exercise. This includes any nonsurgical spinal treatment. "Spinal treatment" means detection or nonsurgical correction by manual or mechanical means of a condition of the vertebral column including distortion, misalignment or subluxation.

Plan – "Plan" refers to the benefits and provisions for payment of the same as described herein.

Plan Administrator – The Plan Administrator is the person responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services.

Plan Document/Master Plan Document – The Document held by the Employer which describes the terms and conditions of the benefits of the Plan. The plan document and any amendments constitute the terms and provisions of coverage under this plan. The plan document is not to be construed as a contract of any type between the Company and any Participant or to be considered for, or an inducement or condition of, the employment of any employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employee.

Plan Supervisor – The Plan Supervisor is the person or firm employed by the Employer who is given authority by the Employer for the processing of claims and payment of benefits in accordance with this Plan.

Post-Service Claim – A claim for a benefit under the Plan that is not a pre-service claim or urgent care claim.

Pre-Service Claim – A claim for a benefit that under the terms of the Plan requires you to receive, in whole or in part, pre-utilization review as a condition to receive the benefit.

Pregnancy - The physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

Primary Care Physician – A physician for which the Employee and/or Dependent obtains the majority of their services from. A patient's Primary care Physician may be a family physician, internist, OB/GYN. Office visits rendered by any other physician (whether self-referred to or referred by the primary care physician) will not be considered "Primary Care Physician" for the purposes of this document.

Prosthetics – Artificial substitutes for body parts and tissue or materials inserted into tissue for functional or therapeutic purposes.

Psychiatric Hospital – A facility licensed by the state in which it operates to provide diagnostic and therapeutic services for inpatient treatment of mental illness, including substance abuse. If the state does not issue such licenses, a psychiatric hospital is a facility which is primarily engaged in providing diagnostic and therapeutic services for the inpatient treatment of mental illness and substance abuse if such services are provided by or under the supervision of an organized staff of physicians and if continuous nursing services are provided by registered nurses.

Qualified Medical Child Support Order (QMCSO) – A QMCSO is defined as a medical child support order which **(a)** creates or recognizes the existence of a child's right to, or assigns to a child, the right to receive benefits for which a participant is eligible under this Plan; and **(b)** with respect to which each of the following requirements are met:

a. the medical child support order clearly specifies
    1. the name and last known mailing address of the participant, and the name and mailing address of the child covered by the order;
    2. a reasonable description of the type of coverage to be provided;
    3. the period to which such order applies;
    4. the Plan to which such order applies; and
b. the medical child support order does not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act, as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993.

Reasonable and Customary – A "reasonable and customary" charge shall be the Maximum Allowable charge made by a physician or supplier of services, medicine or supplies. This Maximum Allowable Fee is determined by comparing similar services or procedures to a national data base. This is adjusted to the locality where services or procedures were performed. The term "area" as it would apply to any particular service, medicine or supply means a county or such greater areas as is necessary to obtain a representative cross section of level of charges. This Plan will utilize the ADP reasonable and customary databases for medical, dental, and anesthesia services. The allowable amount for assistant surgeon services will not exceed 20% of the maximum allowed amount for the surgery. Reasonable and customary limits for anesthesia charges will be based on the most recent guidelines provided by the American Society of Anesthesiologists (ASA). If multiple, bilateral, or incidental surgical procedures, which add significant time or complexity to patient care, are performed during the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s). The Maximum Allowable Charge limit is a cost control feature of this Plan. It is not intended to control or limit a patient's choice, or a provider decision, for necessary medical care. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which requires additional time, skill or expertise.

Recipient – The recipient is the person who receives the organ for transplant from the organ donor. The recipient shall be an Employee or Dependent covered under the provisions of this Plan. Only those organ transplants not considered experimental in nature are eligible for coverage under this Plan.

Registered Nurse – An individual who has received specialized nursing training, is authorized to use the designation of "R.N." and is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Room and Board Charges – Charges made by an institution for room and board and other necessary services and supplies must be regularly made at a daily or weekly rate. The semi-private rate is the charge which an institution applies to the most beds in its semi-private room with 2 or more beds. If there are no such rooms, it will be the rate most commonly charged by similar institutions in the same geographic area. Private room charges will not be covered unless certified as medically necessary by the attending physician and approved by the Plan Supervisor. For the purposes of this benefit, "medically necessary" means the facility has no semi-private or less expensive accommodations, or all such accommodations are occupied, and the patient needs hospitalization immediately and such inpatient treatment cannot be deferred until less expensive accommodations become available. If the patient's condition requires isolation for his/her own health or that of others, a private room may be medically necessary when treating a number of physical and mental conditions. These include communicable diseases which require isolation of the patient for certain periods. Miscellaneous charges are charges made by the hospital at a daily or weekly rate for other hospital services and supplies, or which are regularly made by the hospital as a condition of occupancy of the class of accommodations occupied.

Semi-Private – A class of accommodation in a hospital or Convalescent Nursing Facility in which at least two (2) patient beds are available per room.

Service in the Uniformed Services – The performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a covered employee is absent from a position of employment for the purpose of an examination to determine the fitness of the covered employee to perform any such duty.

Significant Break in Coverage – A period of 63 days or more during which an Employee or Dependent is not covered by any Creditable Coverage. Waiting periods are not included in the calculation of the break in coverage period.

Skilled Nursing Services – Skilled nursing services are the professional services that may be rendered by a registered professional nurse or by a licensed practical nurse under the direction of a registered professional nurse.

Speech Thearpy – for the correction of a speech impairment.

Special Enrollee – An Employee or Dependent who is entitled to and who requests Special Enrollment (as described in the Eligibility section) within 30 days of losing health coverage; or for newly acquired dependents, within 30 days of marriage, birth, adoption, or placement for adoption.

Specialty Drugs - A Specialty Drug is a drug that targets and treats specific complex conditions or illnesses such as cancer, rheumatoid arthritis, multiple sclerosis, hepatitis C, and HIV/AIDS. Specialty Drugs require patient- specific dosing and careful clinical management. Often these drugs are in the form of injected or infused Medicines. Because specialty drugs require special clinical monitoring, they are typically not dispersed through a traditional retail pharmacy; therefore, some medications have to be dispensed through specialty pharmacies. Please refer to benefits or exclusion sections that may apply.

Substance Abuse – Means the taking of alcohol or other drugs:

a. in amounts that place an individual's social, economic, psychological, and physical welfare in potential hazard; **or**
b. to the extent that a person loses the power of self-control as a result; **or**
c. habitually so to endanger public health, morals, safety, or welfare, or a combination thereof.

Substance Abuse Treatment – Effective treatment of substance abuse is a program of substance abuse therapy that:

a. is prescribed and supervised by a physician. It must have a follow-up therapy program directed by a physician on at least a monthly basis; or
b. includes meetings at least twice a month with organizations devoted to the treatment of substance abuse.

The following is <u>not</u> effective treatment:

a. detoxification--mainly treating the aftereffects of a specific substance abuse episode; or
b. maintenance care--providing an environment free of the abused substance.

Summary Plan Description – Each Employee covered under the Plan will be issued an individual booklet which shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. Typically, the booklet is designed to be a summary of the Employee's benefits and in the event of any questions, the master plan document shall be the prevailing document. This Employer issues one booklet that serves as both the Master Plan Document and Summary Plan Description.

Surgical Procedure – Surgery is one of the following procedures performed by a physician, other than a resident physician or intern of a hospital: cutting, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, paracentesis, administering pneumothorax, injecting sclerosing solution, arthroscopic procedures urethral dilation. Surgical procedures do not include suturing, cryosurgery, electrocauterizing, applying plaster casts, or similar procedures. The surgeon's charges incurred during the standard follow-up treatment period will not be covered expenses. These charges should be included in the original surgery charge. Assist surgeon fees will be allowed if medically necessary. The allowable amount for assistant surgeon services will not exceed 20% of the maximum allowed amount for the surgery. Assistant Surgeons will not include Surgical First Assistant (SFA) and or Certified First Assistant (CFA) charges.

Telemedicine Services – the use of a telephone or any other means of communication for a consultation/treatment from a Physician for acute care services.

Total Disability – This means a disability commencing after the date a covered person becomes effective under this Plan and resulting from bodily injury or illness which wholly prevents:

a. an employee from engaging in any and every business or occupation and from performing any and all work for compensation or profit; or

b. a dependent from performing the normal activities of a person of like age and sex.

Treatment – Any service or supply used to evaluate, diagnose, or remedy a condition of a covered person.

Uniformed Services – The Armed Forces, the Army National Guard and Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commission corps of the Public Health Service, and any other category of persons designated by the President of the United States of America in time of war or emergency.

Urgent Care Claim – A claim for medical treatment which, if the regular time periods observed for claims were adhered to:

a. could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
b. would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim will be determined by an individual acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

USERRA – The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Waiting Period – The term that must pass under this Plan (or for purpose of determining creditable coverage, any other health plan) before an Employee or Dependent is eligible to enroll in the Plan (or other health plan). Note, the time between the date a Late Enrollee or Special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage will not be treated as a waiting period.

Basic Life Insurance Benefit

Benefit - If an Employee dies while insured for life under the Plan, the Insurance Company will pay to the named beneficiary the amount of life insurance in force as shown in the Schedule of Benefits.

Beneficiary - "Beneficiary" means the person(s) the Employee names to receive the Life Insurance proceeds upon his/her death. An Employee may change the beneficiary in writing at any time. The beneficiary change will be effective on the date the request is signed.

Life Conversion - Should an employee's employment terminate for any reason, he/she may apply, without medical examination, within 31 days after termination to the Insurance Company for an individual policy. Such converted policy will be on a form then issued by the Insurance Company (other than term insurance) and shall be without disability or other supplementary benefits. The premiums for the converted policy will be at the Insurance Company's then customary rates for the same policy issued to any other person of the same class of risk and age at the time the converted policy is to become effective.

If the group plan is terminated, only those employees who have been covered for at least three years will have the privilege of converting their insurance to a limited amount of whole life or endowment coverage.

Waiver of Premium - If an Employee becomes permanently and totally disabled (unable to engage in any occupation for pay or profit) while under age 60 for at least 9 consecutive months, his life insurance premiums will be waived while the disability continues. The Insurance Company will require satisfactory proof of disability within the first year of commencement of disability and once a year thereafter.

Certificate of Coverage - The information provided in this section concerning basic life insurance benefits is only a brief summary. A separate Certificate of Coverage booklet will be supplied by the insurance carrier with complete benefit information.

If there are any discrepancies between this section and the carrier's Certificate of Coverage booklet, the carrier's booklet governs.

Basic Accidental Death & Dismemberment Benefit

Benefit - This benefit is payable in the event of loss of life or dismemberment within 365 days after the accident occurs. The full amount of insurance is shown in the Schedule of Benefits. The table of losses is as follows:

Loss of…	**Insurance Benefit**
Life	Full amount
One hand, One foot, or One eye	One-half the amount
More than one of the above through one accident	Full amount

With respect to hands or feet, "loss" means dismemberment by severance at or above the wrist or ankle joint. With respect to eyes, "loss" means the entire and irrecoverable loss of sight.

In the case of accidental death, this benefit is paid in addition to Life Insurance. Only one benefit (the larger) will be paid for more than one loss from the same accident.

Exclusions - No benefits shall be paid for loss resulting directly or indirectly, wholly or partially from any of the following:

a. suicide, attempted suicide, or an intentionally self-inflicted injury, while sane or insane;
b. insurrection, riot or war;
c. the committing of, or the attempt to commit an assault or felony;
d. disease or disorder of the body or mind;
e. medical or surgical treatment, diagnosis, or preventive care;
f. ptomaines or bacterial infection except when resulting from purely accidental circumstances;
g. the taking of drugs other than those drugs taken as prescribed by a doctor or voluntarily taking of poison or inhaling gas;
h. engaging in hazardous activities such as, but not limited to, sky diving, hang gliding, auto racing, dirt bike racing or mountain climbing; and
i. travel or flight in, or descent from, any kind of aircraft, including balloons and gliders (except as a fare paying passenger on a regularly scheduled commercial route or chartered flight), or travel in any aircraft not holding a current airworthiness certificate.

Beneficiary - Unless an Employee specifically designate otherwise, the one designation of beneficiary shall apply to both life insurance and accidental death and dismemberment.

Certificate of Coverage - The information provided in this section concerning basic accidental death and dismemberment insurance benefits is only a brief summary. A separate Certificate of Coverage booklet will be supplied by the insurance carrier with complete benefit information.

If there are any discrepancies between this section and the carrier's Certificate of Coverage booklet, the carrier's booklet governs.

Dependent Life Benefits

Benefits - If one of the Employee's covered dependents dies from any cause at any time, the insurance company will pay the Employee the amount shown in the Schedule of Benefits. Dependent Life benefits are terminated at the time of retirement or at termination of employment.

Covered Dependents - For the purpose of this benefit, "dependent" means:

a. the Employee's spouse if not legally separated or divorced, who is living with the Employee; or
b. the Employee's unmarried children from 14 days of age to age 26. Coverage may also extend beyond the age limitations to your children who are incapable of supporting themselves due to mental or physical handicap.

Coverage on any additional dependent commences automatically on the date he qualifies for all other benefits. If an employee's spouse is covered under this Plan as an Employee, he is not eligible for this Dependent Basic Life Insurance. If both spouses are covered under this Plan, only one eligible spouse may cover the eligible children for this benefit.

Conversion - If the Employee should terminate his employment or die while covered under this Plan, the dependents may apply for an individual life policy with the Insurance Company without taking a medical examination. The covered dependent may also apply for an individual policy if any one of the following situations occur:

a. his insurance coverage terminates because he ceases to be an eligible dependent; or
b. all or part of his insurance coverage terminates as a result of any amendment to or termination of this Plan. Under these circumstances, the dependent must have been insured under this Plan for at least five years prior to the date of termination.

The dependent must apply for this individual policy within 31 days after termination of insurance.

Certificate of Coverage - The information provided in this section concerning dependent life insurance benefits is only a brief summary. A separate Certificate of Coverage booklet will be supplied by the insurance carrier with complete benefit information.

If there are any discrepancies between this section and the carrier's Certificate of Coverage booklet, the carrier's booklet governs.

Annual Medical Maximum - The annual maximum payable under the medical portion of the Plan is shown in the Schedule of Benefits. The maximum applies to each individual covered by the Plan. Some benefits, as shown in the Schedule of Benefits, have separate lifetime and/or annual individual maximums. Maximum benefits are limited to the period of time the individual is covered by this Employer and any benefit plans that may be offered.

Lifetime Medical Maximum - The lifetime limit on the dollar value of benefits under this plan no longer applies. The maximum payable under the medical portion of the Plan is shown in the Schedule of Benefits. The maximum applies to each individual covered by the Plan. Some benefits, as shown in the Schedule of Benefits have separate lifetime individual maximums. Maximum benefits are limited to the period of time the individual is covered by this Employer and any benefit plans that may be offered.

Large Claim Management - This Plan allows the Employee and covered dependents access to cost-effective alternative treatment. The purpose of "alternative treatment" is to reduce cost and provide quality care if an Employee or a covered family member are affected by a severe medical problem requiring intensive or long-term care. Expenses which are normally not covered under this Plan, but which are recommended by a Large Claim Management Service and approved by the Plan Sponsor and any re-insurance carrier will be reimbursable under this provision. The Plan Supervisor and reinsurance company will investigate other treatment programs to provide this Large Claim Management. The Employee and the patient's attending physician will be part of this process. This allows the Employee to make health care decisions that meet the patient's individual needs.

Deductibles - Individual: The individual deductible is the total amount of covered expenses that an Employee or dependents must satisfy in each calendar year before an Employee or dependents are eligible for the Comprehensive Medical Benefits.

Family: The family deductible is the total amount of covered expenses covered members of a family must satisfy in each calendar year before all covered family members are eligible for the Comprehensive Medical Benefits. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

Basic Embedded Deductible Explanation - A health plan with an embedded deductible actually has two deductible amounts. In a family plan, for example, the embedded deductibles may start meeting expenses for an individual after the individual has met the individual deductible, and for the entire family after the family deductible has been met. The individual does not have to wait for the family to reach the family deductible before he sees the plan paying for their portion of the claims.

Carryover: There is no carryover of the individual or family deductible from one calendar year to the next.

Any expenses not covered by this Plan, eligible expenses exceeding any plan maximums; pre-utilization penalties and charges in excess of the reasonable and customary amount or negotiated rate will not apply to deductibles.

If this Plan replaces a prior plan during the middle of a calendar year, any deductible met during that calendar year shall apply toward the deductible described in this Plan for the remainder of that calendar year.

Benefits - Covered medical expenses incurred after any deductible are payable at the rate seen in the Schedule of Benefits (unless otherwise stated) and the participant is responsible for the remaining percentage. The percentage may vary among plan options.

Coinsurance Limit - Individual limit – when a percentage of the in or out-of-network expenses incurred for any one family member in one calendar year equals the individual coinsurance limit shown in the schedule of benefits, any benefits payable for such covered expenses incurred for that member in the rest of that calendar year will, after any applicable deductible, be paid at the rate of 100% rather than the percentage shown in the schedule of benefits for in or out-of-network, except where maximum (if applicable) have been met. This applies to all benefit plan options offered.

Family limit – when a percentage of the in or out-of-network expenses incurred for all family members in one calendar year equals the family coinsurance limit shown in the schedule of benefits, any benefits payable for such covered expenses incurred for all covered participants in the rest of that calendar year will, after any applicable deductible, be paid at the rate of 100% rather than the

percentage shown in the schedule of benefits for in or out-of-network, except where maximum (if applicable) have been met. This applies to all benefit plan options offered.

Any expenses not covered by this Plan, plan deductibles, eligible expenses exceeding any plan maximums, pre-utilization penalties, charges in excess of the reasonable and customary amount or negotiated rate will NOT go toward satisfying the coinsurance limit. The copayments or coinsurance that an Employee pays for office visits and prescription drugs at the time of purchase through the drug store or mail-order program will apply toward the coinsurance limit of this Plan.

If this Plan replaces a prior plan during the middle of a calendar year, any coinsurance met during that calendar year shall apply toward the coinsurance limit described in this Plan for the remainder of that calendar year.

Hospital Discounts - Hospitals often give discounts in exchange for a guarantee that their bill will be paid promptly. Ask the Hospital's business office about the availability of a prompt pay discount whenever you or one of your dependents is hospitalized. If you can get a discount, report your findings promptly to the Plan Supervisor so they can make the necessary arrangements with the Hospital.

Covered Medical Expenses - Covered Medical Expenses are the reasonable and customary charges which an Employee is required to pay for the following services and supplies received by a covered family member. The services must be performed upon the recommendation and approval of the attending physician for the medically necessary treatment of any non-occupational injury or non-occupational illness:

A. hospital expenses for semi-private or intensive care room and board charges (as limited in the Schedule of Benefits) and hospital services and supplies furnished while confined or out-patient services are used;
B. charges for reasonable and customary fees of legally qualified physicians and surgeons for necessary medical care or treatment. These charges will qualify whether treatment is provided in or outside a hospital setting;
C. charges of a registered graduate nurse for private duty nursing service, but not by one who lives with the Employee or who is a member of his/her family or spouse's family;
D. Medical services or supplies prescribed by a legally qualified physician or surgeon, as follows:
    a. office visit and consultations for the examination, diagnosis, and treatment of an illness or injury;
    b. drugs or medicines which require a written prescription and must be dispensed by a licensed pharmacist or physician;
    c. diagnostic x-ray, laboratory and microscopic examinations including allergy testing and any medically necessary pre-operative or pre-admission testing. Covered ultrasound charges for covered pregnant Employees and covered dependents will be limited to four (4) tests during a pregnancy.
    d. x-ray, radium and radioactive isotopes therapy;
    e. anesthetics and oxygen;
    f. rental of iron lung and other durable medical and surgical equipment including wheel chairs or hospital-type beds and other mechanical equipment for the treatment of respiratory paralysis required for temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less. Routine maintenance not covered and deluxe items are limited to the cost of standard items;
    g. surgical supplies including casts, splints, trusses, braces, crutches, bandages and dressings. Also necessary prosthetic appliances to replace physical organs or parts or to aid in their functions, but limited to the initial charge or the first such appliance unless due to a bodily change or as recommended and prescribed by a licensed physician;
    h. artificial limbs and eyes--but not eye examinations, eyeglasses, hearing aids or orthopedic shoes or other devices to support the feet;
    i. charges for necessary transportation by professional ambulance services from the place where a covered person is injured or stricken by illness to the first hospital where qualified treatment can be given. This includes any transfers required by the medical condition (not convenience) of the patient;
    j. processing and administration of blood or blood components, including the cost of the actual blood or blood components if replaced;
    k. initial eye exam, contact lenses, and/or lenses and frames following cataract surgery (intraocular lens implants received during surgery will also be considered covered medical expenses);
    l. fees of a physician or speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an illness, other than functional nervous disorder or to surgery as a result of illness;
    m. covered expenses for treatment of nonservice-connected disabilities in Veterans Administration hospitals;
    n. covered expenses for care while confined in a military medical facility, which are incurred by a U.S. military retiree (and his or her covered dependents, if any);
    o. insulin, insulin syringes and needles, and chemical strips used in testing blood, all of which are for treatment of diabetes;

p. contraceptive devices and birth control pills available upon a medical doctor's prescription—this does not include the exam or check-up charge unless an illness or injury is being treated;
q. immunizations or inoculations which include customary childhood vaccinations and flu shots up to the limits shown in the Schedule of Benefits for Preventative Health Care Expenses;
r. charges for an individually prescribed exercise program for cardiac patients provided to improve cardiovascular function and physical work capacity. Services must be prescribed and authorized by the attending physician of patients with a history of bypass surgery, stable angina pectoris or acute myocardial infarction within the past twelve months;
s. routine mammography examinations for asymptomatic women up to the limits shown in the Schedule of Benefits for Preventative Health Care Expenses;
t. routine pap smears and prostate exams up to the limits shown in the Schedule of Benefits for Preventative Health Care Expenses;
u. charges for the reconstruction of a surgically-removed breast, charges for surgery to produce a symmetrical appearance and charges for prostheses and treatment for physical complications from all stages of mastectomy, including lymphedemas and

E. charges for the services of a certified nurse-midwife in accordance with the Plan definition.

SPECIAL CONDITIONS COVERAGE

A. **Prescription Drug Benefit** – Covered prescription drugs will be reimbursed as shown in the Schedule of Benefits.

Retail Pharmacy - As a participant in the group health plan, you are eligible for prescription drug benefits under this Prescription Drug program. This program is considered part of the plan. The program uses a network of preferred pharmacies that have contracted with the Plan to charge covered persons reduced fees for covered prescription drugs. In addition, certain drugs must be purchased at designated pharmacies. The Pharmacy Benefit Manager provides claims processing and ministerial services for the Rx program (but is not an insurer). The reimbursement by the Rx program is determined per script by the reimbursement levels which are applied to each covered drug. Amounts above the per script dollar limit may be excluded and not considered eligible expenses under the Plan or this Rx program. If a drug is purchased at a non-participating pharmacy or a participating pharmacy when the covered participants ID card is not used, the participant must pay the entire cost of the prescription, including copay and then submit the receipt for reimbursement to the Pharmacy Benefit Manager.

Participating Pharmacy - The plan has a network of participating retail pharmacies. You can find a local retail pharmacy by visiting www.true-rx.com and navigate to the pharmacy locator section. You may also call TrueRx at (866) 921-4047. Participating providers can change, so you should check the website from time to time.

Designated Pharmacy - If you require certain prescription drugs, the pharmacy benefit manager may direct you to a designated pharmacy with which it has an arrangement to provide those prescription drugs. These drugs are listed on the formulary that can be found at www.truerx.com or by calling TrueRx at (866) 921-4047

Non-Network Pharmacies – No benefits are available for prescriptions drugs if filled at a non-network pharmacy.

Reimbursement Levels - Benefits for eligible drugs are available for prescription drugs that are considered an eligible expense as set forth in this document. The rx program pays benefits at different levels based upon prescription drug tiers as described below. All prescription drugs covered by the rx program are categorized into these tiers on the Preferred Drug Formulary. The tier status of a prescription drug can change periodically, as frequently as monthly based on the Pharmacy Benefit Managers Preferred drug formulary Management Committee's periodic tier decisions. When that occurs, you may pay more or less for a prescription drug, depending on its tier assignment. Since the Preferred Drug Formulary may change periodically, for the most current information, call TrueRx at (866) 921-4047.Each tier is assigned a reimbursement level which is the amount the Rx program pays. You will also pay a copay when you visit the Pharmacy. As an example, here is how the tier system works with three tiers:

1. Generic tier is the lowest copay. For the lowest out-of-pocket expense, you should consider generic tier drugs if you and your prescriber decide they are appropriate for your treatment.
2. Preferred Brand tier is your middle copay. Consider a preferred brand tier drug if no generic tier drug is available to treat your condition.
3. Non-Preferred Brand tier is your highest copay (if applicable). The drugs in Non-Preferred Brand tier are usually more costly. Sometimes there are alternatives in the other tiers.

You are responsible for your deductible, if any, and also paying the lower of:

1. The applicable copay;
2. The network pharmacy's Usual and Customary charge for the prescription drug;
3. The prescription drug charge that the Pharmacy Benefit Manager agreed to pay the network pharmacy.

Pharmacy benefits apply only if your prescription is an eligible expense. For excluded charges, you are responsible for paying 100% of the cost. The Pharmacy Benefit Manager will assist participants seeking reimbursement from third-party resources but makes no guarantees.

Other programs or services, which may reduce member copay may be implemented by the plan administrator or procedurally changed by the pharmacy benefit manager if, in their discretion and management of the plan, the program or service will benefit the plan and participant and there is a likelihood that plan expenses will be reduced over the longer term. Please see Exclusions section regard the treatment of drugs for which manufacturers provide rebates, discounts, or other payment methods.

Specialty Pharmacy - A prior authorization is required for all specialty drugs, a list of which can be found at www.truerx.com or by call TrueRx at (866) 921-4047. First time dispensing of a specialty drug may be limited to less than a 30-day supply when not prepackaged for a larger quantity. Additionally, a maximum unit of measure quantity limit per person/plan year may apply to some specialty drugs. Covered prescription injectables and certain other specialty drugs such as chemotherapies may only be available through a designated specialty pharmacy. Specialty drugs are categorized into the described copay tiers or as determined by the Pharmacy Benefit Managers' Preferred Drug Formulary Management Committee. For specialty drug maximum unit of measure quantity limit coverage per person/calendar year and specialty drugs available through the Specialty Pharmacy contact the Pharmacy Benefit Manager.

Specialty Drugs - A Specialty Drug is a drug that targets and treats specific complex conditions or illnesses such as cancer, rheumatoid arthritis, multiple sclerosis, hepatitis C, and HIV/AIDS. Specialty Drugs require patient- specific dosing and careful clinical management. Often these drugs are in the form of injected or infused Medicines. Because specialty drugs require special clinical monitoring, they are typically not dispersed through a traditional retail pharmacy; therefore, some medications have to be dispensed through specialty pharmacies. Please refer to benefits or exclusion sections that may apply.

Clinical Trial Coverage - Benefits for clinical trial coverage under this Rx program will be administered consistently with the requirements of the Affordable Care Act.

Limitation of Pharmacy Selection - If the pharmacy benefit manager determines that you may be using prescription drugs in a harmful or abusive manner, or with harmful frequency, your selection of network pharmacies may be limited. If this happens, you may be required to select a single pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single network pharmacy, subject to the terms of the Rx program and Plan.

Supply Limits - Some prescription drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a prescription drug has been assigned a supply limit or maximum unit of measure quantity limit per person/plan year for dispensing call TrueRx at (866) 921-4047. Whether or not a prescription drug has a supply limit or maximum unit of measure quantity limit coverage per person/plan year is subject to TrueRx periodic review and modification. Any one retail non-specialty prescription is limited to a ninety (90) day supply.

Off Label Drugs - Off Label use of drugs may be considered by this plan if all other treatment plans have been tried unsuccessfully. Prior authorization must be obtained through the Plan Supervisor. Medical necessity must be documented. Re-evaluation of the use of the off-label drug will be required after (no longer than) an initial three-month trial period. If substantiated improvement in the patient's condition is not evident, further use of the off-label drug will no longer be approved for coverage.

Opioid Program - The Opioid Program will limit the initial fill to a 7-day supply. Prior authorization will be required for:

1. Doses that are greater than 90 morphine milligram equivalent (MME)/day
2. First long-acting opioid prescription
3. Any patient on the opioid-benzodiazepine-carisoprodol combination

Please contact the Pharmacy Benefit Manager (PBM) with any questions regarding this program.

Orphan Disease - An orphan disease is defined as a condition that affects fewer than 200,000 people nationwide. This includes diseases as familiar as cystic fibrosis, Lou Gehrig's disease, and Tourette's syndrome, and as unfamiliar as Hamburger disease, Job syndrome, and acromegaly, or "gigantism."

Orphan Drug - An orphan drug is a pharmaceutical agent that has been developed specifically to treat a rare medical condition, the condition itself being referred to as an orphan disease. The FDA keeps a list of orphan drugs at their website. http://www.accessdata.fda.gov/scripts/opdlisting/oopd

Exclusion Drug List - Any drug or biological that has received an orphan drug designation that has a single disease state indication except those treating a cancer diagnosis.

Other Provisions - The copayments or coinsurance that an Employee pays at time of purchase through the drug store or mail-order program will not apply toward the coinsurance portion of this Plan.

Preventative Drugs - Any prescription defined as a preventative drug will be paid at 100% as required by the Affordable Care Act.

J-Code Program - Injected or Infused specialty medications administered through home health, an infusion center, physician's office, or out-patient based hospital unit may be reviewed by True Rx for the most cost-effective infusion therapy. Based upon this review, the TPA and/or plan will choose the most cost-effective site of treatment. At that point of the evaluation all other infusion sites will be ***considered out of network/not approved by the plan and therefore not covered*.**

True Advocate – a process by which the Pharmacy Benefit Manager helps the plan participant in finding financial assistance for medications. Financial assistance may include manufacturer's programs and our sourcing medications from international sources. This often occurs when the plan excludes certain medications. Claims that provide more than a 30-day supply, maximum caps shall be assessed every four weeks. The cost for medication that is sourced through international sources shall be invoiced to the Plan.

OnTrack Program – Personalized care for navigating diabetes. A patient centered program that allows plan participants to actively manage diabetes and meet individual goals. The Plan participant will actively participate in the program by one-on-one visits with the PBM' clinical pharmacist; medication review, holistic approach that includes diet, exercise and wellness and creating a specific plan and personalizing goals. Participation has the potential to improve outcome and lower costs. OnTrack can assist plan participants in to better manage their diabetes, lower out of pocket costs to participant and to employer. This program offers free testing and insulin supplies (approved by the PBM). You can contact the PBM regarding this program at diabetes@truerx.com or (866) 921-4047.

True Genomics – is a program that looks at the relationship between the medication we take and how our unique genes determine our bodies' response to that medication. If you qualify for this program a test kit (at home cheek swab) will be sent to your home and you will mail it back to the lab using the mailing labels included. A team of pharmacists will examine the results and evaluate your medications. You will be notified through a secure website your results and evaluation. The PBM will reach out to your provider to recommend a medication that will reduce side effects and increase effectiveness. After working with your provider and the PBM you will receive regular monitoring to assess your health. You can contact the PBM regarding this program at (866) 921-4047.

Clinical Trial Coverage - The Prescription Drug Program will not: (a) deny a Qualified Individual participation in an Approved Clinical Trial; (b) deny (or limit or impose additional conditions on) the coverage of Routine Patient Costs for items and services furnished in connection with participation in an Approved Clinical Trial that would otherwise be covered by the Prescription Drug Program; or (c) discriminate against a Qualified Individual on the basis of the Qualified Individual's participation in an Approved Clinical Trial. If one or more in-network providers is participating in an Approved Clinical Trial, the Prescription Drug Program may require that a Qualified Individual participate in the Approved Clinical Trial through such a provider if the provider will accept the Qualified Individual as a participant in the Approved Clinical Trial, unless the Qualified Individual is participating in an Approved Clinical Trial that is conducted outside the state in which the Qualified Individual resides. The Pharmacy Benefit Manager (PBM) will comply with all Affordable Care Act (ACA) mandated Clinical Trial guidelines.

Approved Clinical Trial - A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(a) the National Institutes of Health;
(b) the Centers for Disease Control and Prevention;
(c) the Agency for Health Care Research and Quality;
(d) the Centers for Medicare & Medicaid Services;
(e) cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veteran Affairs;
(f) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
(g) the Department of Veteran Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration. The study or investigation is a drug trial that is exempt from having such an investigational new drug application. For these purposes, "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Step Therapy Program - The Step Therapy Program encourages the use of generic medicines. Generic Medications will be required in certain drug classes before Brand Medications will be approved. In other drug classes, only Generic Medications will be covered. You may contact the Pharmacy Benefit Manager (PBM) for more information about the Step Therapy Program and when the use of a Generic Medication is required.

Step Therapy Program Categories	
Proton Pump Inhibitors (e.g., Dexilant)	Cholesterol (e.g., Livalo)
Osteoporosis (e.g., Atelvia)	Blood Pressure (e.g., Benicar, Micardis HCT)
Hypnotics/Sedatives (e.g., Zoplimist, Sonata)	Anti-Depressants (e.g., Viibryd, Pristiq)
Migraine Agents (e.g., Relpax)	Nasal Steroids (e.g., Veramyst)
Acne (e.g., Minocycline ER)	IBS Agents (e.g., Pentasa)

**The medications listed are only examples; other drugs in these categories may be part of this program.*

Note: The Step Therapy Program is applicable to members age 18 and over only. Please contact True Rx at (866) 921-4047 with any questions regarding the Step Therapy Program.

Prescription Drug Benefit Exclusion:

a) Prescription drugs dispensed by any mail service program other than the Pharmacy Benefit Manager's (PBM) mail service;
b) Drugs, devices or products or legend drugs with over the counter equivalents and any drugs, devices, or products that are therapeutically comparable to over the counter drug, device or product. This does not apply to over the counter products that the plan must cover as preventative care as required by the Affordable Care Act;
c) Off label use except as describe above;
d) Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription; or drugs in quantity which exceed the limits of the plan or exceeds in age limits set by the Plan;
e) Drugs not FDA approved;
f) Charges for the administration of any drug;
g) Drugs consumed at the time and place where dispensed or where the prescription order is issued, including but not limited to samples provided by a Physician. This does not apply to drugs used in conjunction with diagnostic testing, with chemotherapy performed in the office;
h) Any drug which is primarily for weight loss;
i) Drugs not requiring a prescription by federal law, including drugs requiring a prescription by state law but not federal law, except for injectable insulin;
j) erectile dysfunction or inadequacy drugs, regardless of origin or cause;
k) Fertility drugs;
l) Human growth hormone drugs for children born small for gestational age; It is only covered when allowed by the Plan through pre-certification;
m) Compound drugs all of the ingredients are FDA approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source non-proprietary vehicles and/or pharmaceutical adjuvants;
n) Toenail fungus drugs;
o) Certain prescription legend drugs are not covered when any version or strength becomes available over the counter;
p) Refills of lost or stolen medications;

Certain prescriptions drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. Clinically equivalent means drugs that for the majority can be expected to produce similar therapeutic outcomes for a disease or condition.

B. **Outpatient Surgery** - All expenses incurred for medically necessary surgery performed as outpatient surgery will be paid as shown in the Schedule of Benefits for all reasonable and customary charges made the day of the surgery in connection with the surgery. "Surgery" is further described under the "Definitions."

C. **Physician Office Visit** – Covered expenses include charges for office visits for the examination, diagnosis, and treatment of an illness or injury. Related laboratory tests, x-rays, immunizations, etc. performed in the office on the same day as visit are not included in the in-network copayment. The office visit copayment does not apply to prenatal and postnatal office visits (after the initial diagnosis) by a network OB/GYN who is primarily responsible for the patient's maternity care. The copayment that an Employee pays at the time of service will not apply toward the individual and family deductible and coinsurance limits.

D. **Voluntary Second Surgical Opinion** – This Plan pays as shown in the Schedule of Benefits for charges of a physician for a second surgical opinion on the need or advisability of performing a surgical procedure:
a. for which the charges are a Covered Medical Expense;
b. which is recommended by the first physician who proposed to perform the surgery; and
c. which is not an emergency. This means the procedure can be postponed without undue risk to the patient.

A benefit is also paid for charges made for a third surgical opinion. This will be done when the second one does not confirm the recommendation of the first physician. A surgical opinion includes the exam, x-ray and lab work and a written report by the physician who renders the opinion. The surgical opinion must be performed by a physician who is certified by the American Board of Surgery or other specialty board. It must take place before the date the proposed surgery is scheduled to be done. Benefits are <u>not</u> paid for a surgical opinion if the physician who renders the surgical opinion is associated with or in practice with the first physician who recommended and proposed to perform the surgery. Additional information is detailed under the "Pre-Utilization Program" provision.

E. **Preadmission/Preoperative Testing** – Charges made by a physician, hospital, surgery center, or licensed diagnostic lab facility to test a person while an outpatient before scheduled surgery or inpatient admission will be paid as shown in the Schedule of Benefits if the tests are done within 7 days prior to the Scheduled surgery or admission. If the person cancels the scheduled surgery or admission, benefits are paid the same as any other covered expenses.

F. **Hospital Room and Board** – Semi-Private Room and Intensive Care charges will be covered expenses as shown in the Schedule of Benefits. Charges made by a hospital for routine care of a newborn will be paid as shown in the Schedule of Benefits after any required deductible for the baby. Also covered are professional fees during the initial hospital confinement for circumcision and in-hospital visits. These charges are covered separately from the mother. Check-up charges after the baby is released are not covered except as shown in the Schedule of Benefits under the Preventative Health Care Expenses.

Private room charges will not be covered unless certified as medically necessary by the attending physician and approved by the Plan Supervisor.

G. **Mental and Nervous Disorders** – If a person is an inpatient in a hospital or incurs outpatient expenses, the expenses are covered in the same way as those for any other illness. The Pre-utilization procedures must also be followed for this type of inpatient care.

H. **Substance Abuse Treatment** – If a person is an inpatient in a hospital or incurs outpatient expenses, the expenses are covered in the same way as those for any other illness. The Pre-utilization procedures must also be followed for this type of inpatient care.

I. **Hospital or Qualified Treatment Facility** -

a. treatment of the medical complications of substance abuse up to the annual maximum shown in the Schedule of Benefits; or
b. effective Treatment of Substance Abuse. This is covered in the hospital only if there is not a separate Substance Abuse Treatment Facility section.

The pre-utilization procedures must also be followed for this type of inpatient care. Treatment must be ordered in writing by a qualified physician for the entire length of time the patient is confined.

Full Continuum of Care – Benefits for in-hospital substance abuse and resulting physician fee **will not be covered** unless the hospital and physician certifies that the covered person has completed the full continuum of care necessary and available at that hospital.

Minimum 48-hour Requirement – Benefits for hospital charges and physicians treatment of substance abuse will not be provided for in-patient admissions of less than 48 hours. The lifetime maximum for all combined inpatient and outpatient mental nervous disorders and substance abuse care is shown in the Schedule of Benefits. If a person is not confined in a hospital for substance abuse treatment, the Schedule of Benefits shows the calendar year and lifetime maximum for each individual for this coverage. Care that does not fit the definition of "effective substance abuse treatment" is not covered by this Plan.

Intensive Out-patient Substance Abuse Care – Intensive out-patient programs for treatment of substance abuse will be paid as shown in the Schedule of Benefits:

To be eligible for benefits for this program the Participant must follow all of the following requirements:

a. have at least one family member or significant other willing to complete the program;
b. be committed to completing the program;
c. totally abstain from any mood altering substances (alcohol, marijuana, Valium, etc.). This requirement may be verified with a urine test several times during the program;
d. attend at least two A.A., Al-Anon, or N.A. meetings each weekend and work through the first five steps of the program to the satisfaction of the staff, their peers, and their A.A., Al-Anon, or N.A. sponsor; and
e. complete a twelve-week aftercare program once the regular program is completed.

Care that does not fit the definition of "effective substance abuse treatment" is not covered by this Plan.

J. **Home Health Care Expenses** – Covered Home Health Care Expenses include:

a. part-time or intermittent care by an R.N., or by an L.P.N. if an R.N. is not available;

b. part-time or intermittent home health aide services for patient care;
c. physical, occupational and speech therapy; and
d. medical supplies, drugs and medicines or lab services ordered by a physician.

Home health care expenses are Covered Medical Expense if:

a. the charge is made by a Home Health Care Agency;
b. the charge is made under a Home Health Care Plan; and
c. the care is given to a covered person in his home

Expenses incurred for this benefit will be paid as stated in the Schedule of Benefits.

K. **Extended Care/Skilled Nursing Facility** – Charges made by a qualified extended care or skilled nursing facility for their services and supplies are Covered Medical Expenses. They must be furnished to a person while confined to convalescence from an illness or injury and occur during a "Convalescent Period."

A "Convalescent Period" starts on the first day a person is confined in a facility if he:

a. was confined in a hospital for at least 3 days in a row, while covered under this Plan, for treatment of an illness or injury;
b. is confined in the facility within 14 days after discharge from the hospital; and
c. is confined in the facility for services needed to convalesce from the condition that caused the hospital stay. These include skilled nursing and physical restorative services

Covered charges include:

a. board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily board and room in a private room over the semi-private room rate
b. use of special treatment rooms;
c. x-ray and lab work;
d. physical, occupational or speech therapy;
e. oxygen and other gas therapy;
f. other medical services usually given by a convalescent facility. This does not include private or special nursing, or physician's services;
g. medical supplies; and
h. ambulance transportation to the facility from the hospital where confined.

Covered Extended Care/Skilled Nursing Facility expenses do <u>not</u> include treatment for drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or any other mental disorder.

L. **Hospice Care Expenses** – Covered Medical Expenses in connection with an approved Hospice Care Program will be paid as shown in the Schedule of Benefits. A patient must be referred to the Hospice program by a physician. An interdisciplinary team provides planned and continuous care to terminally ill patients and their families. All medical care is under the direction of a physician. Care is available 24 hours a day, seven days a week. "Hospice Care Program" means a written outline of the care to be provided for the palliation and management of a person's terminal illness developed by or under the supervision of the attending physician. "Palliative care" is a course of treatment primarily directed at lessening or controlling pain; it makes no attempt to cure the person's terminal illness. The charges made for the following furnished to a person for Hospice Care when given as part of a Hospice Care Program are included as Covered Medical Expenses:

<u>Facility Expenses</u> – Charges made in its own behalf by a hospice facility, hospital or convalescent facility for board and room and other services and supplies furnished for pain control and other acute and chronic symptom management.

<u>Other Expenses</u> – Charges made by a Hospice Care Agency or a provider working under the responsibility of the Agency for:

a. part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours in any one day;
b. medical social services under the direction of a physician;
c. psychological and dietary counseling;
d. consultation or case management services by a physician;
e. physical and occupational therapy;

f. part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person;
g. medical supplies, drugs, and medicines prescribed by a physician; and
h. bereavement counseling for the family members of a terminally ill patient after his/her death, up to the individual maximum amount shown in the Schedule of Benefits

Hospice Exclusions – The following charges will not be covered:
a. funeral arrangements, pastoral counseling, financial or legal counseling
b. homemaker or caretaker of services
c. services provided by volunteer agencies

M. **Preventative Health Care Expenses** – Preventive Services means:

- Items or services with a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force including those regarding breast cancer screening, mammography, and prevention, other than those issued on or around November 2009;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for the person receiving the immunization;
- Preventive care and screenings provided for in the comprehensive guidelines supported by the health Resources and Services Administration for infants, children, and adolescents;
- Preventive care and screenings for women as provided for by the Health Resources and Services Administration;

It includes:

- Colorectal cancer examination and screening as recommended by the American Cancer Society;
- Shingles vaccine for Participants 60 years of age or older;
- Human papilloma virus vaccines; flu shots
- Screening mammography and clinical breast exams;
- Pap test for cervical cancer;
- Digital rectal examination and a prostate-specific antigen test;
- CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination for Participants having a family history of one or more first-degree relatives with ovarian cancer, or with clusters of women relatives with breast cancer, or a family history of nonpolyposis colorectal cancer, or a positive BRCA1 or BRCA2 mutation test;
- Any other preventative care as outlined on the Schedule of Benefits.

N. **Physiotherapy** – Covered expenses in connection with any treatment or physiotherapy on the muscles or vertebra which are not a surgical operation, and which are incurred while not confined in a hospital which are billed by a Physician or Physiotherapist shall not exceed the maximum amount shown in the Schedule of Benefits. Charges in excess of the maximum shall not be included as Covered Medical Expenses. "Physiotherapy" means any treatment of an illness or injury by the use of physical means such as air, heat, cold, light, water, electricity, acupuncture, or active exercise. This includes any nonsurgical spinal treatment. "Spinal treatment" means detection or nonsurgical correction by manual or mechanical means of a condition of the vertebral column including distortion, misalignment, or subluxation. A stroke, heart attack, surgical procedure or similar serious illness may require individual evaluation of the annual maximum. If physiotherapy or physical therapy prescribed by the attending physician for a covered individual follows one of these conditions, each claim will be evaluated to determine if the annual maximum will apply. Under no circumstances will maintenance care be covered. Maintenance care does not improve a condition. It maintains a level of comfort but does not actively correct an illness or injury. If the treatment received appears to be maintenance care, the Plan Supervisor reserves the right to request a second medical opinion on the prognosis and effectiveness of the physiotherapy program. Medically necessary x-ray charges incurred for physiotherapy diagnosis or treatment will be considered as any other x-ray under the Covered Medical Expenses and will not be applied toward the physiotherapy maximum.

O. **Ambulance** – Charges for necessary transportation by professional ambulance services from the place where a covered person is injured or stricken by illness to the first hospital where qualified treatment can be given will be considered under this Plan up to the limits shown in the Schedule of Benefits. This includes any transfers required by the medical condition (not convenience) of the patient.

P. **Durable Medical Equipment, Prosthetic Devices, and Orthotic Appliances**
Covered expenses include the following up to the limits shown in the Schedule of Benefits:

Durable Medical Equipment -- Expenses for the initial purchase, including replacement, or rental of equipment that is appropriate for home use and manufactured mainly to treat the injured. Routine maintenance care and repair of rental equipment is not covered. Covered charges are limited to the cost of standard items. The plan will not pay for rental for a longer period of time than it would cost to purchase the equipment. Equipment should be purchased when it costs more to rent it than to purchase it. The cost of delivery and installation are covered. Repair of equipment will not be covered.

Prosthetic Devices -- Expenses for the initial purchase, fitting and replacement of fitted devices which replace physical organs or parts or to aid in their functions. Prosthetic devices should be purchased, not rented and must be medically necessary.

Orthotic Appliances -- Expenses for the initial purchase, fitting, repair, and replacement of braces, splints, and other appliances used to support a weak or deformed part of the body.

Q. Temporomandibular Joint (TMJ) Expenses – The following charges for treatment of temporomandibular joint (TMJ) disorders will be considered covered medical charges up to limits shown in the Schedule of Benefits for a covered individual. This maximum includes all professional and facility fees. These charges will be considered medical in nature whether performed by a medical doctor, a dentist, or an oral surgeon:

a. physical medicine (heat, massage, ultrasound);
b. history/consultations/examinations;
c. diagnostic x-rays;
d. prescription medications; muscle injections;
e. appliance therapy (bite splint) – no more than one every three years with adjustments as necessary; and
f. joint surgery

TMJ Exclusions – alteration of occlusion(orthodontics).

R. **Laboratory Expenses** – Covered expenses include laboratory tests and will be paid as stated in the Schedule of Benefits.

Designated Laboratory Program: Having laboratory services rendered at a Designated Laboratory Facility is voluntary; however, it can produce substantial savings to the Employee. For information on this program and/or a listing of the facility(ies) in your area, ask your Employer or call Dunn and Associates.

S. **Cardiovascular** (Heart) **Care**- Medically necessary cardiovascular (heart) care that is under the direction of a physician licensed in the state practicing will be covered as stated in the Schedule of Benefits. Having cardiovascular care rendered at a Designated Cardiovascular Facility is voluntary; however, for certain cardiovascular related procedures, it can produce substantial savings to the Employee. For information on this program, call Dunn and Associates.
Dependents must have primary coverage through this Plan to be eligible for the Designated Cardiovascular Program. Only adult dependents may be eligible. Notify Dunn and Associates before scheduling services you may wish to receive through the Designated Cardiovascular Program. If urgent care is necessary, please go directly to the nearest facility. It is important for the patient to be seen by a physician immediately. After the patient is stabilized and a procedure is decided upon, Dunn and Associates can be called.

T. **Organ Transplant Expenses** – **Fully-Insured Transplant Policy**
You have an organ and tissue transplant coverage under a separate insurance policy provided by Tokio Marine HCC – Stop Loss Group (TMHCC) and issued wither by National Union Fire Insurance Company of Pittsburgh, PA or HCC Life Insurance Company. Such coverage pays benefits for certain organ and tissue transplants without regard to any benefits that may or may not be provided by this major medical plan. Please contact TMHCC's Transplant Unit toll-free at (888) 449-2377 for benefit information, pre-authorization of transplant services and transplant network provider access. Pre-authorization of transplant services is required prior to seeing a transplant provider for consultation and/or evaluation. Failure to do so could result in reduced benefits. In order to obtain 100% in-network benefits, you must use providers in the transplant network approved by and accessed through TMHCC's Transplant Unit. Expenses billed by the transplant network provider that are not covered by the TMHCC policy are subject to this medical plan's benefits and the payment terms and conditions of the transplant network provider's contracted rates. For more information, contact Dunn & Associates.

U. **Dental Work and Oral Surgery** – Expenses for dental work and oral surgery are Covered Medical Expenses only if they are for the prompt repair of natural teeth or other body tissue needed as a result of an injury. The expenses must be incurred within six months of the date of the injury. Removal of tumors and cysts within the oral cavity will also be covered under the medical portion of this Plan. Covered treatment will not include any treatment of the teeth, jaw, or facial joints, muscles, tissues, or bones unless the treatment is to repair injuries sustained while covered by this Plan.

V. **Cosmetic Surgery** – Cosmetic surgery expenses may be included as Covered Medical Expenses only for the medically necessary treatment or prompt repair of a non-occupational accidental bodily injury sustained while the person is covered under this Plan. Reconstructive cosmetic surgery necessary for the prompt treatment of a diseased condition, or previous therapeutic process treated while covered under this Plan or correction of congenital defects will be Covered Medical Expenses if they are recommended and performed by a licensed physician. This includes reconstructive breast surgery following a radical mastectomy, whether or not recommended by a physician as medically necessary.

W. **Kidney Dialysis –** Kidney dialysis services and supplies (inpatient and outpatient) which are provided and billed by a Facility, Physician or Medicare-certified dialysis center will be covered under the Plan up to the limits shown in the Schedule of Benefits. Charges are reimbursable at the designated percentage of Medicare allowable rates. Charges are limited to a number of treatments (see Schedule of Benefits) per episode of care. Treatment will be considered a separate episode of care if more than 180 days have lapsed since the last treatment. Home self-dialysis will also be considered a covered expense when ordered by the attending physician. Laboratory tests, equipment, and consumable/disposable dialysis supplies related to home dialysis will also be covered when considered medically necessary by the Plan Supervisor. No benefits shall be payable under this Plan for the following services and supplies, as well as services and supplies similar to those listed below (not an all-inclusive listing):

a. home alterations;
b. water supply;
c. electrical power installation;
d. sanitation waste disposal;
e. air conditioning;
f. convenience and comfort items.

Medical Exclusions & Limitations

No benefits shall be payable under this Plan for any expenses caused by, incurred for or resulting from **any** of the following:

A. services and supplies not specifically covered under the Plan, or not incurred during a period of coverage;

B. experimental or investigational services, procedures, or substances which have not been recognized by established medical review boards as accepted standard of medical practice by the Federal Drug Administration or the American Medical Association;

C. cosmetic, elective, plastic, reconstruction, or restorative surgery, except as specifically provided for in this Plan. This exclusion includes but is not limited to rhinoplasty, bariatric banding or stapling, liposuction, abdominal reduction, body contouring procedure, any other surgeries in connection with or as a result of weight loss, breast reductions, or enlargements, and face lifts, blepharoplasty or any similar surgery of the upper or lower eye lid, whether considered medically necessary by a physician or not; whether or not recommended by a physician as medically necessary;

D. hearing aids and the fitting thereof; or hearing services and supplies not rendered in connection with medical or surgical treatment for injury or illness; or voluntary ear implants for hearing loss, except in the case of a life and death situation or an accidental injury which occurs while covered under this Plan;

E. charges for the treatment of refractive errors, including but not limited to eye exams, glasses, contact lenses (or their fitting), radial keratotomy procedures and other forms of surgery and any vision services and supplies not rendered in connection with medical or surgical treatment for injury or illness above the limits shown in the Schedule of Benefits;

F. charges for, or in connection with, the care or treatment of any injury or illness due to insurrections, atomic explosions, war or any act of war; "war" includes armed aggression resisted by the armed forces of any country, combination of countries, or international organization, whether or not war is declared. An act of terrorism will not be considered an act of war; Terrorism is defined as premeditated, politically motivated violence perpetrated against noncombatant targets by subnational groups or clandestine agents, usually intended to influence an audience;

G. medical care or supplies for which:
   a. no charge was made; or
   b. no payment would be required if the covered individual did not have this coverage;

H. charges for intentionally self-inflicted injury or illness, including but not limited to suicide, attempted suicide, voluntarily taking of drugs (except for those taken as prescribed by a physician), the voluntary taking of poison, or voluntary inhaling of gas, unless such an injury results from a medical condition, physical or mental; This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

I. injury or illness resulting from the commission of or attempting to commit an assault or felony or to which a contributing cause was the covered person being engaged in an illegal act or occupation;

J. any treatment of obesity or weight reduction due to any cause whether recommended by a physician or not; except as required by the Patient Protection and Affordable Care Act (PPACA) under the medical plan preventative coverage;

K. charges for housekeeping, custodial, rest or domiciliary care; care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house or any similar facility or institution;

L. oral care and supplies which are used to change vertical dimension and/or closure or any treatment of teeth or nerves connected to teeth except as provided under Oral Surgery or any other dental services not specifically provided for under Covered Charges (except as allowed under any Dental Benefit the Employee may offer in addition to this Plan);

M. any expense or charge for the promotion of fertility including (but not limited to):

a. fertility tests
b. reversals of surgical sterilizations including, but not limited to reconstructions of vasectomy or reconstruction of tubal ligation
c. direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, embryo transfer, or G.I.F.T. (Gamete Intrafallopian Transfer)
d. surgery performed in an attempt to facilitate or enhance the potential for conception
e. any other fertility or infertility treatment;

N. acting as pilot or copilot of an ultralight airplane;

O. repair or replacement of prosthetic devices except as detailed under “Covered Medical Expenses”;

P. travel (mileage, lodging or meal cost) except as allowed under Ambulance and Organ Transplant coverages, whether or not recommended by a physician;

Q. charges for services of a provider who usually resides in the same household with the covered person or is related by blood, marriage, or legal adoption to the covered person or the spouse of the covered person;

R. services or supplies that are not for medically necessary care or for out-of-network charges that exceed reasonable and customary charges or charges not approved by a physician;

S. marital counseling, recreational, educational, or social therapy or training services, except those charges for the education and training of a diabetic to control the disease;

T. services related to sex transformations, sexual dysfunctions or sexual inadequacies including but not limited to sexual therapy and counseling, penile prostheses, or implants, and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency and all related diagnostic testing;

U. any form of non-medical self-care or self-help training and any related diagnostic testing;

V. developmental, educational, scholastic, or vocational services or training, including but not limited to treatment for scholastic improvement, vocational training, visual coordination, and motor coordination;

W. personal comfort items such as television, telephones, extra food trays, air conditioners, humidifiers, hot tubs, whirlpools, physical exercise equipment, even if such items are prescribed by a physician, except as specifically provided under Covered Medical Expenses;

X. nutritional supplements or vitamins, whether or not recommended or prescribed by a physician unless they are for the treatment of a diagnosed illness (including pregnancy) or injury;

Y. expenses incurred prior to effective date or after termination of coverage under this Plan;

Z. illness or injury covered by Worker's Compensation and/or illness or injury if it arises out of employment for pay, profit, or gain except as described under “Non-occupational Illness or Injury”;

AA. any treatment or physiotherapy on the muscles or vertebra which is not a surgical operation above the limits shown in the Schedule of Benefits unless approved in advance by the Plan Supervisor;

BB. professional, facility, or hospital charges to the extent they are allocable to scholastic education or vocational training or for confinements resulting from a local or state mandate (court-ordered);

CC. programs or confinements resulting from an arrest or citation for substance abuse and their related use; for care required while incarcerated in a federal, state, or local penal institution or required while in custody of federal, state or local law enforcement, unless otherwise required by law or regulation;

DD. services or supplies furnished by a provider acting beyond the scope of his license or is not a provider, as defined in this booklet;

EE. Service provided by a government agency to the extent that you are not charged for them, except as may conflict with state or federal law;

FF. any charges for services in connection with weak, strained, or flat feet, any stability or imbalance of the foot, or any metatarsalgia or bunion, unless the charges are for an open cutting procedure, in which case the reasonable and customary charges in connection with the surgery would be considered. Care of corns, bunions, callouses or toenails is covered when medically necessary because of diabetes or circulatory problems;

GG. treatment for learning disabilities, behavioral or conduct disorder conditions and hyperactivity beyond the period necessary to establish a diagnosis except as mentioned in the covered expenses;

HH. medical or dental claims resulting from a motor vehicle accident when any state-required vehicle insurance has lapsed, and the covered employee or individual was the driver;

II. any and all treatment of the Temporomandibular joint (TMJ) and other jaw related disorders and services directly attributable to the TMJ dysfunction above the lifetime maximum benefit provided by this Plan;

JJ. cost of materials used in any occupational therapy;

KK. telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, late fees, finance charges, sales tax, and transport fees;

LL. hospitalization for environmental changes and all related charges (including chelation therapy);

MM. preventative or routine care, including physicals, premarital examinations, and any other routine or periodic examinations except as required by the Affordable Care Act;

NN. massage therapy, hypnosis, or biofeedback, regardless of whether the services are rendered or recommended by a licensed/registered medical professional for any and all causes;

OO. any charges incurred in conjunction with treatment for nicotine use or nicotine addiction except as required by the Patient Protection and Affordable Care Act (PPACA);

PP. genetic testing unless it is for the purpose of determining the appropriate treatment of a diagnosed illness, screening (including but not limited to amniocentesis and chorionic villus sampling) unless it is for the purpose of determining the appropriate treatment of a diagnosed illness. Alpha Feta Protein testing will be covered as required by the Patient Protection and Affordable Care Act (PPACA); or

QQ. treatment of conditions due to hair loss or replacement of hair even if it is a result of medical treatment except when law requires payment under this plan (i.e. Women's Health and Cancer Rights Act of 1998);

RR. services received or supplies purchased outside the United States or Canada, unless you or a dependent is a resident of the United States or Canada, and the charges are incurred while traveling on business or for pleasure;

SS. stand-by charges of a physician unless medically necessary and physically present in the operating room;

TT. charges for services of a resident physician or intern rendered in that capacity;

UU. charges for services which any school system is required to provide under any law;

VV. charges for care, treatment, services or supplies that are not prescribed, recommended, and approved by the covered person's attending physician;

WW. claims not submitted with the Plan's filing limit deadlines as specified in "When to File Claim" under Claim Procedures section;

XX. benefits which are payable under any one section of this Plan shall not be payable as a benefit under any other section of this Plan. For example, if a benefit is eligible under both the Medical and Dental sections, and is paid under the Medical Benefit, the remaining balance will **not** be paid under the Dental Benefit;

YY. take home medication from the hospital;

ZZ. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas;

AAA. exams related to research screenings;

BBB. services received in an emergency room which is not Emergency care, except as specified in this booklet, this includes but is not limited to suture removal in an emergency room;

CCC. acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, and electromagnetic therapy;

DDD. physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, licensing or for any other purpose(s);

EEE. for any services provided to a participant not covered under the benefit booklet in connection with a surrogate pregnancy including but not limited to the bearing of a child by another woman for an infertile couple;

FFF. surgical treatment for gynecomastia;

GGG. treatment of hyperhidrosis (excessive sweating);

HHH. services for which the participant is responsible under the terms of this booklet to pay (copay, deductible, coinsurance);

III. human growth hormone for children born small for gestational age. It is only covered in situations when allowed by the Plan, Administrator when reviewed and deemed medically necessary through prior authorization;

JJJ. removal of wisdom teeth;

KKK. services received from an individual or entity that is not licensed by law to provide service as defined in this booklet. Examples include masseuses and physical therapist technicians;

LLL. for court ordered testing or care unless deemed medically necessary;

MMM. services received from a dental or medical department maintained by or on behalf of the Employer, mutual benefit association, labor union, trust or similar person or group;

NNN. charges that exceed any plan maximum allowable amount;

OOO. private duty nursing rendered in a hospital or skilled nursing facility;

PPP. manipulation therapy services rendered in the home as part of home health care;

QQQ. elective/voluntary abortions or fetal reduction surgery unless as described in the covered medical expenses;

RRR. treatment of sclerotherapy (varicose veins); telangiectatic dermal veins (spider veins) by any method;

SSS. Drugs or drug classes screened must reflect the member's medical history. Screening should only test for the drugs likely to be present, based on the participant's medical history or current clinical status. We will deny payment as not medically necessary if the drug screening does not reflect the participant's medical history. We may audit claims for drug screening reimbursement to confirm the presence of written orders for each test. Routine drug screening is not considered medically necessary;

TTT. Durable Medical Equipment not covered include but is not limited to air conditioners; ice bags/cold pack pump; raised toilet seats; rental of equipment if the participant is in a facility that is expected to provide such equipment; trans lift chairs; treadmill and tub chair;

UUU. Prosthetic appliances not covered include but are not limited to dentures (replacing of teeth or structures supporting the teeth); dental appliances; non-rigid appliances as elastic stockings; garter belts; arch supports or corsets; artificial heart implant; wigs (except as required by the Women's Health and Cancer Rights Act) and penile prosthesis in men resulting from disease or injury;

VVV. Orthotic devices not covered include but are not limited to orthopedic shoes; foot support devices (arch supports, corrective shoes unless they are an integral part of a leg brace); elastic stockings; garter belts; and other supplies not specifically made for the fitting;

WWW. Physical therapy expenses not covered include but are not limited to maintenance therapy; repetitive exercise to improve movement, maintain strength and increase endurance, range of motion and passive exercises that re not related to restoration of a specific loss of function; general exercise programs; diathermy; ultrasound and heat treatments for pulmonary conditions; diapulse and work hardening;

XXX. Occupational therapy expenses not covered include but are not limited to supplies; therapy to improve/restore functions that could be expected to improve as the participant resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns; soft tissue mobilization; augmented soft tissue mobilization; myofascial; adaptions to the home such as rampways; door widening; automobile adaptors; kitchen adaptation and other types of similar equipment;

YYY. Provider charges for consulting with participants by telephone, facsimile machine, electronic mail systems, or other consultation or medical management service not involving direct face to face care with the participant;

ZZZ. Surcharges for furnishing and/or receiving medical records and reports;

AAAA. Charges that are not documented in the provider records;

BBBB. Charges from an outside laboratory or shop for services in connection with an order involving devices; which are manufactured by the laboratory or shop, but which are designed to be fitted and adjusted by a Physician;

CCCC. Membership, administrative, or access fees charged by a provider, including but not limited to charge for educational brochures or calling a patient to provide their test results;

DDDD. Benefits payable under Medicare Part A and/or B or would have been payable if a participant had applied for Parts A and/or B, except as prohibited by federal law, for the purpose of calculating benefits if the participant has not enrolled in Medicare Part B, the plan will calculate benefits as if they are enrolled;

EEEE. Specialty Drugs as defined by the PBM (unless mandated by a regulatory authority);

FFFF. Charges for treatment services, supplies or prescription drugs designed or used to diagnosis, treat, alter, impact or differentiate a participant genetic make-up or genetic predisposition, including but not limited to genetic therapy;

GGGG. Any drug or biological that has received an "orphan drug" designation that has a single disease state indication except those treating a cancer diagnosis;

HHHH. All medications included on True Rx Health Strategist's medications list regarding True Codes.

It is this plan’s intent to comply with the Patient Protection and Affordable Care act (PPACA).

Coordination with Other Plans

This Employee Benefit Plan contains a non-profit provision coordinating it with other Plans, or third-party liability under which an individual is covered, or under which an individual's allowable expenses (medical or dental) are paid or could be paid (regardless of designation of medical or dental benefits or other type of damage award) so that the total benefits available will not exceed 100% of the allowable expenses. This is called "Coordination of Benefits" (COB).

Definitions

A. An "allowable expense" is defined as any necessary reasonable and customary expense covered, at least in part, by one of the plans or by third party liability (or arises from an incident making it an element of damage subject to third party liability). Not included are any expenses excluded by the Plan.

B. "Third Party Liability" as used in this section is defined as the liability of some third person or entity for any damages suffered by an individual covered by this Plan and included in such damages "allowable expenses" as above defined. "Third Party Liability" as defined is intended to and shall include any situation where the covered individual is caused harm, injury, illness, or damage because of the wrongful, negligent, intentional, or tortuous act (including strict liability) of the third party, thus making the third party liable to the covered individual. Liability may also be contractual, but this Plan shall be excluded from the definition along with any plan considered for coordination as below delineated and which form a separate coordination basis. This definition as used in this section is also intended and, shall encompass, all or most situations traditionally grouped under the heading of "subrogation" but in this Plan are dealt with as a coordination situation and governed by the express terms of this section even when advancements are made.

Plans and Third-Party Liability Considered for Coordination - "Plans" means these types of covered or benefits of an individual covered by this Plan:

A. coverage under a governmental program or provided or required by statute, including Part A and Part B of Title XVIII of the Social Security Act as amended (Medicare);
B. other group trusts or other health coverage/insurance of any nature or Employee health coverage; and
C. coverage as provided under the employee's or dependent's motor vehicle insurance medical provisions, under insured or uninsured motorist coverage, homeowners, or like insurance (hereinafter referred to as "Plan Type C").

Order of Benefit Determination - When a claim is made, the primary plan, or primary third party, shall pay its benefits without regard to any other plans or third-party liability. Once those benefits have been maximized, then if there are allowable expenses for which payment is available, the secondary plan or person liable would pay benefits to the extent allowed by the plan or the third-party liability. No plan or third-party liability would pay more than it would without this coordination provision.

The basis for establishing the order in which plans determine benefits shall be as follows:

A. a plan without COB provision will be primary to a plan with COB provision;
B. a plan which covers an individual as an Employee will be primary to a plan which covers an individual as a dependent;
C. a plan which covers an individual as a spouse/domestic partner will be primary to a plan which covers an individual as a dependent child;
D. if an employee is employed with more than one employer and is eligible for coverage under both employer plans, the plan that has employed the employee the longest will be primary;
E. for children's expenses, the primary plan is the plan of the parent whose birthday comes first in a calendar year. If a plan does not have this provision regarding birthdays, then the rule set forth in this plan will be determined in the order of the benefits;
F. if the birthday anniversaries are the same, then the plan which has covered the dependents the longest will be the primary plan;
G. third parties, under third party liability situations, as defined above and elaborated on below, and the Plan Type C's under "Plans and Third-Party Liability Considered for Coordination" are <u>always</u> primary and until all means are exhausted by the individual covered by this Plan to recover fully from the third party for all damages suffered (or responsible insurance) or the Plan Type C, then no amounts of any nature shall be required to be paid under this Plan. The bar of a statute of limitations shall permanently eliminate the Plan's responsibility to pay allowable expenses arising from the incident above described;
H. in the case of <u>separated or divorced parents</u>, the following will apply:
    a. if parents are divorced or separated, and there is a court decree which establishes financial responsibility for medical, dental, and health expenses for the child or requires that person to carry coverage/insurance, the plan or policy of the parent having the coverage/insurance obligation or primary health obligation or primary health obligation which covers

the child will be primary to any other plan covering the child.

b. if there is no such court decree, the plan which covers the child as a dependent of the parent with custody will be primary to the plan of the parent without custody;
c. if there is not such court decree and the parent with custody has remarried, the order of the benefits will be:
    1. the plan of the parent with custody
    2. the plan of the spouse of the parent with custody
    3. the plan of the parent without custody; and
d. an obligation to carry coverage/insurance shall always be considered controlling and primary, above any other health obligation.

When the above rules do not establish an order of benefits, the plan which has the covered individual (patient) the longest will be primary to the plan which has covered the individual for a lesser period.

Third Party Liability – Plan Type C

A. Plan Obligation – If recovery is obtained from a third party and/or Plan Type C, there shall continue to be no obligation on the part of the Plan to pay allowable expenses, as defined by this Plan and SPD, to or for the benefit of, any individual covered by this Plan until the amount of allowable expenses equals the gross amount paid by, or recovered from, a third party and a Plan Type C who or which is liable for those expenses because of third party liability, or under the terms of the Plan Type C contract. The obligation of this Plan to pay allowable expenses in such event shall begin with, and be limited to, those expenses exceeding Plan Type C and third-party liability gross payments and gross recovery, up to the maximum allowed under this Plan. This shall be the case even if the allowable expenses are less than Plan Type C gross payments and third-party liability gross recovery at the time of final resolution with Plan Type C entities and third parties. This shall also be the case if the Plan has made payment under agreement as below provided in this Section, and at the time of final settlement with Plan C entities and gross recovery from third parties, the allowable expenses are below Plan Type C payment and third-party recovery. It shall also be of no consequence that parts of gross recovery or gross payment shall be designated as payment for past, present, or future health expenses or receive any other designation (such as pain and suffering). All amounts paid, no matter how designated, shall be included in gross recovery or gross payments. Likewise, any amounts paid to or recovered by a spouse of the individual covered by this Plan (who has Plan C and/or third-party liability recovery rights), as consortium or on any other basis derivative of the covered individual, shall be attributed to the covered individual and combined with and included in the terms "gross payments" and "gross recovery" for the purposes of determining the timing of and level of payments to the covered individual for allowable expenses under this Plan. For clarification, the following example should be instructive.

   An individual covered by this Plan was injured when the car he was driving was negligently struck by another car. The driver of the other car has $50,000 of insurance coverage but is otherwise destitute. The individual covered by this Plan has his own automobile insurance with $100,000 underinsured motorist coverage. The injured individual recovers $50,000 from the third party, paid by the third party's insurance. The covered individual then recovers another $25,000 from his own policy as an under-insured recovery, and this is the designated totally for lost wages and pain and suffering. At the same time, the covered individual's wife is paid another $25,000 under the underinsured provision. At the time of the final payments, the covered individual's allowable expenses amounted to $30,000. The covered individual continued to incur medical expenses as a result of the accident after all payments and recoveries. These allowable expenses totaled to another $73,000.

   Under this example, the Plan had no obligation to pay any allowable expense arising from the automobile accident, until the allowable expenses had exceeded the $100,000 level. The covered individual received $50,000 from the third party, another $25,000 from the Plan Type C policy (his own insurance) even through it was a payment designated for the purposes other than medical, and the covered individual's wife received a consortium payment of $25,000, which was recovery. The Plan would then only be responsible for paying some portion of $3,000 of allowable expenses.

B. Monies Advanced - Monies may be advanced by this Plan for allowable expenses of individuals covered by this Plan Type C and/or third-party liability is available for those expenses. Advancement shall be at the sole discretion of the trustees of the Plan, but repayment of monies advanced shall be made in full under the terms of Agreement.

   Any advanced monies shall be subject to the following terms and any others the Plan trustees may impose in the discretion:

   a. any agreement must be signed by the covered individual, his spouse, parents, guardians, and his attorney;

b. the Plan administrator must be provided any and all information covered individual, or his attorney has concerning Plan Type C entitles; third parties who may be liable to the covered individual and/or is spouse, including name, address and telephone number; and information concerning any insurance of the third party that may be a source of recovery. This duty shall be a continuing one. This obligation shall exist whether or not money is advanced;

c. the Plan, Plan administrator, and its representatives shall have the right to contact the third party, Plan Type C entitles, and the third party's insurers for any reason, including but not limited to notifying them of the advancement of funds for allowable expenses and the interest of the Plan in any payments or recovery. This obligation shall exist whether money is advanced or not;

d. any monies paid to or recovered by the covered individual and his spouse from the Plan Type C entity, and the third party's insurance, or any other source, shall be paid first directly to the Plan to extent of the Plan advancements for allowable expenses. If, for any reason, such payments cannot be made directly to the Plan, then the Plan shall be a payee along with the covered individual, his spouse, and counsel on any payment or recovery from the Plan Type C, third party, or third party's insurance, or any other source of payment;

e. if, for any reason, direct and full payment for advanced allowable expenses has not been made to the Plan, the covered individual, guardian for such individual, his estate, spouse, other derivative entities or individuals, and his counsel, shall be constructive trustees of any funds received by them as a result of recovery or payment from third parties, third party insurance, or Plan Type C payments because of the incident giving rise to such recovery or payment to the extent that the Plan has advanced money for allowable expenses. The recovery or payments received, to the extent advancements were made, shall be the money and specific property of the plan. If recovery or payment has been by joint check with the Plan or Plan Trust a joint payee, then all other payees shall endorse the check and give the check in total to the Plan Administrator; the check shall be deposited with the Plan, and another check issued by the Plan Administrator jointly to the other payees in the full amount of the original check less the full amount of all funds advanced by the Plan as below provided, which shall be retained by the Plan. If the payment or recovery otherwise reaches the covered individual, spouse, guardian, estate, counsel, or other derivative entities or individuals, and money advanced has not been fully reimbursed, then, to the extent that such funds have not been reimbursed, the covered individual, spouse, guardian, estate, counsel, or other derivative entities or individuals shall first pay from funds in their hands the amount of the unreimbursed advancements (unreduced as hereafter provided) before any other monies are paid out for any other purposes. It is understood that all the terms hereinabove and below provided shall include payments made in error by the Plan, which should not have been paid because of the coordination rules of the SPD;

f. in addition to all other rights to Plan shall have to full recovery of advanced funds, the Plan shall have the right of offset against any other allowable expenses to be paid, presently or in the future, by the Plan to the covered individual or his dependents which may be payable by the Plan, whether arising from the third-party liability incident or otherwise. Consequently, if for any reason, the covered individual or his dependents or counsel are deemed by the Plan to have improperly refused or failed to reimburse advancements, then the Plan shall have the right to offset the unreimbursed advancements made hereunder against other present or future allowable expenses which would otherwise be paid but for the nonpayment of the advancements hereunder. Such offset shall continue until the Plan's advancements are fully satisfied; and

g. the plan shall be made absolutely whole by the individual covered, his spouse, and his counsel, and the right to full return and repayment for monies advanced shall be unreduced and undiminished by:
    1. any reduction for litigation or other expenses incurred by the individual covered, his spouse, or counsel for any reason including expenses incurred for recovery Plan Type C payments or third-party recovery;
    2. any attorney fees of any nature charged by counsel for the covered individual or his spouse for the recovery of the Plan's money or recovery in general;
    3. normal "subrogation deductions" under the law of any state or other jurisdiction including, but not limited to, reductions in repayment of medical expenses because of comparative fault or uncollectability of the full value of the covered individual or spouses claim against a third party or Plan Type C entity because of limited liability insurance for any other cause (for Indiana law see IC 35-51-2-19); or reduction as stated for litigation costs and attorney fees (for Indiana see IC 34-53-1-2); and
    4. any violation of the agreement or the terms herein provided shall subject the individual covered by the Plan and his counsel and spouse to damages to the Plan, actions in replevin, and action for attorney fees and litigation expenses of

every nature necessary for the Plan to recover the full funds advanced and any other damages suffered by the Plan including the right of offset as above provided.

The Agreement to be signed shall reflect these terms as well as any other terms thought appropriate to ensure the return of 100 cents on every dollar advanced by the Plan.

Efford of Covered Individual - An individual who has been injured or is ill or damaged, and who incurred allowable expenses as a result of such injury, illness, or damage, and has a Plan Type C claim and/or third-party claim, in order to qualify for any payment under this plan for such allowable expenses must exhaust all means to recover fully from the third party or Plan Type C for all damages suffered.

Burden of Proof - A covered individual under this Plan who has incurred allowable expenses as a result of accident or injury or condition which would give rise to third party liability or Plan Type C recovery, when submitting claims for allowable expenses, shall have the burden of proving, by clear and convincing evidence, that expenses paid after such an incident encompasses by this Section are not related to the incident.

Coverage - For further emphasis, this section is intended to cover myriad situations where third-party liability or Plan Type C recovery might come into effect including, but not limited to, automobile accidents, which would form a great number of the third-party liability cases; however, whatever situations are included under the definition of "Third Party Liability," this Plan shall <u>not</u> be primary.

Subrogation - The "Coordination with other Plans" section, above, is intended to embrace most, if not all, situations where normal subrogation provisions would apply, and the agreement for repayment of advancements made under that coordination section, along with its specific terms, shall take precedence over this section under third party liability and Plan Type C situations. However, this Plan shall always be subrogated to the rights of recovery of an individual covered by this plan, his heirs, guardians, executors, agents, or other representatives when it provides benefits resulting from accidental injury or illness, or other loss (hereinafter referred to as injury) to that individual. The rights of recovery to which the Plan shall be subrogated includes, without limitation, the injured person's rights to recovery:

a. against any person or entity that caused, contributed to, or is in any way responsible for, the injury;
b. against any person, insurance company, health care provider, or other entity that is in any way responsible for providing indemnification, coverage, compensation, or other payment as a result of the injury;
c. under no-fault, personal injury protection, financial responsibility, uninsured motorist, and underinsured motorist insurance;
d. under motor vehicle and wage loss reimbursement insurance;
e. under homeowners, renters, premises, and owners, landlords and tenant's insurance including medical reimbursement coverages; and
f. under group accident and health insurance, and athletic team, sporting event, school, club, and other specific risk insurance coverages or accident benefit plans.

The injured person and persons acting on his or her behalf shall do nothing to prejudice the Plan's subrogation rights and shall, when requested, provide the Plan with accident-related information, and cooperate with the Plan in the enforcement of its subrogation rights. If the Plan receives notice that it has or may be required to provide injury-related benefits to any person, it shall be entitled to assert a subrogation lien to against responsible entities, persons, insurers, and attorneys when, as necessary, to protect the rights of the Plan and its members and beneficiaries. Even though the Plan may request that a subrogation form must be signed by the injured person, the subrogation right of the Plan shall not be dependent upon the receipt by the Plan of such a form. However, the Plan has the right to hold all benefit payments until a signed subrogation form is received by the Plan.

The amount of the Plan's subrogation interest shall be deducted first from any recovery received by or on behalf of the injured person without regard to whether the recovery has been apportioned between medical or other damages without regard to whether full and complete recovery of damages has occurred. This Plan reserves the right to reduce the amount of its recoverable interest where, at the discretion of its fiduciaries, a reduction is in the best interest of the Plan and its participants and is warranted by the circumstances. The Plan is also entitled to recover any attorney fees that are charged in connection with any recovery unless the Plan agrees in writing to pay those expenses or fees. The Plan also reserves the right to initiate an action in the name of the Plan or in the name of the injured person to recover its subrogation interest. Nevertheless, it is understood that, except for the rights of this Plan to initiate an action to recover amounts advanced, the coordination section and its terms would govern almost all situations; however, if money is advanced to a covered individual and, unbeknownst to the Plan, another Plan as described in the coordination section was primary or third-party liability, or Plan Type C coverage was primary, then this section and its terms are intended to fill such gap, if any.

When to apply - It is recommended that an Employee's local Social Security Office be contacted for information concerning enrollment in Medicare at least 45 days before the month in which a family member can qualify for coverage under the Health Insurance Portion of the Social Security Act of the United States known as Medicare.

Who is eligible to apply - Medicare provisions have been changed by recent government rulings. These provisions will continue to be amended as government regulations change. This Plan will adopt those changes as they are mandated by amendments to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Social Security Act and the Social Security Act and Age Discrimination in Employment Act (ADEA). The following briefly explains how the most recent changes have affected this Employer-sponsored Employee Benefit Plan.

Effective January 1, 1987, the Consolidated Omnibus Budget Reconciliation Act (COBRA) mandated that employers remain the primary payers of medical care for disabled employees and their dependents from the time Medicare coverage begins until termination. However, only active employees and their dependents are included in the Medicare-as-secondary provisions. It does not apply to employees who become totally and permanently disabled and are terminated from employment. (See Termination of Coverage for further information.)

In order to implement these amendments, regulations have been handed down by the Equal Employment Opportunity Commission (EEOC) and the Health Care Financing Administration (HCFA).

This Plan will offer equal levels of medical coverage under the same conditions to all active employees without regard to age.

Important Notice About Your Prescription Drug Coverage and Medicare
This notice applies to all employees and dependents who are Medicare eligible or are preparing to become Medicare eligible.

1. Medicare prescription drug coverage is available to everyone with Medicare.
2. Your employer has determined that the prescription drug coverage offered by the Health Benefit Plan they sponsor is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays.
3. Read this notice carefully - it explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll.

You may have heard about Medicare's new prescription drug coverage and wondered how it would affect you. Your employer has determined that your prescription drug coverage with them is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.
People with Medicare can enroll in a Medicare prescription drug plan from October 15th through December 7th. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between October 15th through December 7th.

If you do decide to enroll in a Medicare prescription drug plan and drop prescription drug coverage sponsored by your employer, be aware that you may not be able to get this coverage back.
If you drop your coverage sponsored by your employer and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

A description of the Prescription drug program offered by your employer can be found in this Summary Plan Description booklet. In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage sponsored by your employer and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next October to enroll.

For more information about this notice or your current prescription drug coverage…
Contact our office for further information or call Dunn and Associates Benefit Administrators, Inc. (812) 378-9960 or (800) 880-9960. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You may also request a copy.

If you do not choose to enroll in the Medicare Part D program, you should <u>always</u> review the language in this Summary Plan Description booklet concerning your prescription drug coverage <u>before</u> the next period you can enroll in Medicare prescription drug coverage. Whether, on average for all plan participants, the plan is expected to pay out as much as the standard Medicare prescription drug coverage payment is re-evaluated from time-to-time.

For more information about your options under Medicare prescription drug coverage…
More detailed information about Medicare plans that offer prescription drug coverage was available in any "Medicare & You" handbook issued each year. All Medicare eligible individuals should receive a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & you handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Termination of Coverage

An Employee's Coverage - The coverage of any Employee will terminate on the date on which any of the following events first occurs:

a. the day of which employment terminates;
b. transfer to a class of employees not covered by the Plan;
c. the date the participant dies;
d. the day on which any required employee contributions are not paid;
e. the date the Plan terminates; or
f. the date the participant enters the Armed Forces, except when covered by USERRA.

"Ceasing active work" will be considered to be cessation of insurance. Insurance coverage may be deemed to continue for some of the coverages, up to the limits shown in the Schedule of Benefits, if you are **not** at work due to illness or injury.

If an Employee becomes totally disabled, then his eligibility date for termination of insurance will be determined from the date his continual disability commenced as follows (if required employee contributions are paid):

Employee Seniority	**Continuation of Eligibility Before Termination**
Up to five years	1st of month following 30 days
Over five years	1st of month following 60 days

At the end of the period determined by this table, the Employee's options for Continuation of Coverage (COBRA) for his health benefits, as explained in this booklet, will be available. If any Employee should become eligible for medical benefits under social security disability, then his benefits under this provision will terminate the date social security medical benefits commences.

Dependent Coverage - The coverage of any Dependent will terminate the end of the month on which any of the following events first occurs:

a. termination of eligibility as a Dependent. Dependent children will terminate at the end of the month in which they turn 26.
b. termination of the covered Employee's coverage for reasons other than attainment of the Lifetime Maximum Benefit;
c. failure to make any of the required contributions; or
d. when a Dependent child becomes covered for employee coverage.

Dependents will continue to be covered for disabled Employees as provided for above under "An Employee's Coverage".

Leave of Absence - Employees who are granted a formal leave of absence for any reason, other than the Family and Medical Leave Act of 1993, may continue coverage under the Plan in accordance to the Employer's personnel policy that is in force at the time of the leave. The Employee will be responsible for the employee portion of the premium during the leave. Family and Medical Leave Act of 1993 (FMLA): During any leave taken under the FMLA, the employer will maintain coverage under this Plan on the same conditions as coverage would have provided if the covered Employee had been continuously employed during the entire leave period.

This plan refers to the City of Greensburg personnel handbook for approved leave. Any additional approved leave beyond FMLA must be approved by the Board of Works, per the unpaid leave of absence policy in place at the time of the leave. A formal leave of absence is not necessary for an Elected Official which has held office for at least one day per year and paid any required premiums. Elected Officials are covered regardless of how many hours worked (per IC 36-4-7-2). In no case, may an employee or Elected Official continue medical coverage for more than 180 days after the last day actively worked. If the employee or Elected Official is unable to resume their duties after a leave of absence, then their continuation of coverage under COBRA are available.

Unused paid-time off, vacation, sick days, bank sick days, etc… are considered actively at work.

Upon an Employee's return to active employment following a leave of absence, coverage under this Plan will begin immediately with no waiting period.

Certificates of Prior Coverage Under the Plan - In 1996 the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was passed by Congress. Under HIPAA, all Employees and their Dependents who are actually covered by the Plan will automatically receive a Certificate of Group Health Plan Coverage ("Certificate") when they lose coverage under the Plan and upon the loss of coverage

should continuation of coverage under COBRA be elected. Additionally, all employees and their Dependents who lose coverage under the Plan may request a new Certificate at any time during the 24 months which follow loss of coverage. The Certificate will include information for both the covered employee and his Dependents unless the information for a Dependent is different from that of the covered employee, and in such case a separate Certificate will be issued for each such person.

The Certificate will be issued free of charge to the employee or Dependent and will show a new Employer or group health plan the period that the Employee or Dependent was covered by the Plan, including the waiting period served prior to the effective date of coverage. A person who receives a Certificate must provide the Certificate to his new group health plan in order for the new group health plan to credit the period that the person was covered by the Plan against the pre-existing condition exclusion waiting period of the new group health coverage, if any.

Recission of Coverage - As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuation of coverage due to fraud or intentional misrepresentation of material fact. A cancellation/discontinuation of coverage is NOT a rescission if:

1. It only has a prospective effect; or
2. It is attributable to non-payment of premiums or contributions.

Retired Public Safety Employees (Firefighters or Police Officers employed by the Employer):
A Public Safety Employee who retires on or after June 30, 1989, may elect coverage for himself, his spouse, and Dependents if the following criteria is met:

a. completed twenty (20) years of creditable employment with a public employer, ten (10) years of which must have been completed with the City of Greensburg immediately prior to his retirement date;
b. not eligible for Medicare on his retirement date;
c. filed a written request to the City of Greensburg Board of Public Works and Safety within ninety (90) days after the employee's retirement date or the date he begins receiving disability payments; and
d. employee agrees to make timely payment of an amount determined by the Employer, but not more than the total amount paid by the Employer and an active Employee for equivalent coverage.

The surviving spouse and Dependents of a Public Safety Employee who dies while in active service or after retirement may continue coverage for himself and his Dependents.

In order to continue coverage, the spouse or Dependent must file a written request for coverage on a form satisfactory to the Employer within ninety (90) days after the employee's death. He must also make timely payment of an amount determined by the Employer, but not more than the total amount paid by the Employer and an active Employee for equivalent coverage.

The person's coverage under this section ends on the earliest of the following:

a. the date the person becomes eligible for Medicare;
b. the date the Employer terminates health coverage for active Public Safety Employees;
c. the first day of the month for which a person fails to make timely payment of premiums; or
d. the date group health benefits become available through a new employer.

AND in addition, in the case of a surviving spouse:
a. the date of the spouse's remarriage; or
b. the date group health benefits become available through surviving spouse's own employment;

AND in addition, in the case of a Dependent:
a. the date the Dependent fails to meet the definition of a Dependent

Retired Employees (Other Than Public Safety Employees):
A retired Employee (other than Public Safety Employees) who retires on or after June 30, 1986, may elect coverage for himself, his spouse, and Dependents if the following criteria is met:

a. completed twenty (20) years of creditable employment with a public employer, ten (10) years of which must have been completed with the City of Greensburg immediately prior to his retirement date;
b. completed fifteen (15) years of participation in the Employer's retirement plan on or before his retirement date;
c. reached age 55;
d. not eligible for Medicare on his retirement date;
e. filed a written request to the City of Greensburg Board of Public Works and Safety within ninety (90) days after the employee's retirement date or the date he begins receiving disability payments; and
f. employee agrees to make timely payment of an amount determined by the Employer, but not more than the total amount paid by the Employer and an active Employee for equivalent coverage.

The person's coverage under this benefit ends on the earliest of the following:

a. the date the person becomes eligible for Medicare;
b. the date the Employer terminates health coverage for active Employees;
c. the first day of the month for which a person fails to make timely payment of premiums; or
d. the date group health benefits become available through a new employer.

AND in addition, in the case of a surviving spouse:

a. the date of the spouse's remarriage; or
b. two (2) years after the death of the Employee

AND in addition, in the case of a Dependent:

a. the date the Dependent fails to meet the definition of a Dependent

USERRA Rights & Coverage

Continuation of Coverage - If a covered employee is absent from a position of employment with the Employer by reason of Service in the Uniformed Services, such covered employee and his or her covered Dependents shall be entitled to elect to continue coverage under the Plan for a period equal to the lesser of (1) the twenty-four (24) month period beginning on the date on which such covered employee is absent from employment with the Employer by reason of Service in the Uniformed Services; or (2) the day following the date on which the covered employee fails to apply for or return to a position of employment with the Employer as determined pursuant to USERRA Section 4312(e).

Cost - If a covered employee and/or the covered Dependent(s) of such covered employee elects continuation coverage, such covered employee and/or covered Dependent(s) shall be required to pay 102% of the full premium cost for such coverage; provided, however, if such covered employee's Service in the Uniformed Services is for a period of fewer than thirty-one (31) days, such person(s) shall not be required to pay more for such coverage than is otherwise required for Covered Persons as described under "Funding" in the General Information section of this document.

Coordination with COBRA - A covered employee who is absent from work by reason of Service in the Uniformed Services may be eligible for continuation coverage as described in the Continuation of Coverage (COBRA) section of this document. The continuation coverage provided in this section shall not limit or otherwise interfere with those COBRA rights detailed; provided, however, any continuation coverage provided under this Article shall run concurrently with any continuation of coverage available under COBRA.

Waiting Periods and Exclusions upon reemployment - Notwithstanding any other provisions, a covered employee and his or her covered Dependents whose benefit coverage is terminated by reason of Service in the Uniformed Services, shall not be subject to any exclusions or waiting period upon reinstatement of such coverage following Service in the Uniformed Services; provided however, the above shall not apply to any condition determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of Service in the Uniformed Services.

Rights, Benefits and Obligations - The covered employee who is absent from employment with the Employer by reason of Service in the Uniformed Services shall be considered on furlough or leave of absence while performing such service and shall be entitled to such other rights and benefits as are generally provided by the Employer to employees having similar status and pay who are on furlough or leave of absence; provided however, a covered employee who knowingly provides written notice of intent not to return to employment at the Employer shall cease to be entitled to such rights and benefits. Furthermore, a covered employee who is absent from employment with the Employer by reason of Service in the Uniformed Services shall be permitted to apply any accrued paid vacation, annual or similar leave prior to the commencement of such Service in the Uniformed Services.

Continuation of Coverage

In compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and technical updates in 1988, 1989 and 1997, all eligible Employees and Dependents covered by this Plan are eligible for "Continuation of Coverage" upon termination of coverage under this Plan. COBRA does not apply to any Life, AD&D or Weekly Indemnity (short-term disability) benefits that may be offered by this Employer.

A **Qualified Beneficiary** is an Employee or Employee's spouse or dependent child who, on the day before a qualifying event, is covered by the Employer's group health plan. A qualified beneficiary also includes a covered Employee's newborn child or children placed for adoption with the covered Employee during the continuation period. As an Employee covered by your Employer-sponsored group health plan, you have the rights to choose this continuation of coverage if you lose your group health coverage because of voluntary or involuntary termination of employment (except for termination for "gross misconduct") or reduction of hours to fewer than the number required for plan participation.

As the spouse or dependent child of an Employee covered by the Employer-sponsored group health plan, you have the right to choose continuation of coverage under the plan if you lose your group health coverage for any of the following reasons:

a. the death of the Employee;
b. a termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment;
c. divorce or legal separation;
d. the Employee becomes entitled to Medicare benefits; or
e. you cease to be a dependent as defined under the plan.

As a retiree (or a retiree's spouse or child) you have the right to continuation coverage if you have a substantial loss of coverage within one year before or after the Employer becomes subject to a Title XI bankruptcy proceeding. Benefits may be continued for up to 18 months for termination of employment or reduction of hours. For all other qualifying events, benefits may be continued for up to 36 months.

Social Security Administration/Railroad Disability - If the Social Security Administration/Railroad Retirement Board determines that you, or a covered dependent, were or became totally disabled at any time during the first 60 days of COBRA coverage, existing coverage for the disabled person may be extended an additional 11 months, for a total of 29 months. To qualify for the extension, you must submit a copy of the Social Security/Railroad Retirement Disability Determination notice within 60 days of the determination date to Dunn and Associates Benefit Administrators. The premiums during the extended 11 months would be at a substantially higher rate than for the initial 18-month period.

Cost of Coverage - This "Continuation of Coverage" will be effective upon application and payment of the required premium. Premium is due on a month-to-month basis and should be paid on the first day of the month for which coverage is requested. The premium must be received within a 30-day grace period or coverage will be canceled. Once the coverage is canceled, it cannot be reinstated. If continuation of coverage is elected, payment for continuation coverage provided during the period preceding the election must be made within 45 days of the date of election. The premium is based on the average monthly cost of providing the identical benefits to any active employee. Each year when the Plan renews coverage, your premium will be adjusted for any changes in cost for active employees. Information can be obtained from the Employer concerning application procedures and the amount of premium. If you do not choose continuation of coverage, your group health insurance coverage will end. If you choose continuation of coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated active employees and family members. The coverage will begin on the date the group health coverage would otherwise have ended.

Termination of Coverage

The continued coverage will be available unless:

a. the COBRA participant fails to make the required premium payment on time;
b. the covered individual becomes entitled to Medicare;
c. the employer-provided plan ceases to be offered to active Employees;
d. the period for COBRA continuation coverage terminates; or
e. The person on continuation coverage due to disability is no longer disabled.

COBRA and Pre-Existing Conditions - This plan will not deny any claims due to a pre-existing condition. Proof of prior coverage is no longer required by this plan.

Notification and Election - The Plan Supervisor has 14 days from the time it is notified of an employee's death, termination of employment, reduction of hours, a Dependent's Medicare entitlement or the Employer's bankruptcy (for eligible retirees) to notify the Employee and his Dependents of their COBRA rights. If a Dependent becomes ineligible under this Plan due to age, divorce or separation, it is the Employee's responsibility to notify this Employer or Plan Administrator within 60 days of the event. The proper forms for application for COBRA "Continuation of Coverage" benefits will then be issued. A beneficiary will have no less than 60 days from the date of notification of COBRA rights or termination of benefits, whichever is later, to elect the continued coverage. To continue coverage, a beneficiary must send written notice to continue benefits under COBRA to the Plan Supervisor before the end of that 60-day period. Should you become incapacitated during the election period, and have no spouse to act on your behalf, time will stop regarding the election period and will resume only when you regain the ability to elect coverage, or an administrator is appointed to handle your affairs. You do not have to show that you are insurable to choose continuation coverage. However, under the law you may have to pay all or part of the premium for your continuation coverage. The law also says that, at the end of the 18-month or 36-month continuation coverage period, you must be allowed to enroll in a conversion health plan if a conversion is included in the Plan. If you have any questions, please contact Dunn and Associates or your Employer. If you or your spouse have changed addresses, please notify your Employer or Dunn and Associates. All notices will be sent to the last known address.

Recission of Coverage - As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuation of coverage due to fraud or intentional misrepresentation of material fact. A cancellation/discontinuation of coverage is NOT a rescission if:

1. It only has a prospective effect; or
2. It is attributable to non-payment of premiums or contributions.

COBRA Continuation of Coverage - **Important.** Read this entire provision to understand a Covered Person's COBRA rights and obligations. The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. This summary provides a general notice of a Covered Person's rights under COBRA but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You, or Your Dependents as required.

The COBRA Administrator for this Plan is: Dunn & Associates Benefit Administrators, Inc.

Introduction - Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant. A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA. Generally, You, your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA Continuation Coverage for Qualified Beneficiaries - The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what "Qualifying Event" is experienced as outlined below. An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.) The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from Your spouse	up to 36 months

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child stops being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA continuation coverage for Retired Employees and their Dependents is described below:

Qualifying Event	Length of Continuation
• If You are a Retired Employee and Your coverage is reduced or terminated due to Your Medicare entitlement, and as a result Your Dependent's coverage is also terminated, your spouse and Dependent Children will also become Qualified Beneficiaries.	up to 36 months
• If You are a Retired Employee and Your employer files bankruptcy under Title 11 of the United States Code, this may be a Qualifying Event. If the bankruptcy results in Loss of Coverage under this Plan, then the Retired Employee is a Qualified Beneficiary. The Retired Employee's spouse, surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.	
➢ Retired Employee	Lifetime
➢ Dependents	36 months

Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

General Provisions

Amendments - The Plan Administrator reserves the right to amend the Plan in order to add or delete any Plan benefit, or otherwise change the terms of the Plan at any time without prior notice to Employees. The Employees will be notified in writing within 120 days of the change in compliance with state and federal requirements.

Assignments - The Plan will pay any benefits accruing under this Plan to the Employee unless the Employee assigns the benefits to a hospital, physician or other provider of service furnishing the service. No assignment, however, shall be binding on the Plan unless the Plan Supervisor is notified in writing of such assignment prior to payment hereunder.

Cessation of Benefits - If the Group policy is terminated, or if it is amended to terminate the health coverage of the class of which the Employee or his Dependents are members, then no benefits will be payable under the Plan for any charges, fees or expenses incurred on or after the date of termination.

Change or Discontinuance of Plan - It is hoped that this Plan will be continued indefinitely, but as is customary in group plans, the right of change, modification or discontinuance at any time must be reserved. The Employer will promptly give notice of any such changes to the Employees affected.

Clerical Errors/Misstatements - Neither clerical error in keeping records pertaining to the coverage, nor delays in making entries thereon, shall invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated, but upon discovery of such error or delay an equitable adjustment shall be made. If any facts relevant to the existence of amount of coverage shall have been misstated, the true facts will determine whether or not, and how much, coverage is in force. Any material misrepresentation on the part of the Employee in making application for coverage, or any application for reclassification of that coverage, or for benefits under this Plan shall render coverage voidable by the Plan Supervisor.

Compliance with Contract Provisions - Failure of the Insurance Company, the Plan Administrator, or the Plan Supervisor to insist upon compliance with any given provision of the group contracts at any given time will not affect its right to insist upon compliance with such provision at any other time.

Conformity with Law - If any provision of the Plan is contrary to any state, federal or other law to which it is subject, the provision is changed to meet the law's minimum requirement.

Contract - This booklet describes the principal features of the Employee Benefit Plan. The complete terms of the Plan are set forth in the Master Plan Document and the group contract issued by the Insurance Company to the policyholder (the Employer). The policies and documents are on file in the office of the Plan Administrator and are open to inspection at any time during regular business hours.

Employee Booklets and Identification Cards - This Summary Plan Description (SPD) will serve as the Employee Booklet to summarize the essential features of the Plan's coverage. Employees will all receive identification cards showing the Plan Supervisor's address and phone to provide coverage and benefit information.

Facility of Benefit Payment - Whenever payments which should have been made under this Plan have been made under any other plans, the Plan shall have the right, to pay over to any organizations making such other payment any amounts it shall determine to be valid. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan Supervisor shall be fully discharged from liability under the Plan.

Free Choice of Physician/Examination - The Employee and his Dependents shall have free choice of any qualified physician or surgeon and the physician-patient relationship shall be maintained.

HMO Option - If an Employee or one of his Dependents elect to be covered under any Health Maintenance Organization (HMO Plan) offered through this Employer or his dependent spouse's employer, that individual will be included in the medical benefits as detailed in the Coordination of Benefits section of this Plan. It will be the responsibility of the Employee to provide the information needed to coordinate the benefits. Health Maintenance Organization (HMO) means any group of health care providers who assume contractual responsibility to provide or assure delivery of ambulatory and inpatient health services to a voluntarily enrolled population that pays a fixed premium.

Maintenance of Employee Records - The Plan shall maintain records from which may be determined the names, addresses, and effective dates of all Employees participating in the Plan. The Plan shall, as often as is necessary, require verification as to Dependents entitled to receive benefits under the Plan.

Not Liable for Acts of Health Care Providers - Nothing contained in this Plan, or its documents shall confer upon an Employee or Dependent any claim, right or cause of action, either at law or in equity against the Plan Administrator, the Employer, or the Plan Supervisor for the acts of any health care provider in which he receives care or services under this Plan. Health care provider for the purposes of this provision includes but is not limited to hospitals, physicians, and pharmacies.

Physical Exams and Autopsy - The Plan Supervisor, at the direction of the Plan Administrator, reserves the right to have a physician of his choice examine a covered Employee or his Dependent whose condition, sickness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as it may reasonably require during consideration of a claim under the Plan. The Plan has the right to obtain this physician's opinion before payment of any benefits of the claim are made. The Plan may request a physician to perform an autopsy in case of death where it is not forbidden by law.

Pre-Existing Conditions - This plan will not deny any claims due to a pre-existing condition.

Pregnancy - Medical Expenses benefits are payable for pregnancy-related expenses of covered female covered participants on the same basis as any other illness while the individual is covered under the Plan. In regard to the maternity stay, this Plan authorizes a stay, for the mother and the child, of 48 hours for uncomplicated normal deliveries and a 96 hour stay for cesarean section. This stay may be changed only by the attending physician in consultation with the mother. Normally, the expenses must be incurred while the individual is covered under the Plan. However, if expenses are incurred after the coverage ceases, they will be considered for benefits if satisfactory evidence is furnished to the Plan Supervisor that the individual has been totally disabled since her coverage terminated.

Right of Recovery - If it is determined that benefits paid under this Plan should have been paid by any other plan, person or organization, the Plan Supervisor (acting as an agent for the Plan Administrator) will have the right to recover those payments from:

a. the person to or for whom the benefits were paid; and/or
b. the other companies or organizations liable for the benefit payment

The Plan also reserves the right to withhold the amount of such excess payment from future benefits payable to the covered person or his assignee.

Genetic Information Nondiscrimination Act of 2008 (GINA) - The new rule which apply for plans beginning on or after December 2, 2009, strictly regulate the collection and use of genetic information, including but not limited to genetic tests and family medical history. Genetic information may not be used for underwriting purposes or benefit determination.

Compliance with HIPAA Nondiscrimination Provisions - HIPAA prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors. These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability. Similarly Situated Individuals. It is important to recognize that the nondiscrimination rules prohibit discrimination within a group of similarly situated individuals. Under 29 CFR 2590.702(d), plans may treat distinct groups of similarly situated individuals differently, if the distinctions between or among the groups are not based on a health factor. If distinguishing among groups of participants, plans and issuers must base distinctions on bona fide employment-based classifications consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is based on relevant facts and circumstances, such as whether the employer uses the classification for purposes independent of qualification for health coverage. Bona fide employment-based classifications might include: full-time versus part-time employee status; different geographic location; membership in a collective bargaining unit; date of hire or length of service; or differing occupations. In addition, plans may treat participants and beneficiaries as two separate groups of similarly situated individuals. Plans may also distinguish among beneficiaries. Distinctions among groups of beneficiaries may be based on bona fide employment- based classifications of the participant through whom the beneficiary is receiving coverage, relationship to the participant (such as spouse or dependent), marital status, age or student status of dependent children, or any other factor that is not a health factor.

Exception for benign discrimination: The nondiscrimination rules do not prohibit a plan from establishing more favorable rules for eligibility or premium rates for individuals with an adverse health factor, such as a disability. See 29 CFR 2590.702(g).

Plan Status - The Trust believes this plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a non-grandfathered health plan means that plan may include certain consumer protections of the Affordable Care Act, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Dunn & Associates. [you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.]

This Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Dunn & Associates. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator. This plan's intent is to comply with all necessary provisions of the Patient Protection and Accountable Care Act.

OTHER FEDERAL PROVISIONS

Family and Medical Leave Act (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee can choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken, and no new pre-existing requirements will be imposed. For more information, please contact Your Human Resources or Personnel office.

Qualified Medical Child Support Orders Provisions - A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process. The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

Newborns and Mothers Health Protection Act - Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier

than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent Children in cases of adoption or Placement for Adoption as required by state and federal requirements.
- Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).

Fraud - Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive). These actions will result in denial of the Covered Person's claim or termination from the Plan and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity should call Dunn & Associates. All calls are strictly confidential.

It is this plan's intended to comply with the Patient Protection and Affordable Care Act (PPACA).

Privacy Provisions

Use and Disclosure of Protected Health Information under HIPAA Privacy and Security Regulations - This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI. This Plan shall Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations. The Plan Sponsor shall use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;
- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Benefits Specialist and Director of Human Resources - This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification - is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) - means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) - is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set - means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure - is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) - is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations - are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information - is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment - means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor - means Your employer.

Plan Administrative Functions - means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing, and monitoring.

Privacy Official - is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) - is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment - is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use - means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

Claims Appeal & Review Procedures

When to Appeal - When a claim is denied in whole or in part, you or your authorized representative will have 180 days following receipt of an adverse benefit decision to appeal the decision.

Appeal Process - To appeal a denied claim (in whole or in part), send a written request to the Plan Supervisor along with the reason you think claim should be reviewed. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Appeals will be handled by an appropriate person who is neither the person who made the original claims decision nor subordinate to that original decision maker. If a claim involves a medical judgment (including whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in that judgment, but not the same person (or a subordinate of the person) who has consulted on the initial decision.

You will be notified of the decision not later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received.

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

Urgent Care Claims: You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 72 hours after the appeal is received.

Notice of Appeal Determination - For all appeals, the Plan Supervisor will review your request and notify you in writing of its decision. A notice of adverse appeal will include:

a. the specific reason(s) for the adverse claim decision;
b. a reference to pertinent Plan provision, internal rules, guidelines, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
c. if the denial is based on medical necessity or experimental treatment, an explanation of the scientific of clinical judgment used in making the decision (or a statement that an explanation will be provided free of charge upon request);
d. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all other relevant documents; and
e. a statement informing the claimant about the right to bring a civil action under state and federal requirements.

Legal Action - A claimant who disagrees with the decision after an appeal may have the right to bring a civil action under section state and federal requirements. No action at law or in equity may be brought to recover under this Plan: (1) if the claimant fails to exhaust the Claims Appeal and Review Procedure; or (2) before final denial of a claim in accordance with that procedure; or (3) later than three years after the date the claim is finally denied.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan. If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.

- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

Appeals Procedure for Adverse Benefit Determinations- If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- Covered Persons must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the EOB form five days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records, and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will consider all comments, documents, records, and other information submitted that relates to the claim. This would include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, Covered Persons will receive written notification letting them know if the claim is being approved or denied. The notification will provide Covered Persons with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- Covered Persons or their Personal Representative must submit a written request for a second review within 60 calendar days following the date received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal five days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records, and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time as the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will consider all comments, documents, records, and other information submitted that relates to the claim that either was not submitted previously or was not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has

obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file a suit under state and federal requirements after they have completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to:
Send appeals to
Dunn & Associates Benefit Administrators, Inc.
PO Box 2369
Columbus, IN 47202-2369

Time period for making decision on appeals - After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.
The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

Right to external review - If after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the Adverse Benefit Determination is based on:

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services; or
- As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Dunn & Associates or Your employer fail to respond to Your appeal within the timelines stated above. You may request an independent review of the Adverse Benefit Determination. Neither You nor Dunn & Associates or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If you wish to pursue an external review, please send a written request to;

Requests should be sent as stated above to:
Send appeals to
Dunn & Associates Benefit Administrators, Inc.
PO Box 2369
Columbus, IN 47202-2369

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, when applicable; (4) the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided with more information about the external review process at the time we receive your request. All requests for an independent review must be made within four (4) months of the date you receive the Adverse Benefit Determination. You, your treating Physician, or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by Dunn & Associates and has no material affiliation or interest with Dunn & Associates or Your employer. Dunn & Associates will choose the IRO based on a rotating list of approved IROs. In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO Within applicable timeframes of Dunn & Associates receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by Dunn & Associates and/or your employer in making a decision on the case; and
- all other information or evidence that You or Your Physician has already submitted to Dunn & Associates or your employer.

If there is any information or evidence you or Your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and Dunn & Associates will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law. The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and Dunn & Associates and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure. You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding your external appeal rights and the independent review process.

Legal Actions following appeals - After completing all mandatory appeal levels through this Plan, Covered Persons have the right to further appeal Adverse Benefit Determinations by bringing a civil action under state and federal requirements. No such action may be filed against the Plan after three years from the date the Plan gives the Covered Person a final determination on their appeal.

Physical examination and autopsy - The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

Right to request overpayments - The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person, or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Get a copy of health and claims records.

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records.

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say “yes” if you tell us, you would be in danger if we do not.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we've shared information.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive.
- We can use your health information and share it with professionals who are treating you.
  Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization.
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
  Example: We use health information about you to develop better services for you.

Pay for your health services.
- We can use and disclose your health information as we pay for your health services.
  Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer this plan
- We may disclose your health information to your health plan sponsor for plan administration.
  Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues.
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research.
We can use or share your information for health research.

Comply with the law.
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director.
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests.
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions.
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice.
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Dunn and Associates Benefit Administrators, Inc.
P.O. Box 2369 - Columbus, IN 47202-2369
(812) 378-9960 or (800) 880-9960
Fax: (812) 378-9967
www.dunnbenefit.com

DUNN
& Associates
BENEFIT ▪ ADMINISTRATORS ▪ INC.

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 1

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: January 1, 2018

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated in the document.

Page: 5
Section: Preferred Provider Organization
Description: The following section has been updated;

Preferred Provider Organizations (PPO's) are networks of health care professionals that are contracted to accept a negotiated reasonable and customary fee as the covered amount for specific services. These preferred providers will file claims directly with the Plan Supervisor and have agreed not to "balance bill" an eligible insured for the amount of the charge above the negotiated fee schedule. The Primary PPO for this Plan is **Encircle/Encore Health Network.**

All providers contracted with Encircle/Encore or directly with Dunn and Associates will be considered "In-Network" Providers. Covered expenses incurred by an "In-Network" provider (i.e. hospital or physician) will be covered at a higher rate than "Out-of-Network" Providers (providers **not** listed as a participating provider of the Encore Network). See the Schedule of Benefit within this Summary Plan Description booklet for additional information and exceptions to this payment process.

An updated list of Encircle/Encore providers can be obtained from the Human Resources Department of this Employer, the Plan Supervisor, or by visiting Encore's web site at **www.encorehealthnetwork.com.** Encore can also be reached by phone **at 888-446-5844.**

Referrals
Referrals to an Out-of-Network provider are covered as Out-of-Network services, supplies and treatment. It is the responsibility of the covered person to assure services to be rendered are performed by In-Network providers in order to receive the In-Network provider level of benefits.

Exceptions
The following listing of exceptions represents services, supplies or treatments rendered by an Out-of-Network provider where covered expenses shall be payable at the In-Network level of benefits:

a. While confined to an In-Network provider hospital, the In-Network provider physician requests a consultation from an Out-of-Network provider.

b. Covered person is outside of the state of Indiana for business or personal reasons when expenses were incurred. *Since it is not always possible to determine this situation by looking at a claim submitted by the provider, it is the covered person's responsibility to notify the Plan Supervisor.*

c. When a covered dependent resides outside the service area of the Preferred Provider Organization, for example a full-time student, covered expenses shall be payable at the In-Network provider level of benefits

Additional Preferred Provider Organizations may be utilized in order to optimize coverage areas; When this occurs, the covered charges will be paid at the "In-Network" rate. It should not be assumed that covered expenses incurred by these providers will always be paid at the "In-Network" rate since providers could be free to become non-participating providers at any time.

Out-of-network claims will be reimbursed at the negotiated rate through direct contract if mutually agreed upon by the plan and the provider or reimbursed by a percentage of Medicare allowed rate. For confirmation of the allowed rates, contact the Plan Supervisor.

Note that providers are free to become non-participating providers at any time; therefore, it is the covered person's responsibility to ensure providers are still in the Encore network prior to having services rendered.

Services received at Columbus Specialty Surgery Center, Tax ID# 45-4115316 located at 2425 North Park Dr. Suite 20 Columbus, Indiana will be considered non-covered benefits under this plan. Payment for all expenses billed by this facility will be the responsibility of the participant.

If a claim is processed utilizing a designated PPO fee schedule, Reasonable and Customary (R&C) limits will not be applied to the claim. The PPO Fee schedule will override the R&C fee schedule.

Decatur County Memorial Hospital and St. Francis Hospital will be paid at the top tier in-network rate. (Same as Encircle).

Page: 6-7
Section: The Pre-Utilization Program
Description: The following section has been updated;

SERVICES REQUIRING PRE-UTILIZATION REVIEW
Clinix must be called PRIOR to the following services being rendered (within 48 hours after services are rendered if emergency) to receive maximum benefits payable under the plan:

Hospital Admissions – All inpatient hospital admissions greater than 18 hours require pre-utilized review. Maternity stays are excluded from this requirement unless the mother or baby remains in the Hospital for more than 48 hours following a normal delivery or for more than 96 hours following a cesarean section.

Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. *However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).* In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Outpatient Surgical Procedures – Any outpatient procedures requiring the use of an operating room or surgery center.

MRI's (outpatient only) – Outpatient Magnetic Resonance Imaging (MRI) procedures.

Home Health Care – Items and services provided as needed in patients' homes by a home health agency (HHA) or by other ~~under~~ arrangement made by a Home Health Agency.

Durable Medical Equipment (DME) – Medical equipment which is not disposable (i.e. is used repeatedly and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth.

Pregnancies – Clinix should be notified when you become pregnant. Inpatient maternity stays of no more than 48 hours following a vaginal delivery or 96 hours following a cesarean section are excluded as mentioned above.

Therapy – Physical, Occupational and Speech Therapy (outpatient basis only).

Cancer Care – Cancer care includes but is not limited to chemotherapy, radiation, and surgical removal.

Sleep Studies – Contact Clinix prior to scheduling sleep study procedures.

PET Scans (outpatient only) – Outpatient Positron Emission Tomography (PET) scans.

Dialysis – Home and Facility Outpatient Dialysis.

Hospice Care – Services provided by a health care facility or program providing medical care and support services, such as counseling, to terminally ill persons and their families.

Skilled Nursing Care – Around-the-clock nursing and rehabilitative care that can only be provided by, or under the supervision of, skilled medical personnel.

Page: 10
Section: Schedule of Benefits
Description: The following section has been revised;

COMPREHENSIVE MEDICAL BENEFITS (Employee and Dependents)

BENEFIT DESCRIPTION	IN-NETWORK DCMH/St. Francis/Encircle	TIER 2 IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Deductible (per calendar year)				In- and Out-of-network deductibles accumulate separately. Deductible applies to all covered expenses unless otherwise stated under Special Conditions or elsewhere in this document.
Individual	No deductible	$750	$1,500	
Family	No deductible	$1,750	$3,500	

BENEFIT DESCRIPTION	IN-NETWORK DCMH/St. Francis/Encircle	TIER 2 IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Covered Expenses	80% no deductible	70% after deductible	60% after deductible	Unless otherwise stated in the Schedule of Benefits or elsewhere in the Summary Plan Description booklet.
Coinsurance Limit (per calendar year)				In- and out-of-network limits do not apply towards each other. After the coinsurance limit has been met, covered expenses are payable at 100% of reasonable and customary for the remainder of that calendar year. Coinsurance limits include applicable copays.
Individual Medical	Included in in-network limit	$1,250	$2,500	
Family Medical	Included in in-network limit	$1,750	$4,000	
Individual Rx	Included in in-network limit	$500	$500	
Family Rx	Included in in-network limit	$1,000	$1,000	
Total Out-of-Pocket (per calendar year)				In- and out-of-network limits do not apply towards each other. The out-of-pocket limit includes deductible, medical and rx coinsurance and any applicable copays.
Individual	Included in in-network limit	$2,500	$4,500	
Family	Included in in-network limit	$4,500	$8,500	
SPECIAL CONDITIONS				
AccuDoc Facilities (Greensburg/Batesville & Harrison, OH)	100% no deductible visits and labs. Other services 80% after deductible.	Not applicable	Not applicable	Additional services are available at AccuDoc Facility locations only. $20 xray copay; $5 allergy shot copay.
Emergency Care				
Facility	$150 copay then 80% no deductible	$250 copay then 70% no deductible	$250 copay then 70% no deductible	
Physician	80% no deductible	70% after deductible	70% after deductible	

BENEFIT DESCRIPTION	IN-NETWORK DCMH/St. Francis/Encircle	TIER 2 IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Ambulance	80% no deductible	70% after deductible	60% after deductible	
Laboratory Expenses	80% no deductible	Designated Facility, Accu Doc, Quest Labs – 100% no deductible Other Facilities – 70% after deductible	60% after deductible 60% after deductible	Designated draw sites include all Quest/LabOne sites, AccuDoc Urgent Care sites, MidAmerica Labs and CRH Labs.
Cardiovascular Care	80% no deductible	Premier Healthway Heart Program 100% no deductible All other 70% after deductible	60% after deductible	Premier Healthway Heart Program at St. Francis is a designated Facility. You must identify yourself as part of the Premier Healthway Program by showing your insurance card sleeve.
Telemedicine	100% no deductible. There is no cost to you the patient for services received through Telemedicine services. See comprehensive medical benefits section of the Summary Plan Description booklet.			

Page: 38
Section: Comprehensive Medical Benefits
Description: The following section has been added:

TELEMEDICINE SERVICES – the use of a telephone or any other means of communication for a consultation/treatment from a Physician for acute care services.

Page: 41
Section: Comprehensive Medical Exclusions & Limitations
Description: The following section has been removed:

HH. charges for pregnancy, childbirth or related medical conditions other than for the employee or the covered spouse of the employee. (i.e. pregnancy related charges for dependent children not covered);

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Page: 50
Section: Termination of coverage
Description: The following section has been corrected:

Employee Seniority	Continuation of Eligibility Before Termination
Up to five years	1st of month following 30 days
Over five years	1st of month following 60 days

Signed this 12 day of January, 2018

TRUSTEE

TRUSTEE

TRUSTEE

WITNESS

DUNN & Associates

BENEFIT * ADMINISTRATORS * INC.

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 2

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: January 1, 2018

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated in the document.

Page: 7
Section: The Pre-utilization Program
Description: The following section has been corrected;

BENEFIT REDUCTION
If the procedures for Pre-utilization Review of Inpatient Hospital Admissions are not followed, covered charges will be subject to a $500 per admission penalty. This penalty will not count toward any deductible or co-insurance maximums.

Signed this 15 day of November, 2018

TRUSTEE

TRUSTEE

TRUSTEE

WITNESS

DUNN & Associates
BENEFIT ▪ ADMINISTRATORS ▪ INC.

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 3

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: January 1, 2017

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated in the document.

Page: 8-9
Section: Eligibility
Description: The following language is being clarified.

ELIGIBILITY FOR EMPLOYEES

Employees - All full-time salaried and hourly employees will be eligible for coverage. Full-time is defined as employees who are scheduled to work at least 30 hours per week at the usual place of business or the location which you are required to travel.

Elected Officials - All elected officials employed by this Employer will be eligible for coverage, except the following: City Council Members, City Attorney, persons appointed to City Boards or Commissions are not eligible for coverage. Elected Officials are covered regardless of hours worked and are not required to report hours worked (IC 36-4-7-2).

Variable Hour employees not regularly scheduled to work more than 30 hours per week are not eligible for coverage under this Plan.

No person may be covered both as an Employee and a Dependent of this Plan.

WAITING PERIOD

Employees - All full-time eligible employees will commence coverage on the first day of the month. Employees starting employment on the first day of the month will be effective immediately, employment beginning on any other day of the month will be effective the first of the following month.

Elected Officials - Elected Officials are covered the first day of employment.

Page: 50
Section: Termination
Description: The following language is being clarified.

LEAVE OF ABSENCE

Employees or Elected Officials who are granted a formal leave of absence for any reason, other than the Family and Medical Leave Act of 1993, may continue coverage under the Plan in accordance to the Employer's personnel policy that is in force at the time of the leave. The Employee will be responsible for the Employee's portion of the premium during the leave.

Family and Medical Leave Act of 1993 (FMLA): During any leave taken under the FMLA, the Employer will maintain coverage under this Plan on the same conditions as coverage would have provided if the covered Employee or Elected Official had been continuously employed during the entire leave period. The Employee will be responsible for the Employee's portion of the premium.

This plan refers to the City of Greensburg personnel handbook in place at the time of leave for approved Leave of Absence policy. A formal leave of absence is not necessary for an Elected Official which has held office for at least one day per year and paid any required premiums. Elected Officials are covered regardless of how many hours worked, and are not required to report hours worked (per IC 36-4-7-2).

If an Employee or Elected Official is unable to resume their duties after a leave of absence, continuation of coverage under COBRA will be offered.

Upon an Employee's return to active employment following a leave of absence, coverage under this Plan will begin immediately with no waiting period.

Signed this 25th day of June, 20 20

Joshua L. Marsh
TRUSTEE

Julie Noble
TRUSTEE

Brenda L Doerger
TRUSTEE

WITNESS

DUNN & Associates
BENEFIT ▪ ADMINISTRATORS ▪ INC.

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 4

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: January 1, 2021

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated in the document.

Page: 12
Section: Schedule of Benefits
Description: The following section has been updated.

BENEFIT DESCRIPTION	AT DECATUR COUNTY MEMORIAL HOSPITAL	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Prescription Drug Benefit			Not applicable.	
Retail Program (30-day supply)		Employee Pays		Deductible waived when network Pharmacy utilized.
Tier 1 Generic		$4		
Tier 2 Brand Preferred		$35		
Tier 3 Brand Non-Preferred		$75		If an insured elects not to purchase a generic drug when available and approved by the physician, the employee will be responsible for the applicable brand copay plus the difference in the cost of the generic and the brand name drug purchased.
Mail Order (90-day supply)				
Tier 1 Generic		$10		
Tier 2 Brand Preferred		$70		
Tier 3 Brand Non-Preferred		$150		
Specialty Rx* (30-day supply)		25% maximum of $200 without assistance		*Specialty Rx* *Coverage available only if the patient does not qualify for patient assistance program. Specialty Rx limited to 30-day supply.*

Page: 31-33
Section: Comprehensive Medical Benefits
Description: The following section has been updated.

A. **Prescription Drugs**
Prescription drugs will be reimbursed as shown in the Schedule of Benefits.

correction - should be 30-day
Network Pharmacies (34-day supply or 90-day supply)
A special program has been designed with **Network Drug Stores in this Employer's area** to provide cost savings to Employees participating in this Plan on most drugs purchased at their stores. In addition to the savings on the drug cost, it will not be necessary to file a claim for drugs purchased at a **Network Store.** On the Employee's first visit, he needs to identify himself as an Employee covered under this Employer Benefit Plan to receive the discounted price at the time of purchase. After the initial visit, their computer will identify the Employee and his dependents. Please refer to the Schedule of Benefits for the applicable copays.

Non-Network Pharmacies
No benefits are available for prescription drugs filled at non-network pharmacies.

Preferred Drug Program
This plan uses a Preferred Drug Listing compiled by a committee of clinical pharmacists and practicing physicians for their safety, quality, and effectiveness. The drugs on the Preferred Drug Listing are known as "Brand Name—Preferred". Please contact Dunn and Associates at (812) 378-9960 or (800) 880-9960 if you have any questions concerning the Preferred Drug Listing. In some cases, Dunn and Associates may ask a provider to contact the Pharmacy Benefit Manager (PBM) directly.

J-Code Program
Injected or Infused specialty medications administered through home health, an infusion center, physician's office, or out-patient based hospital unit may be reviewed by Prescription Benefit Manager for the most cost-effective infusion therapy. Based upon this review, the Plan will choose the most cost-effective site and source of treatment. At the point of the evaluation the administration of the medication will be processed based on the provisions of this plan for in-network and out-of-network levels of payment. The cost of the medication will not exceed the cost available through the Prescription Benefit Manager.

Off Label Drugs
Off Label use of drugs may be considered by this plan if all other treatment plans have been tried unsuccessfully. Prior authorization must be obtained through the Plan Supervisor. Medical necessity must be documented. Re-evaluation of the use of the off label drug will be required after (no longer than) an initial three month trial period. If substantiated improvement in the patient's condition is not evident, further use of the off label drug will no longer be approved for coverage.

Specialty Drugs
A Specialty Drug is a drug that targets and treats specific complex conditions or illnesses such as cancer, rheumatoid arthritis, multiple sclerosis, hepatitis C, and HIV/AIDS. Specialty Drugs require patient-specific dosing and careful clinical management. Often these drugs are in the form of injected or infused Medicines. Because specialty drugs require special clinical monitoring, they are typically not dispersed through a traditional retail pharmacy; therefore some medications have to be dispensed through specialty pharmacies.

As of January 1, 2021 specialty drugs will no longer be covered under this plan if the patient qualifies for patient assistance from the drug manufacturer or any other available assistance plan. If the patient does not qualify for assistance, coverage will be available under this plan. TrueRx will provide guidance and instruction for the patient to assist with the qualification process.

Your Pharmacy Benefit Manager (PBM) consistently reviews pricing for Specialty Drugs to find the best value. Therefore, the PBM reserves the right to change the specialty pharmacies from which Specialty Drugs may be obtained and to negotiate pricing for Specialty Drugs to obtain the most cost-effective solution. If you obtain

Specialty Drugs at pharmacies that are not approved by your PBM, you will be responsible for 100% of the cost of those Specialty Drugs and they will not be covered under this Prescription Drug Program. Any amounts that you spend toward Specialty Drugs from non-approved pharmacies will not count toward any applicable deductibles or out-of-pocket maximum limits related to the Prescription Drug Program or the Health Care Plan. You can always request the currently-approved specialty pharmacies by contacting Dunn & Associates. We will work with True Rx and other PBM's if necessary for the Specialty Drugs. We will assist you in getting the best price available for the plan and the participant. The PBM used for specialty drugs could be changes at any time.

- If you are prescribed a specialty drug, the Plan requires Plan participants to enroll in an advocacy program administered through True Rx.
- All Plan participants using specialty drugs are required to meet prior authorization and administrative review criteria.
- True Rx will help you obtain your specialty drugs by identifying alternative forms of funding. You must enroll in the program and comply with the alternative funding program's eligibility criteria determination process to qualify.
- If you choose not to enroll in the alternative program, you will be responsible for 100% coinsurance on your specialty drugs.
- If you are not eligible for an alternate funding program, your case will be submitted to the Plan for benefit consideration under the 1st level appeal process. Should an exception be approved, your out of pocket cost will be adjusted to the Plan's co-insurance and any other Plan limitations will apply.
- If no alternative funding is found to be available but you are granted an exception on appeal then the Specialty drug copays apply.

Out-of-Pocket Expense/Deductible

Out-of-pocket expense is defined as the amount of total covered expenses that are the responsibility of the covered participant and that accumulate toward the prescription drug program's out-of-pocket maximum or deductible expense. The following amounts do not accrue toward the Out-of-Pocket Expense or Deductible Expense.

- premiums;
- expenses that are not covered under this Prescription Drug Program;
- expenses in excess of the reasonable and customary charges for services or supplies;
- expenses in excess of any maximum benefit list in the Prescription Drug Program;
- penalties;
- expenses reimbursed or covered through assistance programs or discount programs; and expenses related to non-preferred brand-name drugs and brand-name drugs when there is a generic equivalent that is medically appropriate .

Orphan Disease

An orphan disease is defined as a condition that affects fewer than 200,000 people nationwide. This includes diseases as familiar as cystic fibrosis, Lou Gehrig's disease, and Tourette's syndrome and unfamiliar as Hamburger disease, Job syndrome and acromegaly or gigantism.

Orphan Drug

An orphan drug is a pharmaceutical agent that has been developed specifically to treat a rare medical condition, the condition itself being referred to as an orphan disease. The FDA keeps a list of orphan drugs on their website http://www.accessdata.fda.gove/scripts/opdlisting/oopd.

Exclusion Drug List

Any drug or biological that has received an "orphan drug" designation, unless approved by the plan administrator.
Specialty drugs as defined by the PBM (unless mandated by a regulatory authority).

Other Provisions

The copayments or coinsurance that an Employee pays at time of purchase through the drug store or mail-order program will not apply toward the coinsurance portion of this Plan.

Preventative Drugs
Any prescription defined as a preventative drug will be paid at 100% as required by the Affordable Care Act.

Step Therapy Program
The Step Therapy Program encourages members to use medications that are generally recognized as safe and effective, but are also lower-cost. Under this program, in order to receive coverage, you may need to first try a proven, cost effective medication before progressing to a more costly treatment. Please see the table below for the list of drugs/drug categories included in the Step Therapy Program.

Step Therapy Program Categories	
Proton Pump Inhibitors (e.g., Dexilant)	Cholesterol (e.g., Livalo)
Osteoporosis (e.g., Atelvia)	Blood Pressure (e.g., Benicar, Micardis HCT)
Hypnotics/Sedatives (e.g., Zoplimist, Sonata)	Anti-Depressants (e.g., Viibryd, Pristiq)
Migraine Agents (e.g., Relpax)	Nasal Steroids (e.g., Veramyst)
Acne (e.g., Minocycline ER)	IBS Agents (e.g., Pentasa)

**The medications listed are only examples; other drugs in these categories may be part of this program.* Note: The Step Therapy Program is applicable to members age 18 and over only. Please contact True Rx at (866) 921-4047 with any questions regarding the Step Therapy Program.

Page: 39-43
Section: Comprehensive Medical Exclusions and Limitations
Description: The following has been added to this section.

FFFF. Any drug or biological that has received an "orphan drug" designation, unless approved by the plan administrator and specialty drugs as defined by the PBM (unless mandated by a regulatory authority).

Signed this 2nd day of November, 20 2020

Brenda L Dunagan
TRUSTEE

Joshua L Marsh
TRUSTEE

Jill Nobbe
TRUSTEE

Betsy Wiley
WITNESS

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 5

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: April 1, 2021

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated in the document.

Page: 55-56
Section: Continuation of Coverage (COBRA)
Description: The following language has been added to this section;

Effective April 1, 2021, the Plan is hereby amended in response to The American Rescue Plan Act of 2021. All provisions of this Amendment will terminate upon the expiration of the premium assistance available under the American Rescue Plan Act of 2021 on September 30, 2021. All other sections of the Plan remain unchanged.

Special COBRA Premium Assistance Opportunity
The Federal Government, through the passage of The American Rescue Plan Act of 2021, made a temporary COBRA opportunity available for certain Assistance Eligible Individuals (AEI). An Assistance Eligible Individual is a COBRA qualified beneficiary who meets the following requirements during the period from April 1, 2021 through September 30, 2021:

- Is eligible for COBRA continuation coverage by reason of a qualifying event that is a reduction in hours (such as reduced hours due to change in a business's hours of operations, a change from full-time to part-time status, taking of a temporary leave of absence, or an individual's participation in a lawful labor strike, as long as the individual remains an employee at the time that hours are reduced) or an involuntary termination of employment (not including a voluntary termination); and
- Elects COBRA continuation coverage.

COBRA Premium Assistance
Available from April 1, 2021 through September 30, 2021, AEIs who properly elect COBRA continuation coverage under the Plan are eligible for premium assistance. AEIs are not required to pay their normal COBRA premiums otherwise applicable for coverage during this period. The Plan will treat the AEI as having paid the full premium required for COBRA continuation coverage.

Termination of Eligibility for COBRA Premium Assistance
The AEI's eligibility for premium assistance terminates on the earlier of:

1. The end of the maximum required period of continuation coverage for the AEI under the Code's COBRA rules or the applicable State or Federal law (or regulation); or
2. The date that the AEI becomes eligible for Medicare benefits under Title XVIII of the Social Security Act or health coverage under another group health plan, such as a group health plan sponsored by a new employer or a spouse's employer (not including excepted benefits, a qualified small employer health reimbursement arrangement (QSEHRA), or a health flexible spending arrangement (FSA)); or
3. September 30, 2021.

If an AEI receiving premium assistance for COBRA continuation coverage under this provision becomes eligible for coverage under another group health plan (other than those noted above) or Medicare, the AEI is required to

notify the Plan in writing. This notification must be provided to the Plan in the time and manner as is specified by the Secretary of Labor. If an AEI fails to provide this notification at the required time and in the required manner, the individual may be subject to a tax penalty.

Additional COBRA Election Period
The American Rescue Plan Act of 2021 provides an additional election period for AEIs. An AEI whose qualifying event occurred prior to April 1, 2021 and did not elect COBRA continuation coverage when it was first offered or who elected COBRA continuation coverage but is no longer enrolled may be eligible for this additional election opportunity.

If the AEI is eligible for an additional election period, the AEI must elect such COBRA continuation coverage within 60 days of receipt of a notice of the COBRA election period. If the AEI does not elect coverage within 60 days of receipt of the notice, the AEI forfeits the right to COBRA premium assistance. The AEI may continue the coverage in effect at the time of the qualifying event.

NOTE: *The extended deadline relief provided in the Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak "Joint Notice" and Notice 2021-01 does not apply to the 60-day notice or election periods related to COBRA premium assistance.*

The additional election period does not extend the period of COBRA continuation coverage beyond the original maximum period. An AEI may choose to begin COBRA continuation coverage prospectively from the date of the election, or, if the AEI's qualifying event occurred on or before April 1, 2021, choose to start coverage as of April 1, 2021, even if the AEI receives an election notice and makes such election at a later date.

Participants may contact the Plan Administrator for additional information on the premium assistance available under the American Rescue Plan Act of 2021. If a Participant feels that they have been improperly denied premium assistance, they may contact the Employee Benefits Security Administration (EBSA) at 1.866.444.3272.

All other sections of the Plan remain unchanged.

Signed this 28 day of June, 2021

TRUSTEE

Betsy Wiley - Interim Clerk Treasurer
TRUSTEE

TRUSTEE

WITNESS

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 6

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: January 1, 2017

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated in the document.

Page: 6-7
Section: The Pre-Utilization Program
Description: The "Services Requiring Pre-Utilization Review" section has been updated;

SERVICES REQUIRING PRE-UTILIZATION REVIEW

Hospital Admissions – All inpatient hospital admissions over 18 hours require pre-utilized review. Maternity stays are excluded from this requirement unless the mother or baby remains in the Hospital for more than 48 hours following a normal delivery or for more than 96 hours following a cesarean section. Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. *However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).* In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Outpatient Surgical Procedures – Any outpatient surgical procedure that takes place in an operating room or surgery center have a pre-utilization review prior to the procedure. In addition, the following outpatient procedures also require pre-utilization review:

a. Outpatient Chemotherapy
b. Outpatient Radiation Therapy
c. Outpatient Dialysis

Cancer Care – Cancer care includes but is not limited to chemotherapy, radiation, and surgical removal.

Dialysis – Home and Facility Outpatient Dialysis.

Durable Medical Equipment (DME) – Medical equipment which is not disposable (i.e., is used repeatedly and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth.

Home Health Care – Items and services provided as needed in patients' homes by a home health agency (HHA) or by other arrangement made by a Home Health Agency.

Hospice Care – Services provided by a health care facility or program providing medical care and support services, such as counseling, to terminally ill persons and their families.

Infusions – Home and Facility Infusions.

MRI's (outpatient only) – Outpatient Magnetic Resonance Imaging (MRI) procedures.

Outpatient Surgical Procedures – Any outpatient procedures requiring the use of an operating room or surgery center.

Pregnancies – Clinix should be notified when you become pregnant. Inpatient maternity stays of no more than 48 hours following a vaginal delivery or 96 hours following a cesarean section are excluded as mentioned above.

Scans (outpatient only) – Outpatient Positron Emission Tomography (PET) scans and CT scans or computed tomography scans;

Skilled Nursing Care – Around-the-clock nursing and rehabilitative care, that can only be provided by, or under the supervision of, skilled medical personnel.

Sleep Studies – Contact Clinix prior to scheduling sleep study procedures.

Therapy – Physical, Occupational and Speech Therapy (outpatient basis only).

All other sections of the Plan remain unchanged.

Signed this 1st day of October, 2021

TRUSTEE

TRUSTEE

TRUSTEE

WITNESS

DUNN & Associates

BENEFIT ▪ ADMINISTRATORS ▪ INC.

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 7

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: January 1, 2022

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated in the document.

Page: 10-15
Section: Schedule of Benefits
Description: The following benefits are being updated;

Dialysis Benefit	80% no deductible	70% after deductible	60% after deductible	Payable at 200% of Medicare Fee Schedule. Limited to 50 treatments per episode of care. Treatment will be considered a separate episode if more than 180 days have lapsed since the last treatment
Physiotherapy	80% no deductible	70% after deductible	60% after deductible	Limited to an annual individual maximum of: Physical Therapy = 20 visits Speech Therapy = 20 visits Occupational Therapy = 20 visits ABA Therapy = 20 visits Chiropractic Care = 12 visits Cardiac Care = 36 sessions Pulmonary Rehab = 20 visits

DUNN & Associates
BENEFIT ▪ ADMINISTRATORS ▪ INC.

Page: 16-25
Section: Definition
Description: The following definition is being added;

ABA THERAPY
Per Indiana regulation, applied behavioral analysis therapy services, or ABA therapy services, means the design, implementation and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior. The diagnosis should be made by a qualified provider such as a Licensed Physician; Licensed Health Service Provider in Psychology (HSPP); Other Behavioral Health Specialist with training and experience in the diagnosis and treatment of ASD and acting within the scope of licensure and expertise.

Page: 29-38
Section: Comprehensive Medical Benefits
Description: The following is being updated;

D. medical services or supplies prescribed by a legally qualified physician or surgeon, as follows:
   c. diagnostic x-ray, laboratory and microscopic examinations including allergy testing and any medically necessary pre-operative or pre-admission testing. Covered ultrasound charges for covered pregnant Employees and covered dependents will be limited to four (4) tests during a pregnancy.

All other sections of the Plan remain unchanged.

Signed this 11th day of November, 2021

Amy E Burns
TRUSTEE

TRUSTEE

Julie Noble
TRUSTEE

WITNESS

DUNN & Associates

BENEFIT ▪ ADMINISTRATORS ▪ INC.

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 8

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: January 1, 2023

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated in the document.

Page: 10-15
Section: Schedule of Benefits
Description: The chiropractic care maximum has been increased.

Physiotherapy Outpatient Care	80% no deductible	70% after deductible	60% after deductible	Annual limits on number of visits apply. Physical Therapy – Limit 20 visits/yr Occupational Therapy– 20 visits/yr Manipulative Therapy – 20 visits/yr Speech Therapy – 20 visits/yr Cardiac Rehab – 36 visits/yr Pulmonary Rehab – 20 visits/yr

All other sections of the Plan remain unchanged.

Signed this 17 day of Nov, 2022

TRUSTEE

TRUSTEE

TRUSTEE

WITNESS

DUNN & Associates
Benefit ▪ Administrators ▪ Inc.

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 9

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: August 1, 2023

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated inthe document.

Page: 8-9
Section: Eligibility
Description: The following has been added to this section.

WAITING PERIOD
All eligible employees will commence coverage on the first day of the month following the hire date for this Employer. All coverage will commence on these dates if the Employee has agreed to make any required contributions for coverage (but not until an enrollment card has been completed and signed).

If an employee is unable to work due to illness or injury and returns to work within 180 days of losing coverage, they may be reinstated with no waiting period.

All other sections of the Plan remain unchanged.

Signed this 24 day of May, 2023

TRUSTEE

TRUSTEE

TRUSTEE

WITNESS

DUNN & Associates
Benefit • Administrators • Inc.

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 10

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: January 1, 2024

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description/Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated inthe document.

Page: 8-9
Section: Eligibility
Description: The following section has been updated.

If the spouse of the Employee is employed and eligible for coverage under their own employer (regardless of cost), that spouse will NOT be eligible for coverage through this plan. The Working Spouse Rule does not require a spouse to enroll in his/her employer's plan. However, if the spouse is eligible to enroll, there will be no coverage under this plan.

Exception: If the spouse of the employee is employed and eligible for coverage under their own employer (regardless of cost), that spouse may be covered as secondary under this plan if the employer plan of the spouse does NOT meet the ACA's minimum value requirements. The spouse must be enrolled in their employer's plan and that plan will pay as primary to this plan. This exception does not apply if the employer of the spouse offers multiple plan options and at least one of the options meets ACA minimum value requirements.

No person may be an employee and a dependent of this Plan.

It is the responsibility of the employee to notify the Human Resources Department if the spouse's eligibility changes anytime during the year. The employee has 30 days to notify the Human Resources Department. Failure to notify the Human Resources Department of other coverage available to a spouse may be considered insurance fraud and will result in immediate loss of coverage for the spouse. The employee will be responsible for all applicable premiums and any claims paid on the ineligible spouse. Furthermore, additional disciplinary action may be taken against the employee including possible termination of employment, subject to this employer's personnel policy.

All other sections of the Plan remain unchanged.

Signed this 26 day of October, 2023

Trustee

Trustee

Trustee

Witness

DUNN & Associates
Benefit • Administrators • Inc.

EMPLOYEE BENEFIT PLAN: City of Greensburg

AMENDMENT #: 11

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2017

AMENDMENT EFFECTIVE DATE: January 1, 2024

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description/Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated inthe document.

Page: 10-15
Section: Schedule of Benefits
Description: The following section has been updated.

BENEFIT DESCRIPTION	AT DECATUR COUNTY MEMORIAL HOSPITAL	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Lifetime Maximum (per individual)	Unlimited	Unlimited	Unlimited	
Pre-utilization	See pre-utilization section A $500 reduction in benefits will be applied if pre-utilization requirements not met.			
Deductible (per calendar year) Individual Family	 No deductible No deductible	 $750 $1,750	 $1,500 $3,500	In- and Out-of-network deductibles accumulate separately. Deductible applies to all covered expenses unless otherwise stated under Special Conditions or elsewhere in this document.
Covered Expenses	80% no deductible	80% after deductible	60% after deductible	Unless otherwise stated under Special Conditions or elsewhere in this document.

BENEFIT DESCRIPTION	AT DECATUR COUNTY MEMORIAL HOSPITAL	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Coinsurance Limit (per calendar year)				In-network limits include charges at DCMH.
Individual Medical		$1,250	$2,500	In- and out-of-network limits do not apply towards each other.
Family Medical		$1,750	$4,000	
Individual Rx		$500	$500	After the coinsurance limit has been met, covered expenses are payable at 100% of reasonable and customary for the remainder of that calendar year.
Family Rx		$1,000	$1,000	
Total Out-of-Pocket (per calendar year)				In- and out-of-network limits do not apply towards each other.
Individual		$2,500	$4,500	
Family		$4,500	$8,500	The out-of-pocket limit includes deductible, medical and rx coinsurance and copays.

SPECIAL CONDITIONS

BENEFIT DESCRIPTION	AT DECATUR COUNTY MEMORIAL HOSPITAL	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
AccuDoc		100% no deductible office visits $20.00 copay for x-rays		
Physician Office Visit	$20.00 copay then 100% no deductible performed by a DCMH owned Physician	$25.00 copay then 100% no deductible	60% after deductible	
Allergy Injection	$5.00 copay	$5.00 copay	60% after deductob;e	
X-Rays				
Outpatient	$20.00 copay	$25.00 copay	60% after deductob;e	

BENEFIT DESCRIPTION	AT DECATUR COUNTY MEMORIAL HOSPITAL	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Specialist	$20.00 copay then 100% no deductible performed by a DCMH owned Physician	$25.00 copay then 100% no deductible	60% after deductible	
Urgent Care	Not applicable	80% after deductible	60% after deductible	
Emergency Care				
Facility	$150 copay then 80% no deductible	$250 copay then 80% no deductible	$250 copay then 70% no deductible	
Physician	80% no deductible	80% no deductible	70% no deductible	
Ambulance	80% no deductible	80% after deductible	60% after deductible	
Voluntary Second Surgical Opinion	100% no deductible	100% no deductible	100% no deductible	
Preadmission Testing	80% no deductible	80% after deductible	60% after deductible	
Outpatient Surgery	80% no deductible	80% after deductible	60% after deductible	Includes facility and all professional fees.
Hospital Room & Board	80% no deductible	80% after deductible	60% after deductible	Limited to semi-private room rate
Intensive Care	80% no deductible	80% after deductible	60% after deductible	Limited to 4 times semi-private room rate
Mental Health/Substance Abuse Care				
Outpatient	$20 copay then 100% no deductible	$25 copay then 100% no deductible	60% after deductible	
Inpatient	80% no deductible	80% after deductible	60% after deductible	

BENEFIT DESCRIPTION	AT DECATUR COUNTY MEMORIAL HOSPITAL	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Home Health Care	80% no deductible	80% after deductible	60% after deductible	Limited to an annual individual maximum of 100 visits within any calendar year, maximum of 4 hours per visit.
Hospice Care	80% no deductible	80% after deductible	60% after deductible	
Extended Care/Skilled Nursing Facility	80% no deductible	80% after deductible	60% after deductible	Limited to an annual individual maximum of 30 days per convalescent period.
Preventative Health Care	100% no deductible	100% no deductible	100% no deductible	
Physiotherapy Outpatient Care	80% no deductible	80% after deductible	60% after deductible	Annual limits on number of visits apply. Physical Therapy – Limit 20 visits/yr Occupational Therapy– 20 visits/yr Manipulative Therapy – 20 visits/yr Speech Therapy – 20 visits/yr Cardiac Rehab – 36 visits/yr Pulmonary Rehab – 20 visits/yr ABA Therapy – 20 visits/yr
Medical Aids	80% no deductible	80% after deductible	60% after deductible	
Temporomandibular Joint Disorder Expenses	80% no deductible	80% after deductible	60% after deductible	

Preventative health care services include:

- ✓ Evidence-based items or services that have a rating of "A" or "B" and are currently recommended by the U.S. Preventive Services Task Force
- ✓ Immunizations that are currently recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (CDCP)
- ✓ Evidence-informed preventive care and screenings (as provided for in the comprehensive guidelines supported by the Health Resources and Services
- ✓ Administration (HRSA) for infants, children and adolescents
- ✓ Additional preventative care and screenings (as provided for in the comprehensive guidelines supported by the HRSA) for women
- ✓ Pediatric oral and vision exams will be covered under the preventative benefit in accordance to the recommendation in the PPACA.

BENEFIT DESCRIPTION	AT DECATUR COUNTY MEMORIAL HOSPITAL	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Outpatient Laboratory Expenses	100% no deductible	Designated Facility 100% no deductible Other Facilities 80% after deductible	60% after deductible	Call Dunn and Associates for information on designated facilities in your area.
Organ Transplants (fully-insured policy)	See comprehensive medical benefits section of this booklet for additional information. Pre-utilization requirements must be followed and met or there will be a penalty applied.			
Dialysis Benefit	80% no deductible	80% after deductible	60% after deductible	Payable at 200% of Medicare Fee Schedule. Limited to 50 treatments per episode of care. Treatment will be considered a separate episode of care if more than 180 days have lapsed since the last treatment.
Prescription Drug Benefit			Not applicable.	
Retail Program (30-day supply)	Employee Pays			Deductible waived when network Pharmacy utilized.
Tier 1 Generic	$4			
Tier 2 Brand Preferred	$35			
Tier 3 Brand Non-Preferred	$75			If an insured elects not to purchase a generic drug when available and approved by the physician, the employee will be responsible for the applicable brand copay plus the difference in the cost of the generic and the brand name drug purchased.
Mail Order (90-day supply)				
Tier 1 Generic	$10			
Tier 2 Brand Preferred	$70			
Tier 3 Brand Non-Preferred	$150			
Specialty Rx (30-day supply)	Contact PBM for assistance.			Specialty Rx limited to 30-day supply.

All other sections of the Plan remain unchanged.

Signed this 8 day of Nov, 2023

Trustee

Trustee

Trustee

Witness