Plan Document &
Summary Plan Description

for

Richmond Community Schools
Employee Benefit Trust

This booklet describes the benefits in effect on January 1, 2018.

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ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Richmond Community Schools (the "Company" or the "Plan Sponsor") as of January 1, 2018.

EFFECTIVE DATE
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

ADOPTION OF THE PLAN DOCUMENT
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Richmond Community Schools

Name: Todd Terrill

Date: 1/1/2018

Title: Superintendent/Trustee

GENERAL INFORMATION (APPLICABLE TO 501-C-9 TRUST)

NAME OF PLAN: Richmond Community Schools Employee Benefit Trust

TRUST ID NUMBER: 35-2190791

PLAN NUMBER: 501

PLAN EFFECTIVE DATE: November 1, 2013

PLAN REVISION DATE: January 1, 2018

PARTICIPANTS INCLUDED:
This Summary Plan Description is for all eligible Employees of the Richmond Community School Corporation.

NAME AND ADDRESS OF EMPLOYER/PLAN SPONSOR/PLAN ADMINISTRATOR:
Richmond Community School Corporation
300 Hub Etchison Parkway
Richmond, IN 47374
Phone: (765) 973-3300

The Plan Administrator is responsible for compliance with the provisions of ERISA 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
www.dunnbenefit.com

PLAN YEAR/CALENDAR YEAR:
The financial records of the Plan are kept on a Plan Year basis beginning each November 1and ending on each October 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 are fully insured. The premiums for this coverage are paid by the Trust.
b. Medical benefits are self-insured by the Employer. Excess loss policies have been obtained for specific and aggregate coverage on behalf of the Employer. The excess loss premiums are paid by the Trust.
c. Dental benefits are self-insured by the Employer.

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.

The Employer has given the named Plan Supervisor authority to control and manage the operation and administration of this Plan.

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:

<u>For Covered Employees</u>:
Basic Life
Basic Accidental Death & Dismemberment Benefits

<u>For Covered Employees and Dependents</u>
(Administrative/Certified Staff):
Comprehensive Vision Benefits

<u>For Covered Employee and Dependents</u>:
Comprehensive Medical Benefits
Comprehensive Dental Benefits
Dependent Life

Life and AD&D benefits are fully insured. The information provided in this Summary Plan Description is a brief summary of each policy.

This Plan is the result of a collective bargaining agreement.

FUNDING:
The Plan is funded through a 501-C-9 Trust by directed contributions from the Employee and this Employer. Any Employee contributions toward the cost of the coverage's provided by this Plan will be deducted from his pay, and they are subject to change.

TRUSTEES

Superintendent
Richmond Community School Corporation

REA President/Designee
Richmond Community School Corporation

Chief Human Resource Officer
Richmond Community School Corporation

CLAIM PROCEDURES

WHEN TO FILE CLAIM

Report claims promptly. ***Claims should be filed with the Plan Supervisor within 90 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).
c. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

PRE-DETERMINATION

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as <u>required</u> by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan ***before*** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

- **<u>Note that this Plan does not require prior authorization for urgent or Emergency care claims, however Covered Persons may be required to notify the Plan following stabilization. Please refer to the Utilization Management section of this SPD for more details</u>.** A condition is considered to be an urgent or Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit a written letter to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

For Prescription benefits, a claim is considered filed when a Covered Person has submitted the claim for benefits under the Pharmacy benefit terms outlined in this SPD. The address for submitting Prescription claims is on the back of the identification card. If the Pharmacy refuses to fill the Covered Person's Prescription at the Pharmacy counter, the Covered Person should contact the number on the back of the Pharmacy drug benefit identification card for further instructions on how to proceed.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, auto accident, or other accident (if applicable)
- Assignment of benefits (if applicable)

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)
If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting prior authorization, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED
When Dunn & Associates receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If it is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, Dunn & Associates will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

Negotiated Rate: On occasion, Dunn & Associates will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility, and Dialysis treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

NOTIFICATION OF BENEFIT DETERMINATION
If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged

were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

Note: For Prescription benefits, Covered Persons will receive an EOB when a Covered Person files a claim directly with the Pharmacy Benefit Manager (PBM). Benefits received or denied at the point of sale in the Pharmacy are not considered claims. See Procedures For Submitting Claims for more information.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

Dunn & Associates will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to Dunn & Associates for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

PREFERRED PROVIDER ORGANIZATIONS

Preferred Provider Organizations (PPOs) 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 Health Network**.

All providers contracted with Encore or directly with Dunn and Associates will be considered "In-Network" Providers. Covered expenses incurred by an "In-Network" provider (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 providers can be obtained free of charge 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**.

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.

For covered persons traveling for pleasure (short duration only) or business: Covered expenses will also be considered "In-Network" for services meeting the definition of "Emergency Care" in the "Definitions" section of this document.

Covered charges for a student dependent child will be paid at the "In-Network" rate when temporarily residing outside of the Encore Health Network service area while attending an accredited educational institution without regard to the network status of healthcare provider utilized.

Exceptions: Covered expenses will be considered "In-Network" regardless of whether the covered expenses were incurred by an "In-Network" or "Out-of-Network" provider in the following circumstances:

a. anesthesiologist services but only when services are performed in an in-network facility and covered person did not have control over the provider used for such services.

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 and plan coverage and limitations will override the R&C fee schedule.

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.

If a PPO discount or contract is not available for claims, the maximum plan allowance will be set at 120% of Medicare allowed charges. Charges will be paid at the out-of-network rate as shown in the schedule of benefits.

THE PRE-UTILIZATION PROGRAM

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. 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 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

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 under arrangement made by an HHA.

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.

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

Diagnostic Testing- such as PET scans; CT scans and MRI's.

Therapies – such as physical; occupational and speech.

Sleep Studies - Contact Clinix prior to scheduling sleep study procedures

HOW TO OBTAIN PRE-UTILIZATION REVIEW

Call Clinix at ***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 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 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. Clinix 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 a claim is identified as a potential large claim expense by Clinix, 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 / APPEALS
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 $250 per admission penalty. This penalty will not count toward any deductible or co-insurance maximums.

. . . REMEMBER . . .

- ✓ *Call Clinix BEFORE receiving 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 $250 reduction in benefits will apply to the covered charges.***

ELIGIBILITY

ELIGIBILITY FOR EMPLOYEES:
Employees - As required by the Patient Protection and Affordable Care Act (PPACA); all certified and contractual staff meeting the variable or full time hour minimums will be eligible for coverage. Administrators, Board Members and School Attorney will also be eligible for coverage. No person may be covered both as an Employee and a Dependent of this plan.

WAITING PERIOD:
All eligible employees will commence coverage on the first day of the month following enrollment 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).

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.

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, coverage will not be available.

WORKING SPOUSE RULE
If the spouse of the Employee is employed and eligible for coverage under their own employer, benefits under this Plan will continue to be coordinated as described in the Coordination of Benefits section of this document. The spouse's plan will be primary on the spouse's claims and this Plan will pay as secondary if family coverage is elected and the appropriate premium/contribution is paid. However, if the spouse elects not to take coverage that is available through his/her employment (without regard to cost), this Plan will not provide any coverage for that spouse. The Working Spouse Rule does not apply when both husband and wife are employees of this Employer. However, no person may be both an employee and a dependent of this Plan.

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; **or**
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.

PRE-EXISTING CONDITIONS
Effective November 1, 2014 there is no pre-existing conditions as required by the Patient Protection and Affordable Care Act.

OPEN ENROLLMENT
An open enrollment period shall be held annually during the month of November. 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, including shall apply to an Employee or Dependent who enrolls in the Plan during an open enrollment 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/AD&D COVERAGE	
BENEFIT DESCRIPTION	
Employee Only:	
Class 1 – Superintendent	2x annual base salary up to a maximum of $350,000
Class 2 – Administrative	2x annual base salary up to a maximum of $350,000
Class 3 – All Other Active Full-Time (except board members)	$50,000
Class 4 – Retired Superintendent	2x annual base salary* up to a maximum of $350,000
Class 5 – Retired Administrative	2x annual base salary* up to a maximum of $350,000
Class 6 – All Other Retired Employees (except board members)	$50,000
	**at retirement*

DEPENDENT BASIC LIFE BENEFIT (Non-Contributory)	
BENEFIT DESCRIPTION	
Spouse	$5,000
Child(ren) – Birth to 6 months	$1,000
Child(ren) – Age 6 months to age 19 (26 for full-time students)	$2,500

LONG TERM DISABILITY BENEFIT	
BENEFIT DESCRIPTION	
Monthly Benefit	66 2/3% of monthly earnings immediately before beginning of period of disability
Maximum Monthly Benefit	$7,000
Minimum Monthly Benefit	$50
Elimination Period	90 days (benefits are not payable for the elimination period)

COMPREHENSIVE MEDICAL BENEFITS (Employee and Dependents)

	TRADITIONAL DEDUCTIBLE – OPTION 1		HIGH DEDUCTIBLE – OPTION 2 (HSA QUALIFIED)		
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Annual Maximum per Individual	Unlimited	same maximum for in-network applies to out-of-network (combined maximum)	Unlimited	same maximum for in-network applies to out-of-network (combined maximum)	Some covered expenses have separate annual and/or lifetime maximums as stated under Special Conditions.
Pre-utilization	See pre-utilization section	See pre-utilization section	See pre-utilization section	See pre-utilization section	A $250 reduction in benefits will be applied if pre-utilization requirements not met.
Deductible (per calendar year)			*Embedded Deductible*	*Embedded Deductible*	In- and out-of-network deductibles do not apply towards each other. Deductible applies to all covered expenses unless otherwise stated under Special Conditions or elsewhere in this document.
Individual	$1,000	$2,000	$3,000	$6,000	
Family	$2,000	$4,000	$6,000	$12,000	
Covered Expenses	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Unless otherwise stated under Special Conditions or elsewhere in this document.

	TRADITIONAL DEDUCTIBLE – OPTION 1		HIGH DEDUCTIBLE – OPTION 2 (HSA QUALIFIED)		
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Coinsurance Limit (per calendar year)					In- and out-of-network limits do not apply towards each other and do not include deductible.
Individual Medical	$4,000	$8,000	$3,500	$7,000	
Family Medical	$8,000	$16,000	$7,000	$14,000	
Individual Rx	$1,500	$1,500	Applies to deductible then applicable copays	Applies to deductible then applicable copays	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	$3,000	$3,000			
					Coinsurance limits include applicable copays.
Total Out-of-pocket (per calendar year)					In- and out-of-network limits do not apply towards each other.
Individual	$6,500	$11,500	$6,500	$13,000	
Family	$13,000	$23,000	$13,000	$26,000	
SPECIAL CONDITIONS					
Ambulance	80% after deductible	80% after deductible	100% after deductible	100% after deductible	
Anesthesia	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Cardiovascular (Heart)	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Cash Reward Program Billing errors found by Employee –	50% of actual savings to plan	50% of actual savings to plan	50% after deductible of actual savings to plan	50% after deductible of actual savings to plan	Limited to a $500 per occurrence maximum.

	TRADITIONAL DEDUCTIBLE – OPTION 1		HIGH DEDUCTIBLE – OPTION 2 (HSA QUALIFIED)		
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Consultations	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Inpatient consultations limited to one per confinement. Mental Health/ Substance Abuse Consultations payable under Mental Health/ Substance Abuse benefit.
Dental Work (accidental) **and Oral Surgery**	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Limited as stated in the Comprehensive Medical Benefits section.
Diabetic Education, Training and Nutritional Counseling	100% no deductible	100% no deductible	100% after deductible except as required by the ACA/Preventative Guidelines	100% after deductible except as required by the ACA/Preventative Guidelines	
Laboratory Expenses Through a Designated Facility	100% no deductible		100% after deductible		Designated Facilities include **LabOne**/Quest Diagnostics) and Mid America Clinical Lab (www.labcard.com); **LabCorp** (www.labcorp.com); **Reid Physician Associates** call (765)-935-8934 to locate an RPA Primary Physician. **Reid Outpatient Care Center** Call Dunn & Associates for information on designated facilities in your area.
All Other Facilities	60% after deductible	50% after deductible	60% after deductible	50% after deductible	

	TRADITIONAL DEDUCTIBLE – OPTION 1		HIGH DEDUCTIBLE – OPTION 2 (HSA QUALIFIED)		
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Diagnostic Testing (X-ray/MRI/CT/PET) including radiology at Reid Physician Associates (Primary Care) and Reid Hospital	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Deductible applies to all covered expenses unless otherwise stated under Special Conditions or elsewhere in this document.
All Other Facilities	$75 deductible will apply then 80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Dialysis	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Maximum allowable amount 120% of the Medicare allowable for incurred expenses.
Emergency Room					
Facility Fees	80% after deductible	80% after deductible	100% after deductible	100% after deductible	
Physician Fees	80% after deductible	80% after deductible	100% after deductible	100% after deductible	
Extended Care/Skilled Nursing Facility	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Limited to 100 day ANNUAL individual maximum.
Foot Care Expenses	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Hearing Aids	80% after deductible	50% after deductible	80% after deductible	60% after deductible	When hearing aids are not rendered in connection with medical or surgical treatment for injury or illness, coverage will be limited to $2,000 annual individual maximum.
Home Health Care	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Limited to an ANNUAL individual maximum 100 visits with a maximum of 4 hours per visit.

	TRADITIONAL DEDUCTIBLE – OPTION 1		HIGH DEDUCTIBLE – OPTION 2 (HSA QUALIFIED)		
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Hospice Care	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Hospital Physician Visits Inpatient	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Hospital Room and Board	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Private room expenses limited to average semi-private room rate.
Maternity					As required by the Patient Protection and Affordable Care Act.
Prenatal	100% no deductible	50% after deductible	100% no deductible	50% after deductible	
Delivery/Postnatal	80% after deductible	50% after deductible	80% after deductible	50% after deductible	
Breast Pumps	100% no deductible	50% after deductible	100% no deductible	50% after deductible	
Medical Aids (Durable Medical Equipment, Orthotics and Prosthetic Appliances)	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Mental Health/Substance Abuse Care	80% after deductible	50% after deductible	80% after deductible	60% after deductible	

	TRADITIONAL DEDUCTIBLE – OPTION 1		HIGH DEDUCTIBLE – OPTION 2 (HSA QUALIFIED)		
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Morbid Obesity Expenses	50% no deductible	50% no deductible	80% after deductible	60% after deductible	Limited to $1,000 annual individual maximum except expenses required by the Patient Protection and Affordable Care Act. Prescription drugs for morbid obesity MUST be submitted to Plan Supervisor for consideration. Drugs for morbid obesity are NOT reimbursable through the drug program but are reimbursed by the Plan.
Organ Transplants (if not covered under the fully-insured policy)	80% after deductible	Not covered.	80% after deductible	Not covered.	Maximum falls under the overall maximum of the Plan.
Fully-Insured Transplant Policy					
Donor/Organ/Tissue Procurement	100% of actual network cost for solid organs; Bone Marrow allogenic is limited to $30,000.	$15,000 for solid organs; Bone Marrow allogenic is limited to $30,000.	100% of actual network cost for solid organs; Bone Marrow allogenic is limited to $30,000.	$15,000 for solid organs; Bone Marrow allogenic is limited to $30,000.	No Lifetime Maximums. 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.
All Other Services	100% of actual network cost	80% network cost in the nearest network hospital where the transplant is performed	100% of actual network cost	80% network cost in the nearest network hospital where the transplant is performed	
Physician Expenses					
Inpatient	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Outpatient (home, office & urgent care facility)	80% after deductible	50% after deductible	5 visits per year at 100% no deductible then 80% after deductible.	60% after deductible	Outpatient visits include home, office, urgent care facility and walk-in clinics.

	TRADITIONAL DEDUCTIBLE – OPTION 1		HIGH DEDUCTIBLE – OPTION 2 (HSA QUALIFIED)		
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Physiotherapy (Physical, Occupational, Speech and Manipulative)	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Limited to an individual annual maximum of 20 visits. Medical necessity will be reviewed after 20 visits. Manipulative therapy & Acupuncture limited to an annual individual maximum of 20 visits.
Pre-Admission Testing	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Preventative Health Care	100% no deductible	50% after deductible	100% no 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.

Contraception Methods and/or Sterilization					Generic Contraceptive Methods and Counseling approved by the FDA.
Male	100% no deductible	50% after deductible	100% no deductible	60% after deductible	
Female	100% no deductible	50% after deductible	100% no deductible	60% after deductible	
Surgery Inpatient/Outpatient (Facility & Physician fees)	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
Supplemental Accident Expenses Outpatient Care	100% no deductible	100% no deductible	100% after deductible	100% after deductible	Limited to $300 per accident maximum. Only services received within 72 hours of accident will be covered under this benefit.

	TRADITIONAL DEDUCTIBLE – OPTION 1		HIGH DEDUCTIBLE – OPTION 2 (HSA QUALIFIED)		
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Therapies (Radiation, Chemotherapy, Respiration)	80% after deductible	50% after deductible	80% after deductible	60% after deductible	
TMJ Syndrome	80% after deductible	50% after deductible	80% after deductible	60% after deductible	Oral care and supplies which are used to change vertical dimension and/or closure or any treatment of teeth or nerves connected to teeth are not covered.
Voluntary Second Surgical Opinion	100% no deductible	50% after deductible	100% after deductible	60% after deductible	
Wellness Program	100% no deductible	100% no deductible	100% no deductible	100% no deductible	Limited to an ANNUAL individual maximum of $500. Participants include employees or spouse only. Participant must provide proof of attendance at gym, minimum of 10 visits per month or proof of 75% attendance at weight control program meetings.
Telemedicine	100% no deductible	n/a	100% no deductible	n/a	There is no cost to you the patient for services received through Telemedicine services.

			HIGH DEDUCTIBLE HEALTH PLAN OPTION 2 PLAN PARTICIPANTS RX COPAYS APPLY **AFTER** DEDUCTIBLE HAS BEEN MET.		
Prescription Drugs					
CVS/Walgreens (34-day supply)	Employee Pays	No benefits are available for prescription drugs filled at out-of-network pharmacies.	Employee Pays	No benefits are available for prescription drugs filled at out-of-network pharmacies.	The Prescription Drug Program is through the approved Network listed on Employee's ID Card. * If brand name drug purchased when generic drug available and approved by physician, covered person will be responsible for the applicable **brand** copayment plus the difference in the cost of the generic and the brand name drug purchased. Copay may not apply to preventative prescription drugs and contraceptives.
Generic Drugs	$8 (greater of)		$8 (greater of)		
Preferred Brand	30% or $40 (greater of)*		30% or $40 (greater of)*		
Non-Preferred Brand	50% or $60 (greater of)*		50% or $60 (greater of)*		
All Other Pharmacies Retail (34-day supply)					
Generic Drugs	$4		$4		
Preferred Brand	20% or $20 (greater of)*		20% or $20 (greater of)*		
Non-Preferred Brand	30% for $50 (greater of)*		30% for $50 (greater of)*		
CVS/Walgreens Retail or Mail-Order (90-day supply)					
Generic Drugs	$12		$12		
Preferred Brand	30% or $80 (greater of)*		30% or $80 (greater of)*		
Non-Preferred Brand	50% or $120 (greater of)*		50% or $120 (greater of)*		
All Other Pharmacies Retail or Mail-Order (90-day supply)					
Generic Drugs	$6		$6		
Preferred Brand	20% or $40 (greater of)*		20% or $40 (greater of)*		
Non-Preferred Brand	30% or $60 (greater of)*		30% or $60 (greater of)*		
Specialty Prescription Drugs					Limited to a 30-day supply and Axium Specialty Pharmacy. Please contact KPP your Pharmacy Benefit Manager for assistance with the Specialty Pharmacy. KPP contact information can be located on your ID Card.
(30-day supply)					
Generic Drugs	10% maximum of $150	Not applicable	10% maximum of $150	Not applicable	
Preferred Brand	30% maximum of $250		30% maximum of $250		
Non-Preferred Brand	50% maximum of $400		50% maximum of $400		

DENTAL BENEFITS (Employee and Dependents)

BENEFIT DESCRIPTION		PLAN LIMITATIONS
Annual Individual Maximum (per calendar year)	$1,250	
Individual Deductible (per calendar year)	$50.00	
Covered Expenses		
Preventative Care	100% no deductible	
All Other	80% after deductible	
Orthodontic Benefits		
Covered Expenses	60% no deductible	
LIFETIME Individual Maximum	$500	

VISION BENEFITS - *Certified Teachers and Administrators only*

BENEFIT DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Covered Expenses			
Examination	$35.00 co-pay then 100% no deductible	$35.00 co-pay then 100% no deductible	Vision benefits are limited to an ANNUAL individual maximum of $400.
Lenses	$35.00 co-pay then 100% no deductible	$35.00 co-pay then 100% no deductible	This plan will cover contacts or lenses in a 12 month period but not both. All services are limited to every 12 months. Except Frames are limited to every 24 months.
Frames/Contacts/Tints/ Photochromics/All other covered services	80% no deductible	80% no deductible	

DEFINITIONS

ACCIDENTAL INJURY – An accidental injury is a condition caused by accidental means which results in damage to the covered person's body from an external force.

ACTIVE WORK, ACTIVELY WORKING, ACTIVELY AT WORK – A requirement that an Employee be actively at work on 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.

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).

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.

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 authorized representative for 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.

BRAND NON-PREFERRED – Brand Non-Preferred drugs are those drugs not 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. The Preferred Drug Listing is available through web site of approved Network listed on Employee's ID Card.

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.

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. For the 80/20 portion of this Plan, the Employer pays 80% of the covered expense while the Employee is responsible for the remaining 20%. For the out-of-network 60/40 portion of this Plan, the Employer pays 60% of the covered expense and the Employee is responsible for 40%. This is sometimes called a "copayment."

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.

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 define 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 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 EXPENSES – Covered expenses are those which are eligible for payment under the Plan, if all Plan requirements are met.

CREDITABLE COVERAGE – Creditable Coverage includes coverage of an individual under a group health plan (including COBRA), individual health insurance coverage, 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.

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 step-children (parent is currently married to the Employee)
d. a child for whom the employee or employee's spouse has legal guardianship.

Note: When an employee's own natural child(ren) return from living with a custodial or non-custodial parent and are principally dependent upon the employee for maintenance and support and previously covered under this plan as a dependent of the

employee the plan shall resume coverage for the child(ren) effective with the date the child returns to full residency with the employee without any waiting period."

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.

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 amephetamines, cocaine, opiates, barbiturates, bensodiazepines, 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, is able to withstand repeated use and is not generally useful to a person in the absence of injury or illness.

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.

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.

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.

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 – Free-standing or Hospital affiliated facility which provides short periods of stay for the Terminally Ill in a homelike setting for either direct care or respite. The facility must operate as an integral part of a formal Hospice Care Program. If such facility is required by the laws of the state where services are incurred to be licensed, certified, or registered, it is so licensed, certified, or registered.

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;
b. it continually provides on the premises 24 hour a day registered graduate nurse services;
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 residential 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, as well as, dependent spouses and children. Expenses for a baby born to dependent child of employee is not covered under Plan.
    2. Elective abortions - coverage is limited to abortions performed upon recommendation of a physician due to life threatening medical complications.

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 – A covered person who is treated as a registered bed patient in a hospital and for whom a room and board charge is made.

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.

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".

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 is 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 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.

MORBID OBESITY– The body weight is 100 pounds over ideal weight for height and bone structure, and a Body Mass Index of at least 30.0 kg/m^2 and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the body weight is 200 percent or more of the ideal weight for height and a Body Mass Index of at least 30.0 kg/m^2. The associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalmic disorders, and severe arthritis of the weight-bearing joints.

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.

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.

PARTICIPATING PROVIDER – A designated institution, Physician or other provider who holds a participating provider agreement with the preferred provider organization contracted by this Employer.
Covered Personappointed

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, 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.

PLAN – "Plan" refers to the benefits and provisions for payment of 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.

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.

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. This Plan will pay up to 20% of the maximum allowable charge for assistant surgeon services.

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.

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.

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 ROOM AND BOARD – Charges made by a hospital for the cost of room, meals, and services (such as general nursing services) provided to all inpatients on a routine basis in a room designed to accommodate two or more bed patients.

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.

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.

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.

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 reimbursement of assistant surgeon charges will not exceed 20% of the maximum allowed charge for the surgeon's 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).

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.

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.

If Employee becomes totally disabled, benefits will continue for 6 months from last day worked. For Life Conversion, continue to next section.

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.

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 AND 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 full 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 or attempted suicide, whether sane or insane;
b. air travel as a crew member;
c. participation in a riot or from war or an act of war, whether declared or undeclared;
d. commission of an assault or felony;
e. the voluntary taking of:
    1. a prescription drug in a manner other than as prescribed by a physician;
    2. any other federally-or state-controlled substance in an unlawful manner;
    3. non-prescription medicine, in a manner other than as indicated in the printed instructions; or
    4. poison;
f. the voluntary inhaling of gas (unless due to occupational accident); or
g. sickness other than infection occurring as a result of accidental injury.

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 BASIC LIFE BENEFIT

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.

CONTRIBUTIONS
Bi-weekly payroll deductions are made from your paycheck for dependent life insurance.

COVERED DEPENDENTS
For the purpose of this benefit, "dependent" means
1) Your legal spouse under age 70;
2) Your Domestic Partner under age 70 whose relationship with You is recognized by and allowed under applicable state law provided both the Domestic Partner and You:
   a) share the same regular and permanent residence;
   b) have a close personal relationship similar to lawful marriage;
   c) have agreed to be jointly responsible for Basic Living Expenses, incurred during the domestic partnership;
   d) are not married to anyone;
   e) are 18 years of age and older;
   f) are not so closely related by blood to be prohibited under applicable state laws;
   g) were mentally competent to consent to a contract when the domestic partnership began;
   h) are each other's sole domestic partner; and
   i) are responsible for each other's welfare;
3) Your unmarried Child from live birth and under the age of 26, if the Child:
   a) is not eligible under the policy for Personal Insurance;
   b) is not in the military of any country; and
   c) is dependent upon You for principal support and is claimed as a dependent on Your federal income tax return;
4) Your unmarried Child under the age of 26, if the Child:
   a) is registered at and attending an accredited educational institution on a full-time basis as defined by the regulations of the institution, and
   b) is dependent upon You for principal support and is claimed as a dependent on Your federal income tax return; and
5) Your unmarried Child who is disabled and incapable of self-sustaining employment as a result of mental or physical disability. The Child must have been disabled prior to age 26. If the Child is at least age 26 on Your effective date, coverage is subject to AUL's receiving written proof of the disability on that date including but not limited to receipt of Social Security Administration disability benefits. If the Child is not at least age 26, extension of coverage is subject to AUL's receiving written proof of the disability not later than 120 days after the Child attains age 26. Proof of continued disability shall be required not more than once each year thereafter.

If Dependent Insurance is not included in the policy, then references to Dependents and Dependent Insurance are null and void. DEPENDENT INSURANCE means the insurance provided under the AUL policy covering Your Dependents, Section 20, if included in the policy. 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.

LONG TERM DISABILITY BENEFIT

BENEFIT
If while covered, an Employee becomes wholly and continuously disabled by an accidental injury or illness non-occupational in nature beyond the Benefit waiting period shown in the Schedule of benefits, monthly benefits will be paid to you. Disabled means the Employee is unable to perform any and every duty pertaining to his/her employment.

TOTAL DISABILITY
You will be considered "totally disabled" if:

a. during the benefit waiting period and the next twenty four months of a Period of Total Disability, you are under the regular care and attendance of a licensed physician (other than yourself or a member of your immediate family) and are unable to perform the material duties of your regular occupation or employment, and
b. after the satisfaction of the Benefit Waiting Period and the next twenty-four months of a Period of Total Disability, you are unable to engage in any gainful occupation or employment for which you are, or may become, reasonably fitted by training, education or experience.

AMOUNT OF BENEFIT - OFFSET AMOUNT
The monthly benefit while totally disabled shall be the Maximum Benefits shown in the Schedule of Benefits payable under:

a. any Workers' Compensation or Occupational Disease or similar law; or
b. any group or franchise insurance plan; or
c. any Employer-sponsored salary or wage continuation plan; or
d. any local, state, or federal government disability or retirement law; or
e. any mandatory work loss provisions of any "no fault" auto insurance.

Long Term Disability benefits are paid in addition to the following sources of disability income that you may qualify to receive:

a. benefits from a personal individual disability income policy; or
b. benefits from any of the following:

1. an individual deferred compensation agreement; or
2. any employee savings plan; or
3. an individual retirement account (IRA or 401K Plan); or
4. a profit sharing savings plan maintained in addition to an Employer-sponsored defined benefit or defined contribution pension plan.

ELIMINATION PERIOD
It begins with the first day of total disability. If during this period, the total disability stops for not more than 7 days, the total disability will be considered as continuous. But the days that the insured is not totally disabled will not count towards satisfying the elimination period. No benefit is payable during this period.

WHEN PAYMENTS BEGIN
Monthly benefits will accrue from the first day after the qualifying period and will be payable while you continue to be "totally disabled", if due proof of the disability is given to the insurance company. However, benefits will not be payable beyond the date you attain age 65, if disability occurs prior to age 61. For disabilities commencing on or after age 61, benefits are payable for period of up to 3 ½ years, but not beyond age 70.

SUCCESSIVE PERIODS OF DISABILITY
If two or more disabilities, commencing while you are insured under this benefit are due to the same or related causes, and not separated by 180 consecutive days or more of regular, active full-time work at your usual place of business with the Employer, if any, they will be considered as having occurred during one Period of Disability.

However, during the Benefit Waiting Period, successive periods of total disability due to the same or related causes shall be considered one Period of Total Disability if separated by less than 14 days of active, full-time employment.

PARTIAL DISABILITY BENEFITS
After a period of Total Disability, you may be able to perform part time work at your current job or another job, but for a lower income. The partial benefits fills the gap by providing Monthly Benefits for Partial Disability.

Benefits will continue until one of the following occurs:

a. you make a complete recovery; or
b. you reach the end of the Benefit Period for Monthly benefits; or
c. your earnings from employment exceed 80% of your pre-disability income; or
d. you become totally disabled again.

For an Employee who has established Total Disability for at least the Benefit Waiting Period and who later goes on Partial Disability, **one benefit** (the partial benefit) **will be paid.**

NON-COVERED DISABILITIES

No benefits are payable for disability due to self-inflicted injuries, due to war, or due to participation in or as a result of participation in, the commission of a felony. Benefits are limited for disability resulting from mental or emotional disease or alcoholism or drug abuse

LIMITATIONS

No benefits are payable for the following:

a. A day on which an Employee works for pay or profit.
b. A day an Employee is not under the care of a legally qualified physician. The Employee must have been seen in person and treated by a physician to be deemed "under his care".
c. Any illness or injury which is excluded under the Health Benefits provided by this Employer,.
d. Any illness or injury caused by, contributed to by, or resulting from your intentionally self-inflected injuries; active participation in a riot; loss of a professional license, occupational licenses or certification; or commission of a crime for which you have been convicted under state or federal law.
e. Any pre-existing condition. The Employee will be considered as having a pre-existing condition if Employee received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 6 months just prior to the effective date of coverage and the disability begins in the first 12 months after effective date of coverage.

COMPREHENSIVE MEDICAL BENEFITS

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 excess loss carrier will be reimbursable under this provision.

The Plan Supervisor and excess loss company (when applicable) 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.

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.

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 me 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.

BENEFITS
Traditional Deductible/Option 1 covered medical expenses incurred after any Deductible are payable at the rate of 80% (unless otherwise stated in the Schedule of Benefits) and the Employee is responsible for paying the remaining 20% when an in-network provider is used. For out-of-network services, covered medical expenses incurred after any Deductible are payable at the rate of 50%. The Employee is responsible for paying 50%.

High Deductible/Option 2 covered medical expenses incurred after any Deductible are payable at the rate of 80% (unless otherwise stated in the Schedule of Benefits) and the Employee is responsible for paying the remaining 20% when an in-network provider is used. For out-of-network services, covered medical expenses incurred after any Deductible are payable at the rate of 60%. The Employee is responsible for paying 40%.

COINSURANCE LIMIT
Traditional Deductible/Option 1 Individual Limit: When 20% for in-network (50% for out-of-network) of such 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 family member in the rest of that year will be paid at the rate of 100% rather than 80% for in-network (50% for out-of-network), except where maximum benefits have been met. The deductible is not included in coinsurance limit.

Traditional Deductible/Option 1 Family Limit: For a family unit, when 20% for in-network (50% for out-of-network) of such expenses 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 family members in the rest of that year will be paid at the rate of 100% rather than 80% for in-network (50% for out-of-network), except when maximum benefits have been met. The deductible is not included in coinsurance limit.

High Deductible/Option 2 Individual Limit: When 20% for in-network (40% for out-of-network) of such 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 family member in the rest of that year will be paid at the rate of 100% rather than 80% for in-network (60% for out-of-network), except where maximum benefits have been met. The deductible is not included in coinsurance limit.

High Deductible/Option 2 Family Limit: For a family unit, when 20% for in-network (40% for out-of-network) of such expenses 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 family members in the rest of that year will be paid at the rate of 100% rather than 80% for in-network (60% for out-of-network), except when maximum benefits have been met. The deductible is not included in coinsurance limit.

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 emergency room charges 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.

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 and only under the home health care benefit;

D. medical services or supplies prescribed by a legally qualified physician or surgeon, as follows:
   a. drugs or medicines which require a written prescription and must be dispensed by a licensed pharmacist including prescription drugs for Attention Deficit Disorder (ADD) and Attention Deficit/Hyperactivity Disorder (ADHD) when covered person not over 25 years old (medication dispensed in the physician's office is not covered);
   b. contraception available upon a medical doctor's prescription;
   c. prescription drugs and diagnostic testing for sexual dysfunction or sexual inadequacies. However, the quantity of Viagra (and any equivalent drugs) will be limited to 10 pills per month;
   d. oxygen;
   e. 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;
   f. surgical supplies including casts, splints, trusses, braces, crutches, bandages and dressings;
   g. artificial limbs and eyes--but not eye examinations, eyeglasses, or orthopedic shoes or other devices to support the feet;
   h. processing and administration of blood or blood components, including the cost of the actual blood or blood components if replaced;
   i. 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);
   j. covered expenses for treatment of non-service-connected disabilities in Veterans Administration hospitals;

k. 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);

l. insulin, insulin syringes and needles when dispensed at the same time as the insulin and in a days supply corresponding to the amount of insulin purchased, and chemical strips used in testing blood, all of which are for treatment of diabetes;

m. 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;

n. 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;

o. breast reduction surgery when deemed to be medically necessary by this Plan's pre-utilization vendor. The pre-utilization vendor will use accepted national guidelines to determine medical necessity; and

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

SPECIAL CONDITIONS COVERAGE

A. **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. This includes any transfers required by the medical condition (not convenience) of the patient.

B. **Anesthesia** – General and regional anesthesia when it is medically necessary that the service be performed by an anesthesiologist instead of the surgeon or assistant surgeon. Benefits will be payable for medically necessary services by a certified Registered Nurse Anesthetist if the service provided is within his or her license.

C. **Consultations** – A physician, at times, may refer a patient to a second physician for help in diagnosing and treating a condition. When this occurs and a consultation charge is billed, it will be payable under the plan. Mental Health/ Substance Abuse Consultations payable under Mental Health/ Substance Abuse benefit.

D. **Dental Work and Oral Surgery** – Covered expenses for dental work and oral surgery will be considered covered only if they are for the treatment and/or repair of natural teeth or other oral tissue injured as the result of an accident (this does not include injuries to teeth due to biting or chewing). All treatment and/or repair must be rendered within six (6) months of the accident. Removal of tumors within the oral cavity will be covered under the medical portion of this Plan.

E. **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. Reconstructive 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 of covered dependents will be Covered Medical Expenses if they are recommended and performed by a licensed physician. This includes reconstructive breast surgery following a radical mastectomy. Botox injections used for the treatment of a diseased condition will be included as a covered medical expense if they are recommended and performed by a licensed physician.

F. **Dietetic and Nutritional Education, Training and Counseling** – Charges for initial dietetic education, training and nutritional counseling to control the disease for individuals newly diagnosed as diabetic will be payable under the plan up to the limits shown in the Schedule of Benefits. A state-licensed provider operating within the scope of his/her license must perform Dietetic and Nutritional education, training and counseling.

G. **Diagnostic X-ray/Laboratory Testing** – The following procedures are covered when ordered by a physician because of specific symptoms:

a. radiology, ultrasound, and nuclear medicine;
(Covered routine ultrasound charges for covered pregnant Employees and spouses will be limited to one (1) test during a pregnancy. Any ultrasound charges beyond the first test will be covered only if a medical complication is sufficiently documented by the pregnant female's physician. Ultrasounds to check for delivery date or size will not be covered after the first ultrasound reimbursed under plan.)
b. laboratory and pathology;
c. EKG's, EEG's and other electronic diagnostic medical tests;
d. psychological testing;
e. neuropsychological testing; and
f. allergy testing

Mental Health/Substance Abuse diagnostic services payable under Mental Health/ Substance Abuse benefit.

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.

H. **Emergency Room** – Services received in an emergency room are covered as stated in the Schedule of Benefits. The copayment will not apply toward the coinsurance limit of this Plan. The copayment will be waived if admitted as an inpatient from emergency room.

I. **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 physicians services;
g. medical supplies; and
h. ambulance transportation to the facility from the hospital where confined.

J. **Foot Care Expenses** – Foot care and orthotics will be covered up to the limits shown in the Schedule of Benefits. The annual maximum does not apply to expenses for open cutting procedures and care of corn, bunions, callouses or toenails when medically necessary because of diabetes or circulatory problems.

K. **Hearing Aids** – Hearing aids and the fitting thereof will be covered. When hearing aids are not rendered in connection with medical or surgical treatment for injury or illness, coverage will be limited to the annual individual maximum shown in Schedule of Benefits. Voluntary ear implants due to a diagnosed medical illness or injury will be covered under the applicable medical portion of this plan.

L. **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 that meets Medicare's requirements and licensed in the state in which it operates;
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. Custodial care is not covered.

M. **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:

Facility Expenses – 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.

Other Expenses – 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; and
g. medical supplies, drugs, and medicines prescribed by a physician.

Hospice Exclusions – The following charges will not be covered:

a. Bereavement counseling
b. Funeral arrangements, pastoral counseling, financial or legal counseling
c. Homemaker or caretaker of services
d. Services provided by volunteer agencies

N. **Hospital Medical Visits** – Covered expenses are physician medical visits in a hospital facility. One visit per physician per day per diagnosis is allowed. For surgical admissions, the diagnosis must be different than the surgical diagnosis.

O. **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.

P. **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, aqua therapy, 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 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.

Q. **Maternity** – Benefits are payable for maternity-related expenses of covered female Employees and Dependent spouses and Dependent children on the same basis as any other illness while the individual is covered under the Plan. Expenses for a baby born to dependent child of employee is not covered under Plan.

In regards 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.

Newborn charges are considered separate from the mother's charges and are payable only under the newborn's eligibility record.

R. **Medical Aids** – Medical aids include: prosthetic devices, durable medical equipment and orthotic appliances.
Prosthetic Devices: Covered expenses are initial purchase, fitting, repair, and replacement of fitted devices which replace body parts or perform bodily functions.

Durable Medical Equipment (DME): Covered expenses are the initial purchase (including repair and replacement) or rental of equipment that is appropriate for home use and manufactured mainly to treat the injured or ill. Routine maintenance is not covered. Repairs of rental equipment are not covered expenses. Covered charges for deluxe items are limited to the cost of standard items.

The plan will pay for ONE of the following: a manual wheelchair, motorized wheelchair if medically necessary or motorized scooter unless necessary due to growth of the person or changes to the person's medical condition require a different product as determined by the plan.

If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries or replacement only if required:

a. Due to growth or development of a Dependent Child;
b. When necessary because of a change in the covered persons physical condition; or
c. Because of deterioration caused from normal wear and tear.

The repair/replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse as determined by the Plan are not covered and replacement is subject to prior approval by the Plan.

The plan covers taxes, shipping and handling charges for durable medical equipment.

Orthotic Appliances: Covered expenses are initial purchase, fitting, repair, and replacement of braces, splints, and other appliances used to support or restrain a weak or deformed part of the body. The following items are not covered:

a. corrective shoes, unless they are an integral part of a leg brace above the limits shown in Schedule of Benefits for Foot Care Expenses;
b. standard elastic stockings unless for diagnosed circulatory illness;
c. garter belts;
d. other supplies not specifically made and fitted; and
e. shoe inserts, even if specially made above the limits shown in Schedule of Benefits for Foot Care Expenses.

S. **Mental Health/Substance Abuse Care** –

Mental and Nervous Disorders

If a person is an inpatient in a hospital, the expenses are covered in the same way as those for any other illness up to the Annual and Lifetime Maximums shown in the Schedule of Benefits. The Pre-utilization procedures must also be followed for this type of inpatient care.

If a person is not a hospital inpatient, the Schedule of Benefits shows the lifetime maximum for each individual for this coverage.

Substance Abuse Treatment

If a person is confined as an inpatient in either a qualified hospital or treatment facility, the covered charges are as follows:

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.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such programs must be a less restrictive alternative to Inpatient treatment.

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

T. **Morbid Obesity Expenses** – Medical treatment of morbid obesity, as defined in the Definitions section of this document, will be considered for payment under this Plan up to the limits shown in the Schedule of Benefits. Covered expenses include office visits, consultations, prescribed medication, and nutritional training when services prescribed and/or rendered by a legally qualified physician. Nutritional training must be prescribed by a legally qualified physician and performed by a Registered Dietician.

Expenses NOT covered include, but are not limited to bariatric banding or stapling, liposuction, abdominal reduction, body contouring procedures, and any other surgeries in connection with or as a result of weight loss whether or not the surgery has been deemed to be medically necessary.

Claims for reimbursement of prescribed medication for morbid obesity must be submitted to Dunn & Associates and will not be covered under the Prescription Drug Benefit copayments.

U. **Organ Transplant Expenses** – Charges incurred for organ transplant surgery will be considered as follows to allow for reasonable and medically necessary care and treatment.

Covered Transplants
a. heart
b. kidney;
c. liver;
d. lung;
e. pancreas;
f. combined heart/lung
g. combined kidney/pancreas;
h. bone marrow transplants;
i. high dose chemotherapy – *the use of a chemotherapeutic agent or agents for the treatment of, or for preventing recurrence of, cancer or cancer-like illness, with or without irradiation, in doses which exceed the FDA approved or commonly recognized dosage range for the drug or drugs employed, and which is expected to result in effects upon the bone marrow which would likely be lethal if untreated.*

All other transplants not specifically mentioned which are considered experimental will be excluded. No benefits will be paid for any charges associated with them.

Large Case Management
This Plan will work with Large Case Management to assess the covered person's continuing care needs and discuss with the physician less costly alternative means of care as described in the beginning of this Comprehensive Medical Benefits section.

Pre-utilization Program: Transplant benefits will be payable only when you receive written statements confirming the need for surgery from two physicians, not in the same practice, who are board certified in the involved field of surgery. The statements must certify that other types of treatment would not be effective in treating your condition. The two written opinions and certifications must be received by the Plan Supervisor at least five (5) working days before transplant surgery. The Plan Supervisor will respond to request for pre-utilization upon receipt of all necessary information. If the second physician's opinion does not support the first physician's opinion, a third opinion must be sought. *If these pre-utilization guidelines for transplant surgery are not met, none of the benefits described in this transplant section will be paid*.

Covered Organ Transplant Expenses will include:
a. hospital inpatient care
   1. room and board
   2. miscellaneous charges
b. physician services
   1. surgery
   2. assistant surgery
   3. anesthesia

4. inpatient medical visits
5. intensive medical care
6. consultations
7. home and office visits

c. diagnostic services
   1. radiology, ultrasound and nuclear medicine
   2. laboratory and pathology
   3. EKG, EEG and other electronic machine tests
   4. psychological testing
   5. neuropsychological testing

d. therapy services
   1. radiation therapy
   2. physical therapy
   3. respiratory therapy
   4. occupational therapy
   5. speech therapy (therapy for voice training or to correct lisping not covered)
   6. audiotherapy
   7. visual therapy
   8. chemotherapy

e. services and supplies for high dose chemotherapy when provided as part of a treatment plan which includes bone marrow transplantation (Limit: Benefits will be paid only if the individual is a participant in an FDA approved phase III or IV clinical trial and no alternative conventional treatment can be expected to result in an equal or better benefit or outcome.)

f. skilled nursing facility (SNF) care
   1. no benefits are payable after the patient has reached the maximum level of recovery possible for his or her condition and requires only supportive care

a. home health care services - must be prescribed by the physician before discharge from a hospital or a Skilled Nursing Facility

b. private duty nursing
   1. must be performed by a registered nurse or a licensed practical nurse and recommended by a physician. The nurse cannot be a family member of the recipient or normally live in the recipient's home. Private duty nursing limited to $10,000 per individual per transplant benefit period.

c. rental of durable medical equipment for use outside the hospital. Charges are limited to the purchase price of the same equipment

d. prescription drugs, including immunosuppressive drugs, oxygen, and diagnostic services

e. surgical dressings and supplies

f. transportation and lodging
   2. transportation, lodging and meals for the patient and one other person to and from the site of the transplant surgery are covered (if the patient has not reached his or her 18th birthday at the time of the transplant, transportation, lodging and meals for two other people will be covered up to a total benefit of $200 per day for lodging and meals combined)
   3. these services are covered only if the patient must travel at least 50 miles to the transplant site
   4. benefits are paid as any other Major Medical expense subject to a maximum of $10,000 per individual, per transplant benefit period

g. donor organ procurement (maximum benefit of $15,000 per type of transplant)
   1. evaluation and surgical removal of donor organ
   2. transportation of the donor organ
   3. storage costs

   Donor expenses will be paid whether or not the donor is covered under the Plan.

   If the donor is covered under any plan, that plan will be primary and obligated to pay donor expenses. If a donor is not covered under another plan, this Plan will pay expenses incurred by the donor and as part of the recipient's expenses for purposes of deductible, coinsurance, coinsurance limits, Plan maximums, etc.

   If the scheduled transplant is canceled due to the patient's condition or death, and the organ cannot be used by another patient, procurement benefits will still be paid. Benefits are paid as any other Major Medical expense subject to a maximum of $15,000 per type of transplant.

<u>Transplant Benefit Period</u>

The benefits of this transplant provision will begin five (5) days before the date of the transplant and end 18 months after the transplant or when the maximum benefit is reached (earliest of). This is the maximum time-frame allowable under the Transplant Benefit Period for the kidney or combined kidney/pancreas transplants regardless of any Coordination of Benefits standards with any other policy, including Medicare.

If two or more transplants are performed, the Plan Supervisor will consider reimbursement for transplant services during each benefit period as follows:

Benefits will be paid only to the extent that benefits would have been paid if a transplant were performed.

a. due to unrelated causes, they will have separate transplant benefit periods; or
b. due to related causes, they will have separate transplant benefit periods if the transplants are separated by a period of ninety (90) calendar days; or
c. due to related causes and not eligible for separation (under 2, above), the transplants will have the same transplant benefit period.

If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for transplant services:

a. up to the recipient's death, or
b. up to and including the date the decision is made by the recipient's physician not to perform the transplant.

Organ Transplant Exclusions

The Plan will not pay for:

a. services and supplies which are not directly related to the receipt of the organ;
b. artificial or animal organs;
c. the cost of the organ itself;
e. expenses the Employee incurs before his coverage begins or after it ends;
f. services or supplies to the extent that the Employee has no legal obligation to pay for them;
g. services or supplies furnished by any provider acting beyond the scope of his license;
h. personal hygiene and convenience items, even if prescribed by a physician;
i. any expenses when approved alternative remedies are available;
j. any financial consideration to the donor other than for a covered expense which is incurred in the performance of or in relation to transplant surgery; and
k. services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received.

In an effort to control cost and provide access to high quality of care, this Plan may implement an organ transplant network contract. This contract will be approved by the Plan Sponsor, Large Case Management, and Reinsurance Carrier. In most cases, the contract will include case rates for designated transplant procedures covered by this Plan. If an approved contract is in place the contract provisions and rates will supercede any organ transplant limitations in the Summary Plan Description booklet except for the Lifetime Maximum and travel expenses.

FULLY-INSURED TRANSPLANT POLICY

Benefits for the treatment of Transplants of the following human to human organ transplants:
Heart;
Heart/kidney
Heart/Lung(s);
Lung(s);
Liver;
Liver/cadaveric;
Liver/kidney;
Liver/live donor;
Pancreas;
Kidney;
Kidney/Pancreas (simultaneous);
Pancreas (after kidney);
Small Bowel;
Bone Marrow

A covered transplant procedure will include only the following human to human transplant procedures when the procedure is used to treat leukemia, lymphoma, blood and genetic diseases and solid tumors: 1) allogeneic related; 2) allogeneic unrelated; 3) autologous;

4) synogeneic; 5) cord blood; 6) peripheral stem cells will be covered under a separate insurance policy through United States Fire Insurance Company, managed by Fairmont Specialty. For specific benefit questions or to access a covered Provider or Facility, please call the Pre-Certification number on your ID Card.

Lifetime Maximum Transplant Benefit under this policy is unlimited.

Annual Maximum Number of Covered Transplant procedures of the same type are limited to two per policy year.

Lifetime Maximum Number of Covered Transplant procedures of the same type are limited to four per covered person's lifetime.

There is no deductible for transplant policy covered expenses. However, there is a precertification penalty of $5,000 per covered transplant procedure if the precertification requirements are not met.

The Transplant Benefit Period for all organ transplants (other than bone marrow) will commence five (5) days prior to the transplant procedure and will terminate 12 months after the transplant procedure. For all bone marrow transplants the benefit period will commence 30 days prior to the transplant procedure and will terminate 12 months after the transplant procedure.

Lodging and meals limited to a daily maximum of $200 per day; Transportation limited to a two trip maximum with an per transplant maximum (included transportation, lodging and meals) of $10,000.

Private Duty Nursing limited to $200 per day and limited to a per transplant maximum of $10,000.

All other services and supplies are limited to a per transplant maximum of $10,000.

Donor expenses including, transportation, lodging, meals, medical expenses and follow up care are limited to $10,000 per transplant.

Please refer to the Transplant Policy/Certificate for specific policy provisions. All other eligible transplants, other than those outlined above are covered under the group health plan (employer sponsored plan); as any other covered expense and will applicable to all precertification requirements and benefit limitations please refer to the schedule of benefits in this booklet.

V. **Physician Expenses**– Covered expenses include medically necessary care rendered by a physician in a hospital, urgent care facility, home, or office for the treatment of an illness or injury.

W. **Preadmission Testing** – Charges made by a physician, hospital, surgery center, or licensed diagnostic lab facility to test a person while an outpatient before scheduled inpatient admission will be paid as shown in the Schedule of Benefits if the tests are done within 72 hours prior to the scheduled admission, not performed to establish a diagnosis, or repeated after admitted.

If the person cancels the scheduled admission, benefits are paid the same as any other covered expenses.

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

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 brand name drugs on the Preferred Drug Listing are known as "Brand Preferred". Likewise, the brand name drugs not on the Preferred Drug Listing are known as "Brand Non-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 approved Prescription Benefit Manager (PBM) directly.

Generic Drugs

A generic drug 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.

Network Pharmacies (34-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. The Prescription Drug Program is through the approved Network listed on Employee's ID Card.

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.

Non Network Pharmacies

No benefits are available for prescription drugs filled at non-network pharmacies.

Mail Order Drugs (90-day supply)

There will be a Mail Order Drug program for Employees or Dependents who are on maintenance drugs.

Other Provisions
If brand name drug purchased when generic drug available and approved by physician, covered person will be responsible for the **brand** copayment plus the difference in the cost of the generic and the brand name drug purchased.

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.

Claims for reimbursement of prescribed medication for morbid obesity and smoking cessation will not be covered under the Prescription Drug Benefit. See the separate Morbid Obesity and Smoking Cessation Benefit sections for covered drugs and how to receive reimbursement.

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.

Prior Authorization Requirements
Before certain prescription drugs are dispensed to you, it is the responsibility of your Physician, your Pharmacist or You to obtain prior authorization. It will then be determined if the prescription drug is in accordance with your plan guidelines, is both a covered expense as defined by the plan and not an experimental, investigational or unproven drug.

Y. **Preventative Health Care Expenses** – Expenses incurred for lab work or physician charges for checkups and for the detection of cancer will be paid as shown in the Schedule of Benefits. This includes, but is not limited to, annual female pap smear exams, mammogram, prostate, and colon cancer screening.

In addition, charges for routine electrocardiograms (EKG), treadmill, blood testing and other "checkup" lab charges will be covered as well as professional and diagnostic fees related to the preventative care. Included are "sports" physicals and routine well-baby checkups, lab, immunization/inoculation charges and flu shots.

- Evidence based items or services that have in affect a rating of "A" or "B" in the current recommendations of the U.S. Preventative Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children/adolescents, evidence-informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Additional preventative care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
- Well-Woman preventative care visit(s) for adult women to obtain the recommended preventative services that are age and developmentally appropriate, including preconception and prenatal care. This well woman visit should , where appropriate, include other preventative services listed in the Health Resources and Services Administration guidelines, as well as other referenced in the Affordable Care Act:
    1. Screening for gestational diabetes
    2. Human Papillomavirus (HPV) DNA testing
    3. Counseling for sexually transmitted infections
    4. Counseling/screening for human immune-deficiency virus
    5. Counseling/screening for interpersonal and domestic violence.

  For more information; please visit the following websites
  http://www.healthcare.gov/law/resources/regulations/prevention
  http://www.hrsa.gov/womensguidelines/

Z. **Smoking Cessation Expenses** – A smoking cessation benefit will be available. Covered expense will be payable as shown in the Schedule of Benefits. Covered expenses include smoking cessation products prescribed by a legally qualified physician. Over the counter products will NOT be covered. Related physician office visits will be considered under the allowances for Preventive Care. Drugs for smoking cessation are now reimbursable through the drug program.

AA. **Supplemental Accident Expenses** – Payments, up to the maximum shown in the Schedule of Benefits, will be paid toward the expenses for medically necessary outpatient care of accidental injuries. The outpatient expenses must be incurred within 72 hours of the accident for which charges are being made. The time limit does not apply to rabies injections.

BB. **Surgery** (facility and physician fees) – Inpatient and outpatient physician surgical services and the associated facility fees are covered when medically necessary.

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 reimbursement of assistant surgeon charges will not exceed 20% of the maximum allowed charge for the surgeon's charge. Assistant Surgeons will not include Surgical First Assistants (FSA) and or Certified First Assistants (CFA) charges.

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).

CC. **Therapies** – Covered therapies include:

a. Chemotherapy – The treatment of disease by chemical or biological antineoplastic agents.
b. Dialysis – The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body. This includes hemodialysis and peritoneal dialysis.
c. Radiation Therapy – The treatment of disease by x-ray, radium, or radioactive isotopes.
d. Physical Therapy – The use of physical measures, activities and devices, designed to reduce the incidence and severity of physical disability, bodily malfunction and pain.
e. Occupational Therapy – The use of purposeful activity designed to improve or restore functions that have been impaired due to congenital disability, illness, or injury; or, where the function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.
f. Respiratory/Inhalation Therapy – The introduction of dry or moist gases into the lungs for treatment purposes.
g. Speech Therapy – Treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

Medically necessary x-ray charges incurred for therapy diagnosis or treatment will be considered as any other x-ray under the Covered Medical Expenses.

DD. **Temporomandibular Joint (TMJ) Expenses** – The following charges for treatment of temporomandibular joint (TMJ) disorders will be considered covered medical charges for a covered individual. These charges will be considered medical in nature whether performed by a medical doctor, a dentist or an oral surgeon:

a. diagnostic services;
b. assistant surgeon services;
c. removable orthotic appliances; and
d. expenses for anesthesia, surgery, home and office visits and equilibration.

TMJ Exclusions:

a. orthodontia (including services and supplies);
b. fixed orthotic appliances;
c. crowns; and
d. orthognathic/prognathic/maxillofacial surgery (surgical straightening of jaw).

EE. **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 not 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.

FF. **Cash Reward Program** – When a covered person receives medical care, try to keep notes on the services and supplies received, request an itemized billing for the charges incurred, and check these documents against the Explanation of Benefits (EOB) received from the Plan Supervisor. If there are any discrepancies between the services and supplies received and the billed amount shown on the EOB, please notify the Plan Supervisor in writing. The Plan Supervisor will investigate the charges in question and if an error by the provider was made, 50% of the actual savings to the Plan will be paid to the covered person up to the maximum shown in the Schedule of Benefits.

GG. **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 of covered dependents born under this Plan 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, as well as, breast reduction surgery when deemed to be medically necessary by this Plan's pre-utilization vendor. The pre-utilization vendor will use accepted national guidelines to determine medical necessity.

HH. **Dialysis –** Dialysis services and supplies (inpatient and outpatient) which are provided and billed by a Physician or Medicare-certified dialysis center will be covered under the Plan up to the limits shown in the Schedule of Benefits.

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.

Maximum allowable amount 120% of the Medicare allowable for incurred expenses. Please see schedule of benefits for limitations.

II. **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.

JJ. **Wellness Benefit** – Covered expenses include:

a. weight reduction programs offered by organizations (such as Weight Watchers®); and
b. health club facilities licensed to do business in the state in which they are operating; and
c. wellness/exercise programs offered by a facility such as a hospital or a parks and recreation department (including charges for personal trainers at such facilities); and
d. Iron Man, triathlon, marathon, mini-marathon, 5K, 10K and cycling events.

All covered expenses will be considered for payment up to the limits shown in the Schedule of Benefits.
Participants must attend ten (10) sessions per month for health club facilities and exercise programs to qualify for reimbursement under this plan. Participants must have 75% attendance to any weight reduction program to qualify for reimbursement under this plan. Appropriate attendance documentation must be submitted with each claim.

Family Memberships: If a family membership is purchased, but the employee has single medical coverage, reimbursement will be made for the equivalent single membership. If the employee has employee + spouse coverage, reimbursement will be made for the equivalent employee + spouse membership.

Expenses NOT covered include, but are not limited to:

a. home exercise equipment; and
b. bariatric banding or stapling, liposuction, abdominal reduction, body contouring procedures, any other surgeries/treatments in connection with weight loss or as a result of weight loss whether or not the surgery/treatment has been deemed to be medically necessary; and
c. treatment for any complications resulting from non-covered weight loss surgeries and treatments; and
d. food or food supplements; and

e. organized sport league fees; and
f. babysitting fees.

Covered persons should consult with a physician before participating in any weight reduction program, health club facility or wellness/exercise program and keep the physician informed of progress.

KK. **Infertility Treatment** – to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person

LL. **Modifiers or Reducing Modifiers** if Medically Necessary, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the plans guidelines are to allow 120% of Medicare fee allowance for the primary procedure and a percentage (%) of the fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan

COMPREHENSIVE MEDICAL EXCLUSIONS AND 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. services and supplies for research studies or screening examinations, except as specifically stated as covered in the Comprehensive Medical Benefits section of this document;

C.

D. 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 enlargements, and face lifts, or blepharoplasty or any similar surgery of the upper or lower eye lid whether or not recommended by a physician as medically necessary. Breast reductions are also excluded unless deemed to be medically necessary by this Plan's pre-utilization vendor. The pre-utilization vendor will use accepted national guidelines to determine medical necessity;

E. hearing aids and the fitting thereof or hearing services and supplies not rendered in connection with medical or surgical treatment for injury or illness (above limits shown in the Schedule of Benefits);

F. charges for the treatment of refractive errors, including but not limited to eye exams, glasses, contact lenses (or their fitting), radial keratotomy procedures (RK), photorefractive Keratectomy (PRK), Lasik, Epi-Lasik and other forms of surgery and any vision services and supplies not rendered in connection with medical or surgical treatment for injury or illness, except vision exams covered for participants up to age 21 will be covered under the medical plans preventative coverage;

G. 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;

H. 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 substantial groups or clandestine agents, usually intended to influence an audience; or

I. 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;

J. 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, beyond the first 72 hours after incident, unless such an injury results from a medical condition, physical or mental;

K. 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, except as required by the Patient Protection and Affordable Care Act (PPACA) under the medical plan preventative coverage;

L. any treatment of obesity or weight reduction due to any cause except as specifically stated as covered under Morbid Obesity Expenses and then only up to the limits stated in the Schedule of Benefits; except as required by the Patient Protection and Affordable Care Act (PPACA) under the medical plan preventative coverage;

M. charges for housekeeping, custodial, rest or domiciliary care;

N. 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);

O. 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) or Z.I.F.T. (Zygote Intrafallopian Transfer)

d. surgery performed in an attempt to facilitate or enhance the potential for conception
e. freezing or storage of embryo, eggs or semen;
f. any other fertility or infertility treatment or prescription drugs;

P. travel, except as allowed under Ambulance and Organ Transplant coverage, whether or not recommended by a physician and mileage costs;

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 or premarital counseling, recreational, diversional, 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. Prescription drugs and diagnostic testing will be considered under the Plan but only up to the limits set forth in the Comprehensive Medical Benefits section under "Covered Medical Expenses";

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. expenses incurred at a health spa or similar facility;

Y. nutritional supplements or vitamins, whether or not recommended or prescribed by a physician (exception: Vitamin B12 injections, IV iron therapy and prenatal vitamins will be covered if medically necessary);

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

AA. 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";

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;

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 above the limits shown in Schedule of Benefits for Foot Care Expenses, 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 without regard to Foot Care Expenses maximum. Care of corns, bunions, callouses or toenails is covered when medically necessary because of diabetes or circulatory problems without regard to Foot Care Expenses maximum as well; above the limits shown in the schedule of benefits.

GG. services or supplies used to treat conditions related to: (1) learning disabilities; (2) behavioral problems; (3) mental retardation; or (4) senile deterioration; beyond the period necessary for diagnosis except as specifically stated as covered elsewhere in this document;

HH. charges for a baby born to an employee's dependent child;

II. 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;

JJ. any organ transplant not specifically listed as covered which are considered experimental;

KK. cost of materials used in any occupational therapy;

LL. telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, and late fees or finance charges;

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

NN. preventative or routine care, including physicals, premarital examinations, and any other routine or periodic examinations above the limits shown in this document;

OO. alternative/complementary treatment; including but not limited to holistic or homeopathic medicine; massage therapy, hypnosis, biofeedback, or alternate treatment that is not accepted medical practice as determined by the Plan; regardless of whether the services are rendered or recommended by a licensed/registered medical professional for any and all causes;

PP. services and supplies related to the treatment of abuse of nicotine from tobacco or other sources, except as specifically stated as covered under Smoking Cessation Benefit and then only up to the maximum stated in the Schedule of Benefits;

QQ. genetic testing (unless it is for the purpose of determining the appropriate treatment of a diagnosed illness), counseling,and screening beyond what is required by applicable law (including but not limited to amniocentesis and chorionic villus sampling). Alpha Feta Protein testing will be covered;

RR. treatment and prescription drugs for 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);

SS. 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;

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

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

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

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

XX. claims not submitted within the Plan's filing limit deadlines as stated in the Claim Procedures section of this document;

YY. 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;

ZZ. take home medication from the hospital;

AAA. prescription drugs for the treatment of Attention-Deficit Disorder (ADD) or Attention-Deficit/Hyperactivity Disorder for individuals over 25 years of age (including but not limited to Dexedrine and Ritalin);

BBB. growth hormones;

CCC. medications that can be purchased over the counter (OTC) including but not limited to bandages, vitamins, and aspirin (exception: prenatal vitamins will be covered);

DDD. any medications dispensed in the physician's office; and

EEE. prescription drugs in quantities that exceed the limits established by Plan.

FFF. Abortions – unless a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term;

GGG. Aquatic Therapy – unless provided by a qualified physical therapist;

HHH. Assistance with activities of daily living;

III. Assistant Surgeon services unless determined medically necessary by the Plan;

JJJ. Auto Excess – illness or bodily injury for which there is a medical payment or expense coverage provided or payable under any automobile insurance coverage;

KKK. Blood Donor expenses;

LLL. Blood Pressure cuff and monitor;

MMM. Cardiac Rehab beyond including self-regulated physical activity that the covered participant performs to maintain health that is not considered to be a treatment program;

NNN. Court-Ordered any treatment or therapy which is court ordered, ordered as a condition of parole, probation, custody or visitation evaluation, unless treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after driving while intoxicated conviction or any other classes ordered by the court;

OOO. Developmental Delays occupational, physical and speech therapy services related to developmental delays, mental retardation or behavorial therapy that are not medically necessary and are not considered by the Plan to be medical treatment;

PPP. Duplicate Charges/Inappropriate Billing including the preparation of medical reports/itemized bills;

QQQ. Examinations for employment; insurance, licensing or litigation purposes;

RRR. Family Planning consultations for family planning;

SSS. Financial Counseling;

TTT. Home Modifications, or modifications to your home or property such as but not limited to; escalators; elevators; wheelchair lifts; stair lifts or ramps;

UUU. Infant Formula administered through a tube as the sole source of nutrition for the covered person;

VVV. Lamaze Classes or any other child birth classes;

WWW. Maximum Benefit charges in excess of the maximum benefit allowed by the Plan;

XXX. Military related illness/injury to a covered participant on active military duty, unless payment is legally required;

YYY. Nocturnal Enuresis Alarm – bed wetting unless determined medically necessary by the Plan;

ZZZ. Non-custom Molded Shoe inserts;

AAAA. Pharmacy Consultations charges for or relating to consultative information provided by a pharmacist regarding a prescription order; including but not limited to information relating to dosage instruction; drug interactions; side effects and the like;

BBBB. Private Duty Nursing Services;

CCCC. Room and Board Fees when surgery is performed other than at a hospital or surgery center

DDDD. Self-Administered Services or procedures that can be done by the covered person without the presence of medical supervision;

EEEE. Surrogate Parenting/Gestational Carrier services;

FFFF. Taxes sales tax, shipping and handling unless covered elsewhere in this plan document;

GGGG. Transportation services which are solely for the convenience of the covered participant; participants close relatives or the participant's Physician;

HHHH. Travel costs whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan;

IIII. Weekend Admissions to hospital confinement (after 3PM on Friday or before noon on Sunday) are not eligible for reimbursement under this Plan, unless the admission deemed an emergency, or for care related to pregnancy that is expected to result in childbirth;

JJJJ. Wrong Surgeries additional costs and/or care related to wrong surgeries; including but not limited to surgery performed on the wrong body part; surgery performed on the wrong person; objects left in patients after surgery; etc…

KKKK. Drugs or drug classes screened must reflect the participant's medical history. Screenings 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 screenings are not considered medically necessary.

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

The plan does not limit a covered person's right to choose his or her own medical care. If a medical expense is not a covered expense under this plan, or is subject to a limitation and/or exclusion, a covered person still has the right and privilege to receive such medical service/supply at the covered persons own expense.

COMPREHENSIVE DENTAL BENEFITS

BENEFIT
Covered Dental Expenses include the charges of a dentist or duly qualified physician for services and supplies required in connections with the dental care and treatment of any illness, defect or accidental bodily injury, or in connection with preventative dental care, except charges in excess of reasonable and customary. The Covered individual may choose any licensed dentist practicing within the scope of his/her profession or any physician furnishing dental services for which he/she is licensed.

DEDUCTIBLE
The dental deductible amount is the total amount of covered expenses that an Employee or dependent must satisfy in each calendar year before an Employee or dependent is eligible for Comprehensive Dental Benefits.

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

MAXIMUM BENEFITS
The maximum dental benefit shown in the Schedule of Benefits applies separately to each covered individual for all covered dental services received in any one calendar year.

COVERED EXPENSES

A. Preventative services and supplies:
   a. oral exam, but not more often than every 6 months; limit of 2 exams per year payable under Type I coverage; and
   b. prophylaxis, but not more often than every 6 months; limit of 2 cleanings per year payable under Type I coverage.
   c. fluorides, but not more often than every 6 months;

B. Diagnostic and therapeutic services:
   a. space maintainers;
   b. sealants;
   c. full mouth x-rays, but not more often than every 3 years;
   d. bite-wing x-rays, but not more often than every 6 months;
   e. emergency pallative treatment;
   f. extractions and oral surgery, but any additional charges for removal of stitches or post-operative examination in connections with the procedure shall not be included;
   g. periodontics for treatment of the gums and supporting structures of the teeth;
   h. endodontics;
   i. anesthetics in conjunction with oral surgery, periodontics, fractures and dislocations;
   j. injectable antibiotics administered by a dentist or physician.

C. Restorative services and supplies - charges made to restore the structure of a tooth or teeth broken down by decay or traumatic injury:
   a. amalgam, silicate, plastic or composite restorations;
   b. crowns and gold restorations, except that
      1. crown or gold restorations will be limited to the charge for an amalgam, silicate, plastic or composite restoration unless the tooth structure cannot be restored with such other material;
      2. replacements of crown or gold restoration will be covered only if it is over five years old; and
      3. precision attachments, personalization, characterizations or specialized techniques shall not be covered.

D. Prosthetic services and supplies:
   a. full dentures, removable partial dentures, fixed bridges (including crowns and inlays) or adding/replacing teeth to an existing prosthesis; and
   b. repair or rebasing of an existing full or partial denture if such denture has not been replaced by a denture covered under this plan.

E. Orthodontic services and supplies - charges made for services and supplies in connections with orthodontic treatment for covered dependent children up to 19 years of age:
   a. this plan will not cover that portion of charges for orthodontic services that incur prior to the time an Employee or dependent become eligible;
   b. this plan will pay that portion that incurs after eligibility commences if there was a written signed contract at the time the orthodontic work started indicating the date and amount of charges; and
   c. the plan will not pay for that portion of orthodontic service charges that continue after termination from the plan.

COMPREHENSIVE DENTAL EXCLUSIONS AND LIMITATIONS

No payment shall be made under this part of the Plan for expenses incurred as a result of the following:

A. charges for treatment by other than a dentist or physician except treatment performed under the supervision and direction of a dentist or physician, by any person duly licensed or certified to perform such treatment under applicable professional statues and regulations;

B. services or supplies partially of wholly cosmetic in nature;

C. education or training in personal oral hygiene or dental plaque control;

D. supplies used for dietary or nutritional counseling;

E. any services or supplies reimbursed under the medical portions of this plan;

F. charges for crowns and restorations other than those listed in the subsections captioned "Restorative Services and Supplies";

G. services and supplies not specifically covered under the plan or not incurred during a period of coverage;

H. dental care or supplies for which no charge was made, or no payment would be required if the covered individual did not have this coverage; or

I. illness or injury covered by Workmen's Compensation and/or any illness or injury if it arises out of employment for pay, profit or gain.

COMPREHENSIVE VISION BENEFITS, EXCLUSIONS AND LIMITATIONS

ELIGIBILITY FOR EMPLOYEES
All Certified, Contractual, Administrators, School Attorney and Board Members are eligible for and electing vision coverage.

BENEFIT
Vision coverage provided for certain kinds of eye care. The Plan will pay the amount charged by a legally qualified optician, optometrist, or ophthalmologist for covered expenses for a covered person up to the individual maximum shown in the Schedule of Benefits.

DEDUCTIBLE
The vision deductible amount is the total amount of covered expenses that an Employee or dependent must satisfy in each calendar year before an Employee or dependent is eligible for Vision Benefits. There is no carryover of deductible from one calendar year to the next.

MAXIMUM BENEFITS
The maximum vision benefit shown in the Schedule of Benefits applies separately to each covered individual for all covered vision services received.

COVERED EXPENSES
Covered vision care expenses are the charges which a covered person is required to pay for the following services and supplies received while eligible:

a. eye examinations, including related diagnostic services, when performed by a physician;
b. prescribed eye lenses and/or frames;
c. prescribed contact lenses;

Medically necessary contact lenses must be prescribed by a in-network physician as (required for certain medical conditions) and approved by the vision network. Otherwise, the "elective" allowance will prevail.

Contact lenses are considered to be elective if you elect to wear contact lenses instead of glasses for personal choice, versus a medical condition that prevents you from wearing eyeglasses.

Any expense is deemed to be incurred on the date on which the service or material(s) which first gave rise to the expense is rendered or obtained.

This plan will cover contacts or lenses in a 12 month period but not both. All other services are limited to every 12 months except for frames. Frames are limited to every 24 months..

Covered vision care expenses do not include and no benefits are payable for:

A. any services or materials other than specifically set forth above or any lenses which do not require a prescription;
B. any services or materials provided as a result of a Workers Compensation or occupations disease law or for which no charge is made or furnished by or payable under any plan or law or any government, federal or state, or any political subdivision thereof;
C. premium costs for contact lens insurance;
D. any charges above the individual maximum shown in the Schedule of Benefits;
E. LASIK procedures; and
F. no-line multi-focal lenses.

COORDINATION WITH OTHER PLANS

BENEFITS SUBJECT TO THIS PROVISION
This provision shall apply to all benefits provided under any section of this Plan.

EXCESS INSURANCE
If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

a) Any primary payer besides the Plan;
b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) Any policy of insurance from any insurance company or guarantor of a third party;
d) Worker's compensation or other liability insurance company; or
e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

VEHICLE LIMITATION
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

ALLOWABLE EXPENSES
"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section herein, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.
"Claim Determination Period" shall mean each calendar year.

CLAIM DETERMINATION PERIOD
Claim Determination Period shall mean each calendar year.

EFFECT ON BENEFITS:

APPLICATION TO BENEFIT DETERMINATIONS
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

ORDER OF BENEFIT DETERMINATIONS
For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;

2. The benefits of a plan which covers the person on whose expenses claim is based as an employee or spouse of an employee, shall be determined before the benefits of a plan which covers such person as a dependent child;
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
5. A plan which covers an individual as a spouse will be primary to a plan which covers and individual as a dependent child;

6. a plan which covers an individual as a spouse will be primary to a plan which covers an individual as a dependent child;

7. 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;

8. if the birthday anniversaries are the same, then the plan which has covered the dependents the longest will be the primary plan;

9. 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;

A. 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.

B. 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.

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.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such

purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

RIGHT OF RECOVERY

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. **Please see the Recovery of Payments provision above for more details.**

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the

Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

EXCESS INSURANCE
If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS
Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH
In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

OBLIGATIONS
It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
2. To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
6. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.
7. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
8. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

OFFSET
Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

MINOR STATUS
In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION
The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

MEDICARE PROVISIONS

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. at (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 also may 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.

<u>For more information about your options under Medicare prescription drug coverage…</u>
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 employment terminates;
b. transfer to a class of employees not covered by the Plan;
c. participant dies;
d. any required contributions are not paid;
e. Plan terminates; or
f. participant enters the Armed Forces, except when covered by USERRA.
g. has the last date of the month in which you tell the plan to cancel your coverage if you are voluntarily canceling it while remaining eligible because of change in status or special enrollment
h. the date you submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

If an Employee becomes totally disabled, benefits will continue for 6 months from LTD qualification. At the end of the 6-month period, 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.

Certified & Classified Employees – who complete a full school year contract they will have medical insurance coverage until September 1 of the calendar year in which the contract was completed.

DEPENDENT COVERAGE

The coverage of any Dependent will terminate on the last day of the month on which any of the following events first occurs:

a. termination of eligibility as a dependent; age 26 dependents term end of month following 26th birthday as required by the Affordable Care Act.
b. failure to make any of the required contributions; or
c. the day of the month in which your coverage ends except in the event that the employee dies, coverage for the dependent can continue for three months following the death of the employee, provided that the dependent pays the applicable contribution when due
d. the date you or your dependent submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

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 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. The Employee will be responsible for the Employee's portion of the premium.

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.

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.

CONTINUATION OF COVERAGE (COBRA)

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.

Federal law requires that most group health plans (including this Plan) give qualified beneficiaries the opportunity to continue benefits when there is a qualifying event that would result in a loss of coverage under this plan. Continuation of coverage is the same coverage that the plan gives to participants under the plan who are not receiving continuation of coverage. Each qualified beneficiary who elects continuation of coverage will have the same rights under the plan as any other participant or beneficiary.

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 DISABILITY/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 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.

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of the notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?
The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?
You always have 60 days from the time you lose your job-based coverage to enroll in the marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace Coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though – if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

CAN I ENROLL IN ANOTHER GROUP HEALTH PLAN?
You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?
When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your current health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance Payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

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
Effective November 1, 2014 there will be no pre-existing conditions as required by the Patient Protection and Affordable Care Act.

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.

RETIREE HEALTH BENEFITS

Certified Employees that participate in the teachers' retirement fund under Indiana Code 5-10-8-2.6 or former certified employees who qualify for a benefit under Indiana Code 5-10-8-2.6 will be eligible for continued health benefits through this Plan if they meet the following criteria on or within sixty (60) days of his/her retirement date:

a. completed nineteen (19) years of creditable service with a public Employer, twelve (12) years of which must have been completed immediately preceding the retirement date;
b. completed at least fifteen (15) years of participation in the retirement plan of which the employee is a member;
c. reached age 55;
d. not eligible for Medicare coverage prescribed by 42 U.S.C. 1395 et seq.;
e. filed a written request to the Trustees of the Richmond Community Schools Employee Benefit Trust within ninety (90) days after the employee's retirement date; and
f. employee agrees to pay the premium required by this Employer for such coverage (amount will not exceed the costs based on current COBRA rates.)

Classified Contractual employees hired prior to January 1, 2006 that choose to retire prior to age 65, the following guidelines will be observed in regard to continuation of insurance coverage:

a. completed twenty (20) years of service with Richmond Community Schools at least of fifteen (15) years must have been as a contractual employee;
b. completed at least fifteen (15) years in participation in the retirement plan of which the employee is a member;
c. reached age 55;
d. not eligible for Medicare coverage prescribed by 42 U.S.C. 1395 et seq.;
e. filed a written request to the Trustees of the Richmond Community Schools Employee Benefit Trust within ninety (90) days after the employee's retirement date; and
f. employee agrees to pay the premium required by this Employer for such coverage (amount will not exceed the costs based on current COBRA rates.)

Classified Contractual employees hired after January 1, 2006 that choose to retire prior to age 65, the following guidelines will be observed in regard to continuation of insurance coverage:

a. completed twenty (20) years of service with Richmond Community Schools, ten (10) years of which must have been completed immediately preceding the retirement date;
b. completed at least fifteen (15) years in participation in the retirement plan of which the employee is a member;
c. reached age 55;
d. not eligible for Medicare coverage prescribed by 42 U.S.C. 1395 et seq.;
e. filed a written request to the Trustees of the Richmond Community Schools Employee Benefit Trust within ninety (90) days after the employee's retirement date; and
f. employee agrees to pay the premium required by this Employer for such coverage (amount will not exceed the costs based on current COBRA rates.)

Richmond Community Schools will credit Classified Contractual employee with one year of credible experience for every two years of non-contractual experience. The credit will apply to insurance continuation benefits only and will not apply to any other retirement benefit.

Benefits will cease when the employee, or if applicable, a retiree who is receiving health insurance benefits pursuant to Article VI, Section 1(d) of the collective bargaining agreement between Richmond Community Schools and the Richmond Education Association, becomes eligible for Medicare or when the Employer terminates the health insurance program (whichever occurs first).
Dependent(s) of the Retired Employee will be eligible for the continued health benefits if they continue to meet all provisions of the Richmond Community Schools Employee Benefit Trust. Coverage for spouse will be terminated on the earliest of the following events:

a. when the Employer terminates the health insurance program
b. two (2) years after the date of the Employee's death
c. the date the dependent no longer meets the definition of a dependent (as stated in this Summary Plan Description/Master Plan Document)
d. the date the spouse remarries
e. dependent becomes eligible for Medicare coverage

Once a retiree declines retiree coverage, that retiree no longer has open enrollment rights following the declination of retiree coverage. The tie to Richmond Community Schools retiree coverage is broken at the time of declination.

USERRA RIGHTS AND COVERAGE

CONTINUATION 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.

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 ERISA 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 ERROR/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 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 feature 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.

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.

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. A 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 physicians 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
Effective November 1, 2014 there will be no pre-existing conditions as required by the Patient Protection and Affordable Care Act.

PREGNANCY
Medical Expenses benefits are payable for pregnancy-related expenses of covered female employees and dependents on the same basis as any other illness while the individual is covered under the Plan. In regards to the maternity stay, this Plan authorizes a stay, for the mother and child, of 48 hours for uncomplicated normal deliveries and a 96 hour stay for cesarean. This stay may be changed only by the attending physician in consultation with the mother.

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. [For ERISA plans, 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 the 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.

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.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION
For the purpose of determining the applicability of and implementing the terms of this provision of the Plan or any provision of similar purpose of any other plan, the Plan Supervisor (under the direction of the Plan Administrator) may, without the consent or notice of

any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Plan Supervisor deems to be necessary for such purposes.

Any person claiming benefits under this Plan shall furnish to the Plan Supervisor such information as may be necessary to implement this provision.

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 PROVISION
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 ERISA.
- 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.

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 of 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.

EMPLOYEE RIGHTS UNDER ERISA

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons shall have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report (Form 5500 series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "Fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA

ENFORCING COVERED PERSONS' RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If there are any questions about this Plan, contact the Plan Administrator. For any questions about this statement or about a Covered Person's rights under ERISA, or for assistance in obtaining documents from the Plan Administrator, Covered Persons should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

CLAIM APPEAL AND REVIEW PROCEDURES

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 take into account 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 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 take into account all comments, documents, records and other information submitted that relates to the claim 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 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 suit under ERISA 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 affect 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. Refer to the ERISA Statement of Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

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 PERIODS 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 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 the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section of this SPD for more details. 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.

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