

Summary Plan Description – July 1, 2024

**Southeast Dubois County School Corporation
Employee Benefit Trust**

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NAME OF PLAN: Southeast Dubois County School Corporation Employee Benefit Trust
TRUST ID NUMBER: 35-2030550
PLAN NUMBER: 501
PLAN EFFECTIVE DATE: December 1, 1997
PLAN REVISION DATE: July 1, 2024

Participants Include: This Summary Plan Description is for all eligible employees of Southeast Dubois County School Corporation.

Name & address of Employer/Plan Sponsor/Plan Administrator:

Southeast Dubois County School Corporation
432 E 15th St.
Ferdinand, IN 47532-9199
Phone: (812) 817-0900
Fax: (812) 367-1075

The Plan Administrator is responsible for compliance with the provisions of any state and/or federal requirements relating to this Plan.

Agent for Service of Legal Process:

The Plan Administrator named above.

Plan Supervisor:

Dunn and Associates Benefit Administrators, Inc.

4550 Middle Road; Suite A

PO Box 2369

Columbus, IN 47202

Phone: (812) 378-9960

Fax: (812) 378-9967

Web: www.dunnbenefit.com (includes *Dunn Online*)

Dunn Online is a service that provides plan participants with the ability to view their own eligibility and claims data plus more.

Plan Year/Calendar Year:

The financial records of the Plan are kept on a Plan Year basis beginning each September 1 and ending on each August 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. Medical benefits are self-insured by the Employer. Reinsurance policies have been obtained for aggregate coverage on behalf of the Employer. The reinsurance premiums are paid by the Trust.

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

For Covered Employees and Dependents:

Medical Benefits

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 coverages provided by this Plan will be deducted from his pay, and they are subject to change.

Trustees:

Superintendent

Southeast Dubois County School Corporation

432 E 15th St.

Ferdinand, IN 47532-9199

School Board President

Southeast Dubois County School Corporation

432 E 15th St.

Ferdinand, IN 47532-9199

President of Southeast Dubois County School Corporation CTA

Southeast Dubois County School Corporation

432 E 15th St.

Ferdinand, IN 47532-9199

When to File a 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).

Supporting Documentation

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

Claim Form

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

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

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

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

Prescription Drug Claim

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

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

Second Surgical Opinion Claims

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

Primary Coverage/Insurance Involved

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

Notification of Benefit Determination

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

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

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

Urgent Care Claims

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

Other Claims (Pre-Service and Post-Service)

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

Ongoing Course of Treatment

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

Claims Payment to an Estate or Minor

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

Preferred Provider Organization (PPO)

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

- The Primary PPO for this Plan is **Patoka Valley Health Care Cooperative (PVHCC)**.
- The Wrap Network (outside of the PVHCC area) for this Plan is **United Health Care**.

For Covered Participants living within the PVHCC service area

All providers contracted with the primary PPO 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 primary PPO Network). See the Schedule of Benefit within this Summary Plan Description booklet for additional information and exceptions to this payment process. When services are not available within the primary PPO Service Area, an "In-Network" physician may refer the patient to a provider in the "Wrap" Network. If such a referral is needed, PVHCC (the primary PPO) **MUST** be notified **PRIOR** to the visit to the "Out-of-Network" provider. If the referral is approved by the primary PPO, covered expenses will be paid at the "In-Network" rate. If the referral is not requested and/or not approved by the primary PPO, the covered expenses will be paid at the "Out-of-Network" rate.

For Covered Participants living outside of the Primary PPO service area - Wrap Network (outside of the PVHCC area)

All providers contracted with the **United Health Care (UHC)** "wrap" network will be considered "In-Network" providers. The covered person will not be required to get a referral approval from PVHCC if participant lives outside of the primary PPO service area. 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 wrap network). See the Schedule of Benefit within this Summary Plan Description booklet for additional information and exceptions to this payment process.

Primary PPO Service Area:

Full County – Crawford, Daviess, Dubois, Martin, Orange, Perry, Pike, and Spencer.

Partial County – Gibson zip code 47660 (Oakland City) and Warrick zip code 47673 (Tennyson)

An updated list of PPO providers can be obtained free of charge from the Human Resources Department of this Employer, the Plan Supervisor, or by contacting the network(s) directly:

<u>PPO Network</u>	<u>Website</u>	<u>Phone</u>
PVHCC	www.pvcooperative.com	(812) 683-3332 or (800) 318-1590
United Health Care	https://whyuhc.com/uhss	(844) 849-5748

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

Referrals

Referrals to an Out-of-Network provider are covered as Out-of-Network services, supplies and treatment. It is the responsibility of the covered person to assure services to be rendered are performed by In-Network providers in order to receive the In-Network provider level of benefits. PVHCC may only make a referral to an out-of-network provider if there is not a specialist provider within any network. ***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 appropriate network prior to having services rendered.***

Exceptions

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

- a. a covered person is outside of the state of Indiana for business or personal reasons for a short duration when expenses were incurred. "Short duration", for the purposes of the plan is defined as four (4) weeks or less. When travel is for business, "short duration" does not apply.
- b. a covered person temporarily residing outside of the network area to attend school or training.

Services received at Riverview Surgery Center located in Rockport, Indiana. Tax ID# 45-2951941 will be considered a non-covered benefit under this plan. Payment for all expenses billed by this facility will be the responsibility of the participant.

Services received at Pro-Rehab located in Ferdinand, Indiana. Tax ID#35-2071262 will be considered in-network.

Pre-Utilization in Indiana

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

Services Requiring Pre-Utilization Review

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

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

How to obtain pre-utilization review

Call Clinix 1-800-227-2298 and provide the following information to the case manager:

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

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

otherwise legally incapacitated) may designate an authorized representative for purposes of requesting pre-utilization review of services or appealing a denial involving Care Management in writing. Except that in the case of a claim involving urgent care, a health care professional with knowledge of the condition may always act as an authorized representative.

Notification of Pre-utilization determination

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

Continued Confinement

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

Concurrent Review

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

Discharge Planning

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

Case Management

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

Disease Management

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

If there is a disagreement/appeal

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

Benefit Reduction

If the procedures for Pre-utilization Review of Hospital Admissions are not followed, covered charges will be subject to a 20% per admission penalty. This penalty will not count toward any deductible or co-insurance maximums.

Remember

- ✓ Call Clinix *BEFORE* receiving the care mentioned above.

- ✓ *In emergencies, the Employee still needs to let Clinix know that a covered person has been admitted to the hospital within 48 hours of the admittance.*
- ✓ *An Employee should check his coverage under this Plan. Clinix reviews and approves the hospitalization. It does not approve Employee or dependent eligibility or that all charges are covered. An Employee must check his Plan for eligible procedures and charges.*
- ✓ *If the Employee does not follow procedures as required for hospital admissions, a \$250 per admission penalty will apply to the covered charges.*

Pre-Utilization outside of PVHCC

For Eligibility and Pre-certifications outside of the PVHCC service area, call United Health Care (UHC) (888) 619-0752. **Deaconess Hospitals and Ascension/St. Vincent Hospitals are in the PVHCC network and should be precertified by Clinix.**

Eligibility for Newly Hired employees:

Employees – Full-time is defined as employees who are scheduled to work at least 30 hours per week at the usual place of business or the location which you are required to travel. No person may be both an employee and a dependent of this Plan. Upon retirement, employees may be eligible to continue coverage under this Plan. For more information, refer to the Retiree Health Benefits section within this document.

Waiting Period:

All eligible employees will commence coverage on the first day of the month following employment 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 before such eligibility date (or on or within 30 days of such eligibility date if eligible for a Special Enrollment Period.) If application is made after the initial date of eligibility (other than during a special enrollment period available to special enrollees), the Employee shall be considered a Late Enrollee and, coverage for the eligible employee shall not become effective until the end of the next Open Enrollment period.

Eligibility for dependents:

An Employee may request coverage for his/her eligible dependents. 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 on or before the effective date. If the Employee makes a written request for coverage after the date on which he is eligible for dependent coverage, those persons who are his dependents shall be considered Late Enrollees and, coverage shall not become effective until the next Open Enrollment period.

Working Spouse Rule:

If the spouse of the Employee is employed and eligible for coverage under their own employer (regardless of cost) that spouse will NOT be eligible for coverage through this plan. The Working Spouse Rule does not require a spouse to enroll in his/her employer's plan.

Compliance with Health Insurance Portability and Accountability Act of 1996:

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

Special Enrollment Period (other coverage):

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

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

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility. However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in

connection with the other coverage.) The Employee or Dependent must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage. The effective date of coverage as the result of a special enrollment shall be the first day following the loss of coverage if proper enrollment procedures are completed within thirty (30) days of the loss of coverage.

Special Enrollment Period (Dependent Acquisition):

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

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

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

Special Enrollment Period (CHIP):

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

Open Enrollment

An open enrollment period shall be held annually during the month of October/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 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.

Medical Benefits			
Benefit Description	In-Network	Out-of-Network	Plan Limitations
Annual Maximum	Unlimited	Unlimited	Per Individual
Pre-Utilization	See pre-utilization section	See pre-utilization section	A reduction in benefits may apply if pre-utilization requirements are not met.
Deductible	EE/\$5,000 FAM/\$10,000	EE/\$10,000 FAM/\$20,000	Calendar year, in- and out-of-network deductibles do not apply towards each other. Deductible applies to all covered expenses unless otherwise stated under Special Conditions. Family deductible is considered met once any combination of family members meets the family deductible listed. Embedded deductible.
Covered Expenses	100% after deductible	100% after deductible	Unless otherwise stated under Special Conditions.
Coinsurance Limit			In- and out-of-network coinsurance limits do not include deductibles and do not apply toward each other. After the coinsurance limit has been met, covered expenses are payable at <u>100%</u> of reasonable and customary for the remainder of that calendar year. Coinsurance limits include any applicable copays.
Medical	EE/\$0 FAM/\$0	EE/\$0 FAM/\$0	
Rx	EE/\$0 FAM/\$0	EE/\$0 FAM/\$0	
Total	EE/\$0 FAM/\$0	EE/\$0 FAM/\$0	
Maximum Out of Pocket	EE/\$5,000 FAM/\$10,000	EE/\$10,000 FAM/\$20,000	Per calendar year.
Special Conditions			
Cash Reward	100% after deductible	100% after deductible	Limited to per occurrence maximum of \$500.
Dialysis	100% after deductible	100% after deductible	The maximum allowable amount is 200% of Medicare allowable for incurred expenses. Limited to 50 treatments per episode of care. Treatment will be considered a separate episode of care if more than 180 days have lapsed since the last outpatient treatment.
Emergency	100% after deductible	100% after deductible	Facility and Professional.
Extended Care/Skilled Nursing	100% after deductible	100% after deductible	Limited to an annual individual maximum of 60 days per convalescent period.

Benefit Description	In-Network	Out-of-Network	Plan Limitations
Foot Care	100% after deductible	100% after deductible	Limited to an annual individual maximum of \$500.
Home Health Care	100% after deductible	100% after deductible	Limited to an annual individual maximum of 100 visits and maximum of 4 hours per visit.
Hospice Care	100% after deductible	100% after deductible	Limited to an annual individual maximum of 30 days.
Hospital Room & Board	100% after deductible	100% after deductible	Limited to semi-private room rate, Intensive Care, limited to 4 times semi-private room rate.
Laboratory Expenses	100% after deductible at designated facilities – 100% after deductible all other facilities	100% after deductible	Designated facilities include Dubois County Health Department, Quest Labs, Lab Corp and Alverno Labs.
Mental Health/Substance Abuse	100% after deductible	100% after deductible	In and outpatient.
Organ Transplant	100% after deductible	100% after deductible	Please refer to the fully insured organ transplant policy certificate. Requirements must be followed and met, or a penalty may apply.
Outpatient Surgery	100% after deductible	100% after deductible	Includes facility and all professional fees.
Physician Office Visit	100% after deductible	100% after deductible	Primary Care Physician only.
Physiotherapy	100% after deductible	100% after deductible	Limited to an annual individual maximum of 30 visits. Includes ABA, Physical, Speech, Occupational, Cardiac Rehab and Chiropractic care.
Preventative Care	100% after deductible	100% after deductible	This plan follows the guidelines set forth by the US Preventative Task Force.
Temporomandibular Joint Disorder	100% after deductible	100% after deductible	
Transportation	100% after deductible	100% after deductible	Limited to a maximum of \$5,000 per trip.
Voluntary Second Surgical Opinion	100% after deductible	100% after deductible	

Benefit Description	In-Network	Plan Limitations
<p>Prescription Drug</p> <p style="text-align: center;">Generic Preferred Non-Preferred</p>	<p>30- or 90-day supply</p> <p>\$0 after deductible</p> <p>\$0 after deductible</p> <p>\$0 after deductible</p>	<p>Copays apply after the deductible has been met.</p> <p>If an insured elects not to purchase a generic drug when available and approved by the physician, the employee will be responsible for the brand copay plus the difference in the cost of the generic and the brand name drug purchased.</p> <p>High Deductible Plan - Embedded deductible/out of pocket maximum, if a member has family coverage, any combination of covered family members can help meet the family deductible/out of pocket maximum up to each person's individual deductible/out of pocket maximum.</p> <p>Out-of-Network - Discounts are available through pharmacies participating in Preferred network. Only the copay will need to be paid by the covered person up front.</p>
<p>Specialty Drug</p>	<p>Specialty drugs will no longer be covered under this plan. Please contact the Pharmacy Benefit Manager for guidance.</p>	

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

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

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

Active Work, Actively Working, Actively at Work – A requirement that an Employee be actively at work on a full-time basis at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go. Shall mean the Employee who has begun and is performing all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another designated location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to an approved FMLA leave. An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

ADA - Shall mean the American Dental Association.

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

AHA - Shall mean the American Hospital Association.

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

"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review (may not apply to short-term disability claims/appeals).
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate (may not apply to short-term disability claims/appeals).

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

determine that the same medical treatment or care is Alternate Treatment for other covered persons under this Plan in any other instance.

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

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

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

Approved Clinical Trial - means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services (CMS), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required). The Affordable Care Act requires that if a “qualified individual” is in an “Approved Clinical Trial,” the Plan cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate. “Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device, or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s Network area unless out of network benefits are otherwise provided under the Plan.

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

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

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

the Plan Administrator and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider. The Participant is responsible for any applicable payment of co-insurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

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

Brand Non-Preferred – Brand Non-Preferred drugs are those drugs 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.

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

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

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

CDC - shall mean Centers for Disease Control and Prevention.

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

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

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

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

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

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

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

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

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

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

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

Community Mental Health Center – This is a facility which:

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

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

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

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

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

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

- a. it is licensed to provide and is engaged in providing, on an inpatient basis, for persons convalescing from injury or disease, professional nursing services rendered by a registered graduate nurse or by a licensed practical nurse under the direction of a registered graduate nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
- b. its services are provided for compensation from its patients and which patients are under the full-time supervision of a physician or registered graduate nurse;

- c. it provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered graduate nurse;
- d. it maintains a complete medical record on each patient;
- e. it has an effective utilization review plan; and
- f. it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the mentally handicapped, custodial, or educational care or care of mental disorders.

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

Convalescent Nursing Facility – An institution, or distinct part thereof, that is operated pursuant to law and meets all the following conditions:

- a. it is licensed to provide, and is primarily engaged in providing, on an Inpatient basis, for persons convalescing from injury or illness, professional nursing services rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily activities;
- b. its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
- c. it maintains a complete medical record on each patient;
- d. it has an effective utilization review plan; and
- e. it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally retarded, custodial, or educational care, or care of Mental Disorders.

The term shall also apply to expenses incurred in an institution referring to itself as a skilled nursing facility, extended care facility, convalescent nursing home, or any other similar designation.

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

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

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

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

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

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

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

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

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

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

Dependents – Shall be any of the following:

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

The term "children" will include:

- a. an Employee's own natural children;
- b. an Employee's legally adopted child (or one for whom legal adoption proceedings have been initiated)
- c. all stepchildren (parent is currently married to the Employee)
- d. a child for whom the employee or employee's spouse has legal guardianship.

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

Mentally or Physically Handicapped Dependents - The term "dependent" shall also mean an unmarried child, who, if on such child's termination date, is incapable of self-sustaining employment by reason of mental or physical handicap and such child is chiefly dependent upon the Employee for support and maintenance. Proof of incapability must be submitted to the Plan Supervisor within 120 days of the child's 19th birthday. The child must have been incapacitated prior to age 19 and covered as a dependent under this Plan. The Plan Supervisor also has the right to require, at reasonable intervals, proof that an employee's child has been fully handicapped continuously since the last proof was submitted. After a child's coverage has been continued under this section for two years, the Plan Supervisor will not require this proof more often than once a year. If an Employee fails to submit any required proof or refuses to permit a medical examination of the child as requested, he/she will no longer be considered fully handicapped.

The term "Dependent" does **NOT** include the following the following:

- a. any full-time member of the Armed Forces, except as otherwise required under USERRA; or
- b. any person who is covered under this Plan as an Employee
- c. any person covered as a dependent of more than one Employee of this Employer

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

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

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. PPO rate or Reasonable and Customary does not apply in this instance. 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.

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

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

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

Embedded Deductible

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

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

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

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

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

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

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

All phases of clinical trials shall be considered Experimental.

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

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and

- e) efficacy as compared with the standard means of treatment or diagnosis; or
- 3. if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and
 - e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

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

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

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

Routine patient care costs for clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

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

- a. for a fee provides convalescents with room, board and 24-hour care by one or more professional nurses and other nursing personnel needed to provide adequate medical care;
- b. is under full-time supervision of a doctor or registered graduate nurse (RN);
- c. keeps complete medical records on each patient;
- d. if not operated by a doctor, has the services of one available under an established agreement;
- e. is not an institution, or part of one, used mainly as a rest facility, a facility for the aged, drug addicts, alcoholics, the mentally handicapped, or custodial or educational care or care of mental disorders; and
- f. has an effective utilization review plan.

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

Foot Care (non-surgical) Expenses – Foot care and orthotics will be covered up to the limits shown in the Schedule of Benefits with the exception of medically necessary services covered the same as any other medical condition. Such services are as follows:

- a. open cutting operation/surgery;
- b. care of corns, bunions, calluses or toenails when medically necessary because of diabetes or circulatory problems;
- c. care of heel spurs

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

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

Genetic testing for susceptibility to malignant diseases is considered medically necessary when the following criteria are met:

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

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

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

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

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

Hospice Benefit Period – A specified amount of time during which the covered person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a covered person certifies a prognosis of terminally ill, and the covered person is accepted into a Hospice program. The period shall end the earliest of six (6) months from this date or at the death of the covered person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof may be required by the Plan Administrator or its designee before a new Hospice Benefit Period can begin.

Hospice Care Program – A formal program directed by a Physician to help care for a Terminally Ill person that meets the standards set by the National Hospice Organization and has been approved by the Plan Supervisor. If the Hospice Care Program is required by a

state to be licensed, certified, or registered, the program must also meet such requirements to be considered an eligible Hospice Care Program.

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

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

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

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

- a. sterilization including vasectomy and tubal ligation
- b. the condition of being pregnant and all conditions and/or complications resulting from the pregnancy
 1. pregnancy is covered the same as any other illness for female employees and covered dependents.
 2. elective abortions - coverage is limited to abortions performed upon recommendation of a physician due to medical complications.

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 condition caused by accidental means which results in damage to the covered person's body from an external force.

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

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

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

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

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

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

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

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

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

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

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

Mental Health Parity – Pursuant to the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

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

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

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.

No Surprise Act – Protection from Surprise Medical Bills (<https://www.in.gov/healthcarereform/no-surprises-act>)

What is balance billing? Balance billing occurs when a health care provider bills a patient after the patient’s health insurance company has paid its portion. The balance bill is for the difference between the amount the provider charges and the price the insurance company sets, after the patient pays any co-pay, co-insurance, or deductible. Balance billing can occur when a consumer receives health care services from an out-of-network provider or an out-of-network facility. In-network providers agree with an insurance company to accept the insurance payment in full. In-network providers agree not to balance bill. Out-of-network providers do not have this agreement with the insurance company. Therefore, in the past they sometimes billed the patient for the amount not covered by insurance. Some health plans, such as Preferred Provider Organization (PPO) or Point of Service (POS) plans, offer some coverage for out-of-network care, but the provider can still balance bill the patient. Other plans offer no coverage for out-of-network providers and leave the financial responsibility entirely on the consumer. Balance billing is prohibited in both Medicare and Medicaid.

What is surprise billing? Surprise billing occurs when a patient receives a balance bill after unknowingly receiving care from an out-of-network provider or an out-of-network facility, such as a hospital. This can occur in emergency and non-emergency situations. Some states have enacted protections for consumers against surprise billing. However, state laws do not apply to self-insured health plans, which account for the majority of people who get coverage through an employer. Now, federal law adds additional protections.

What protections are in place?

A new federal law, the No Surprises Act, protects you from:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Paperwork Reduction Act Statement According to the Paperwork Reduction Act of 1995

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Retired Employee – An employee who on the date of retirement is at least 50 years of age and has at least 10 years of service with the Employer.

Room and Board Charges – Charges made by an institution for room and board and other necessary services and supplies must be regularly made at a daily or weekly rate. The semi-private rate is the charge which an institution applies to the most beds in its semi-

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

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

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

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

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

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.

Out-of-Pocket Expense/Deductible

The following amounts do not accrue toward the Out-of-Pocket Expense or Deductible Expense.

- premiums;
- expenses that are not covered under this Prescription Drug Program;
- expenses in excess of the reasonable and customary charges for services or supplies;
- expenses in excess of any maximum benefit list in the Prescription Drug Program;
- penalties;
- expenses reimbursed or covered through assistance programs or discount programs; and
- expenses related to non-preferred brand-name drugs and brand-name drugs when there is a generic equivalent that is medically appropriate.

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

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

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

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

The following is not effective treatment:

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

Charges for treatment of substance abuse that is not effective treatment as defined are not covered.

Summary Plan Description – Each Employee covered under the Plan will be issued an individual booklet which shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. Typically, the booklet is designed to be a summary of the Employee's benefits and in the event of any questions, the master

plan document shall be the prevailing document. This Employer issues one booklet that serves as both the Master Plan Document and Summary Plan Description.

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

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

Total Disability (Totally Disabled) – A physical state of a covered person resulting from an illness or injury which:
Employee - Wholly prevents the employee from engaging in any and every business or occupation and from performing any and all work for compensation or profit. Dependent – Wholly prevents the dependent from performing the normal activities of a person of like age and sex in good health.

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

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

Urgent Care Claim – A claim for medical treatment which, if the regular time periods observed for claims were adhered to:
a. could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
b. would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

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

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

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 re-insurance carrier will be reimbursable under this provision. The Plan Supervisor and reinsurance company will investigate other treatment programs to provide this Large Claim Management. The Employee and the patient's attending physician will be part of this process. This allows the Employee to make health care decisions that meet the patient's individual needs.

Deductibles - The deductible amount 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 High Deductible Health Plan (HDHP). The family deductible is considered satisfied once any combination of family members meets the family deductible listed.

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

If two or more covered family members incur total covered medical expenses equal to the Family Deductible in one year, there will be no further deductibles taken for any covered family members for that calendar year.

Charges in excess of reasonable and customary amounts, negotiated rates, eligible expenses exceeding any plan maximums and pre-utilization penalties will not apply to the deductible.

Benefits – Covered medical expenses incurred after any Deductible are payable at the rate of 100% (unless otherwise stated in the Schedule of Benefits) and the Employee is responsible for paying the remaining 0% when an in or out of network provider is used.

Coinsurance Limit - Individual Limit: When 0% 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 calendar year will, after any applicable deductible, be paid at the rate of 100% rather than 0% for in-network (50% for out-of-network), except where maximum benefits have been met.

Family Limit: For a family unit, when 0% 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 calendar year will, after any applicable deductibles, be paid at the rate of 100% rather than 0% for in-network (50% for out-of-network), except when maximum benefits have been met.

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 that an Employee pays for office visits and prescription drugs at the time of purchase through the drug store or mail-order program will apply toward the coinsurance limit of this Plan.

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

- A. hospital expenses for semi-private or intensive care room and board charges (as limited in the Schedule of Benefits) and hospital services and supplies furnished while confined or out-patient services are used;
- B. charges for reasonable and customary fees of legally qualified physicians and surgeons for necessary medical care or treatment. These charges will qualify whether treatment is provided in or outside a hospital setting;
- C. charges of a registered graduate nurse for private duty nursing service, but not by one who lives with the Employee or who is a member of his/her family or spouse's family;
- D. Medical services or supplies prescribed by a legally qualified physician or surgeon, as follows:
 - a. drugs or medicines which require a written prescription and must be dispensed by a licensed pharmacist or physician;
 - b. diagnostic x-ray, laboratory and microscopic examinations including allergy testing and any medically necessary pre-operative or pre-admission testing. Covered ultrasound charges for covered pregnant Employees and covered dependents will be limited to four (4) tests during a pregnancy.
 - c. x-ray, radium, and radioactive isotopes therapy;
 - d. anesthetics and oxygen;
 - e. rental of iron lung and other durable medical and surgical equipment including wheelchairs 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;

- f. surgical supplies including casts, splints, trusses, braces, crutches, bandages, and dressings. Also, necessary prosthetic appliances to replace physical organs or parts or to aid in their functions, but limited to the initial charge or the first such appliance unless due to a bodily change or as recommended and prescribed by a licensed physician;
 - g. artificial limbs and eyes, but not eye examinations, eyeglasses or orthopedic shoes or other devices to support the feet;
 - h. charges for necessary transportation by professional ambulance services from the place where a covered person is injured or stricken by illness to the first hospital where qualified treatment can be given. This includes any transfers required by the medical condition (not convenience) of the patient;
 - i. processing and administration of blood or blood components, including the cost of the actual blood or blood components if replaced;
 - j. 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);
 - k. fees of a physician or speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an illness, other than functional nervous disorder or to surgery as a result of illness;
 - l. covered expenses for treatment of nonservice-connected disabilities in Veterans Administration hospitals;
 - m. 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);
 - n. insulin, insulin syringes and clintests;
 - o. contraceptive devices and birth control pills available upon a medical doctor's prescription;
 - p. immunizations or inoculations which include customary childhood vaccinations and flu shots up to the limits shown in the Schedule of Benefits for Preventative Health Care Expenses;
 - q. 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;
 - r. routine mammography examinations for asymptomatic women;
 - s. routine pap smears and prostate exams;
 - t. charges for the reconstruction of a surgically removed breast, charges for surgery to produce a symmetrical appearance and charges for prostheses and treatment for physical complications from all stages of mastectomy, including lymphedemas; and
- E. charges for the services of a certified nurse-midwife in accordance with the Plan definition.

SPECIAL CONDITIONS COVERAGE

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

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 directly.

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

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

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

Network Pharmacies (30-day supply)

A special program has been designed with **Network Drug Stores in this Employer's area** to provide cost savings to Employees participating in this Plan on most drugs purchased at their stores. In addition to the savings on the drug cost, it will not be necessary to file a claim for drugs purchased at a **Network Store**. On the Employee's first visit, he needs to identify himself as an Employee covered under this Employer Benefit Plan to receive the discounted price at the time of purchase. After the initial visit, their computer will identify the Employee and his dependents. For brand name drugs, the cost depends on whether the drug is on the Preferred Drug Listing.

Non-network Pharmacies

When a non-network pharmacy is used, the covered person must pay for the entire cost of each prescription at the time it is filled and file a claim for reimbursement.

Tiered Pharmacy Network

A tiered pharmacy network will be implemented. This will increase your prescription drug copay for generic or brand name medications if you have them filled at a CVS, Walgreens or Rite-Aid Pharmacy. Also, a narrow formulary will be implemented. The Pharmacy Benefit Manger will notify all members that are or may be affected by this implementation.

Mail-Order Drugs (90-day supply)

This plan does not offer mail order drug program. 30-day and 90-day supplies can be provided at retail.

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.

Generic Enforcement

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

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.

Other Provisions

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

CanaRx

(90-day supply) CanaRx is a voluntary prescription drug program that is available to eligible employees, retirees and their covered dependents. For additional information, please refer to the CanaRx handouts available through your Employer. All member copayments have been waived for this program.

Reimbursement Levels - Benefits for eligible drugs are available for prescription drugs that are considered an eligible expense as set forth in this document. The rx program pays benefits at different levels based upon prescription drug tiers as described below. All prescription drugs covered by the rx program are categorized into these tiers on the Preferred Drug Formulary. The tier status of a prescription drug can change periodically, as frequently as monthly based on the Pharmacy Benefit Managers Preferred drug formulary Management Committee's periodic tier decisions. When that occurs, you may

pay more or less for a prescription drug, depending on its tier assignment. Since the Preferred Drug Formulary may change periodically, for the most current information, call TrueRx at (866) 921-4047. Each tier is assigned a reimbursement level which is the amount the Rx program pays. You will also pay a copay when you visit the Pharmacy. As an example, here is how the tier system works with three tiers:

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

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

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

Pharmacy benefits apply only if your prescription is an eligible expense. For excluded charges, you are responsible for paying 100% of the cost. The Pharmacy Benefit Manager will assist participants seeking reimbursement from third-party resources but makes no guarantees. Other programs or services, which may reduce member copay may be implemented by the plan administrator or procedurally changed by the pharmacy benefit manager if, in their discretion and management of the plan, the program or service will benefit the plan and participant and there is a likelihood that plan expenses will be reduced over the longer term. Please see Exclusions section regard the treatment of drugs for which manufacturers provide rebates, discounts, or other payment methods.

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

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

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

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

Specialty Drugs - A Specialty Drug is a drug that targets and treats specific complex conditions or illnesses such as cancer, rheumatoid arthritis, multiple sclerosis, hepatitis C, and HIV/AIDS. Specialty Drugs require patient- specific dosing and careful clinical management. Often these drugs are in the form of injected or infused Medicines. Specialty drugs are not covered under this plan TrueRx will provide guidance and instruction for the patient to assist with the qualification process.

- If you are prescribed a specialty drug, the Plan requires Plan participants to contact True Rx.
- True Rx will help you obtain your specialty drugs by identifying alternative forms of funding. You must enroll in the program and comply with the alternative funding program's eligibility criteria determination process to qualify.

- If you choose not to enroll in the alternative program, you will be responsible for 100% coinsurance on your specialty drugs.

True Advocate

This program is a specialty medication solution that provides a dedicated case manager to the participant to help reduce cost to the participant and the Plan.

True Codes - Several medications are assigned billing codes which are used for the purpose of billing medical plans for reimbursement for a drug. Some drugs involve more complex administration than a patient is typically able to provide for themselves. These claims often have limited information regarding dose or quantity of the drug being administered. True Codes is the process of evaluating the medications for potential cost-reduction of the treatment. This may involve evaluating the appropriateness of the medication to be given in an alternative site of care, such as home infusion or alternative infusion center, and/or evaluating the cost of the medication if it was processed through the pharmacy benefit instead of the medical benefit.

Certain prescription drug services will be subject to a True Codes review. True Codes may be either prospective, with a process established with the Plan Administrator to provide prior authorization and review of the claim before treatment begins, or retrospective, to identify ongoing claims that may be of cost-savings potential through an alternative site of care and/or providing the medication through the pharmacy benefit. True Codes involves a review of a Covered Person's records, identifying code medication, evaluating appropriateness of the medication to be given at alternative sites of care, and evaluating the cost of the medication through the pharmacy benefit.

The Plan Administrator or a third party, hired by The Plan Administrator, will identify Covered Persons eligible for True Codes based on parameters such as complexity of the medication treatment. Once Covered Persons are identified, additional information such as the Covered Person's weight, diagnosis, or dose may be requested. Upon evaluation, a determination may be made to adjust the medication source or site of treatment. In addition to this review, True Rx Health Strategists shall provide, the Third Party Administrator, a list of medications that meet the criteria of this program and the drugs on said list shall automatically be excluded from the Plan's medical benefits and provided by the Plan's pharmacy benefits in accordance with this "Case Management" Section.

The Plan Administrator has at its sole and exclusive discretion, the authority to select and require a Covered Person to receive treatment from an alternative site of care, qualified to administer the medication in accordance with generally accepted standards of care for the medication, at a more reasonable cost. Services received from sites of care not selected and/or approved by the Plan Administrator shall not be covered by the Plan. If a Covered Person obtains drug administration services at a site of care that is not approved by the Plan Administrator, the Covered Person will be responsible for 100% of the cost of those drugs and services, and they will not be covered under this Plan. Any amounts that a Covered Person spends at non-approved sites of care will not count toward any applicable deductibles or out-of-pocket maximum limits related to the Plan.

TrueGuard

This program helps keep unnecessary combinations of medication off of the pharmacy benefit plan.

Out-of-Pocket Expense/Deductible

Out-of-pocket expense is defined as the amount of total covered expenses that are the responsibility of the covered participant and that accumulate toward the prescription drug program's out-of-pocket maximum or deductible expense. The following amounts do not accrue toward the Out-of-Pocket Expense or Deductible Expense.

- premiums;
- expenses that are not covered under this Prescription Drug Program;
- expenses in excess of the reasonable and customary charges for services or supplies;
- expenses in excess of any maximum benefit list in the Prescription Drug Program;
- penalties;
- expenses reimbursed or covered through assistance programs or discount programs; and expenses related to non-preferred brand-name drugs and brand-name drugs when there is a generic equivalent that is medically appropriate.

Off Label Drugs - Off Label use of drugs may be considered by this plan if all other treatment plans have been tried

unsuccessfully. Prior authorization must be obtained through the Plan Supervisor. Medical necessity must be documented. Re-evaluation of the use of the off-label drug will be required after (no longer than) an initial three-month trial period. If substantiated improvement in the patient's condition is not evident, further use of the off-label drug will no longer be approved for coverage.

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

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

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

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

Orphan Drugs

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

Out-of-Pocket Expense/Deductible

The amount of total covered expenses that are the responsibility of the Covered Person and that accumulate toward the Prescription Drug Program's Out-of-Pocket Maximum. Or Deductible Expense. The following amounts do not accrue toward the Out-of-Pocket Expense or Deductible Expense.

- a. premiums;
- b. expenses that are not covered under this Prescription Drug Program;
- c. expenses in excess of the reasonable and customary charges for services or supplies;
- d. expenses in excess of any maximum benefit list in the Prescription Drug Program;
- e. penalties;
- f. expenses reimbursed or covered through assistance programs or discount programs; and expenses related to non-preferred brand-name drugs and brand-name drugs when there is a generic equivalent that is medically appropriate.

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

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

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

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

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

Step Therapy

The Step Therapy Program encourages members to use medications that are generally recognized as safe and effective but are also lower-cost. Under this program, in order to receive coverage, you may need to first try a proven, cost-effective medication before progressing to a more costly treatment. Please see the table below for the list of drugs/drug categories included in the Step Therapy Program.

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

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

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

- B. **Physician Office Visit** (includes visits to urgent care facilities)
Covered expenses include charges for office visits performed by a physician for the examination, diagnosis, and treatment of an illness or injury and any related services (i.e., laboratory tests, x-rays, and immunizations) performed in the office on the same day as the visit.

- C. **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 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-certification Program” provision.

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

- E. **Inpatient Hospital Stay Facility Fees** - Covered inpatient hospital stay expenses are payable up to the limits shown in the Schedule of Benefits and include room and board charges and medically necessary non-professional services and supplies furnished by the hospital for medical care (i.e., expenses for operating room, diagnostic services, and medications.) Take-home items are not included.

- F. **Emergency Room** - Services which meet the definition of Emergency Care, as defined in the "Definitions" section of this document will be covered as shown in the Schedule of Benefits. Follow-up care is not considered Emergency Care. Care received in an emergency room which does not meet the definition of Emergency Care is not covered.
- G. **Mental and Nervous Disorders** – If a person is an inpatient in a hospital or incurs outpatient expenses, the expenses are covered in the same way as those for any other illness. The Pre-utilization procedures must also be followed for this type of inpatient care.
- H. **Substance Abuse Treatment** – If a person is an inpatient in a hospital or incurs outpatient expenses, the expenses are covered in the same way as those for any other illness. Pre-utilization procedures must also be followed for this type of inpatient care.
- I. **Laboratory Expenses**– Covered expenses include laboratory tests and will be paid as stated in the Schedule of Benefits.

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

- J. **Preventative Health Care Expenses** - Expenses incurred for lab work or physician charges for checkups and for the detection of cancer will be paid up to the maximum shown in the Schedule of Benefits. This includes, but is not limited to, annual female pap smears exams, mammograms, prostate, and colon cancer screenings. In addition, charges for routine electrocardiograms (EKG), treadmill, blood testing and other "checkup" lab charges will be covered up to the maximum shown in the Schedule of Benefits. The maximum includes professional and diagnostic fees related to preventative care. It includes "sports" physicals and routine well-baby checkups, lab, and immunization/inoculation charges. Also included are 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. Please visit www.healthcare.gov for a list of items included on this list.

K. 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; and
- 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.

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

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
- 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

M. **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 treatment of an illness or injury by the use of physical means such as air, heat, cold, light, water, electricity, massage, or active exercise. A stroke, heart attack, surgical procedure or similar serious illness may require individual evaluation of the annual maximum. If physiotherapy or physical therapy prescribed by the attending physician for a covered individual follows one of these conditions, each claim will be evaluated to determine if the annual maximum will apply. Under no circumstances will maintenance care be covered. Maintenance care does not improve a condition. It maintains a level of comfort but does not actively correct an illness or injury. If the treatment received appears to be maintenance care, the Plan Supervisor reserves the right to request a second medical opinion on the prognosis and effectiveness of the physiotherapy program. Medically necessary x-ray charges incurred for physiotherapy diagnosis or treatment will be considered as any other x-ray under the Covered Medical Expenses and will not be applied toward the physiotherapy maximum.

N. **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; and
- 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
 - a. physical, occupational or speech therapy
 - b. oxygen and other gas therapy
 - c. other medical services usually given by a convalescent facility. This does not include private or special nursing, or physicians' services
 - d. medical supplies
 - e. ambulance transportation to the facility from the hospital where confined

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

O. **Organ Transplant Expenses**

You have organ and tissue transplant coverage under a separate insurance policy provided by Tokio Marine HCC – Stop Loss Group (TMHCC) and issued either by National Union Fire Insurance Company of Pittsburgh, Pa. or HCC Life Insurance Company. Such coverage pays benefits for certain organ and tissue transplants without regard to any benefits that may or may not be provided by this major medical plan. Please contact TMHCC's Transplant Unit toll-free at 1-888-449-2377 for benefit information, pre-authorization of transplant services, and transplant network provider access.

Pre-Authorization of Transplant Services

Pre-authorization of transplant services is required prior to seeing a transplant provider for a consult and/or evaluation. Failure to do so could result in reduced benefits.

NOTICE- Transplant Network

In order to obtain 100% in-network benefits, you must use providers in a transplant network approved by and accessed through TMHCC's Transplant Unit. Expenses billed by the transplant network provider that are not covered by the TMHCC policy are subject to this medical plan's benefits and the payment terms and conditions of the transplant network provider's contracted rates. For more information, contact Dunn and Associates Benefit Administrators, Inc.

- P. **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.
- Q. **Dental Work and Oral Surgery**
Covered expenses include the following:
- a. treatment of a fractured jaw or of accidental injuries to natural teeth within 6 months of the accident;
 - b. alveoloplasty or alveolectomy (area occupied by not less than six teeth per jaw);
 - c. treatment of cellulitis;
 - d. excision of soft tissue lesion of the oral cavity; biopsy; excision of tori; excision of benign hard tumor (osteoma), radicular or dentigerous cyst;
 - e. closure of oro-antral fistula;
 - f. removal of salivary stone from duct or gland;
 - g. therapeutic nerve block with alcohol or other sclerosing solutions;
 - h. surgical removal of impacted teeth;
 - i. surgical treatment of the Temporomandibular (TMJ) and other jaw disorders and services attributed directly to the TMJ dysfunction.
- R. **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 will be Covered Medical Expenses if they are recommended and performed by a licensed physician. This includes reconstructive breast surgery following a radical mastectomy.
- S. **Dialysis Treatment** - Kidney 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. PPO rate or Reasonable and Customary does not apply in this instance. 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.

- T. **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.
- U. **Emergency Accident/Illness** – Covered expenses incurred as the result of an emergency accident or illness will be covered as stated in the Schedule of Benefits. An emergency accident is a sudden external event resulting in bodily injury. “Emergency accident” does not include physical conditions resulting from illness or disease. An emergency illness is a medical condition that is not accident related. It is characterized by the sudden onset of acute symptoms. The lack of immediate medical attention may result in:
- a. permanently jeopardizing health;
 - b. serious medical consequences,
 - c. serious impairment of bodily function, or
 - d. serious and permanent dysfunction of any bodily organ or part.
- Diagnostic services are not covered under this benefit. See Diagnostic/X-ray/Lab Services benefit for information on coverage.
- V. **Transportation Benefit** – Charges for necessary transportation by professional ambulance services from the place where a covered person is injured or stricken by illness to the first hospital where qualified treatment can be given will be considered under this Plan up to the limits shown in the Schedule of Benefits. This includes any transfers required by the medical condition (not convenience) of the patient.

Medical Exclusions & Limitations

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

- A. services and supplies not specifically covered under the Plan, or not incurred during a period of coverage; or
- 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; or
- C. cosmetic, elective, plastic, reconstruction or restorative surgery, except as specifically provided for in this Plan. This exclusion includes but is not limited to rhinoplasty, bariatric banding or stapling, liposuction, abdominal reductions or body contouring procedure, any and all surgeries in connection with or as a result of weight loss, breast reductions or enlargements, face lifts or blepharoplasty or any similar surgery of the upper or lower eye lid, whether considered medically necessary by a physician or not; or
- D. hearing aids and the fitting thereof; or hearing services and supplies not rendered in connection with medical or surgical treatment for injury or illness; or voluntary ear implants for hearing loss, except in the case of a life and death situation or an accidental injury which occurs while covered under this Plan. Vision exams for covered participants up to age 21 will be covered under the medical plan's preventative coverage; or
- E. charges for the treatment of refractive errors, including but not limited to eye exams, glasses, contact lenses (or their fitting), radial keratotomy procedures and other forms of surgery and any vision services and supplies not rendered in connection with medical or surgical treatment for injury or illness, except as required by the Patient Protection and Affordable Care Act (PPACA); or
- F. charges for, or in connection with, the care or treatment of any injury or illness due to insurrections, atomic explosions, war or any act of war; "war" includes armed aggression resisted by the armed forces of any country, combination of countries, or international organization, whether or not war is declared. An act of terrorism will not be considered an act of war. Terrorism is defined as premeditated, politically motivated violence perpetrated against noncombatant targets by substantial groups or clandestine agents, usually intended to influence an audience; or
- G. medical care or supplies for which:
 - a. no charge was made;
 - b. no payment would be required if the covered individual did not have this coverage; or
- H. charges for intentionally self-inflicted injury or illness, including but not limited to suicide, attempted suicide, voluntarily taking of drugs (except for those taken as prescribed by a physician), the voluntary taking of poison, or voluntary inhaling of gas, unless such an injury results from a medical condition, physical or mental; or
- I. injury or illness resulting from the commission of or attempting to commit an assault or felony or to which a contributing cause was the covered person being engaged in an illegal act or occupation; or
- J. any treatment of obesity or weight reduction due to any cause (including drugs), except as required by the Patient Protection and Affordable Care Act (PPACA); or
- K. rest, sanatorium or custodial care; or
- L. oral care and supplies which are used to change vertical dimension and/or closure or any treatment of teeth or nerves connected to teeth except as provided under Oral Surgery or any other dental services not specifically provided for under Covered Charges (except as allowed under the Employee Dental Benefit); or

- M. any expense or charge for the promotion of fertility including (but not limited to):
 - a. fertility tests; or
 - b. reversals of surgical sterilizations including, but not limited to reconstructions of vasectomy or reconstruction of tubal ligation; or
 - c. direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer; or
 - d. surgery performed in an attempt to facilitate or enhance the potential for conception; or
- N. acting as pilot or copilot of an ultralight airplane; or
- O. repair or replacement of prosthetic devices except as detailed under "Covered Medical Expenses"; or
- P. travel, except as allowed under Transportation Benefit, whether or not recommended by a physician; or
- Q. services or supplies made by a physician, nurse or other medical practitioner who resides in the household of the covered individual; or is a member of your immediate family; or
- 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; or
- S. marital counseling, recreational, educational or social therapy or training services, except as required by the Patient Protection and Affordable Care Act (PPACA); or
- T. services related to sex transformations, sexual dysfunctions or sexual inadequacies; or
- U. any form of non-medical self-care or self-help training and any related diagnostic testing; or
- 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; or
- W. personal comfort items such as television, telephones, extra food trays, air conditioners, humidifiers, hot tubs, whirlpools, physical exercise equipment, etc.; or
- X. nutritional supplements or vitamins, whether or not recommended or prescribed by a physician unless they are for the treatment of a diagnosed illness (including pregnancy) or injury; or
- Y. expenses incurred after termination of coverage under this Plan; or
- Z. illness or injury covered by Workmen's Compensation; or
- AA. any treatment or physiotherapy on the muscles or vertebra which is not a surgical operation above the limits shown in the Schedule of Benefits unless approved in advance by the Plan Supervisor; or
- BB. 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); or
- CC. programs or confinements resulting from an arrest or citation for substance abuse and their related use; or
- DD. learning disabilities, behavioral or conduct disorder conditions, except as required by the Patient Protection and Affordable Care Act (PPACA); or
- EE. any organ transplant not specifically listed as covered, except as required by the Patient Protection and Affordable Care Act (PPACA); or

- FF. cost of materials used in any occupational therapy; or
- GG. telephone consultations, charges for failure to keep a scheduled visit or charges for completion of a claim form, late fees, finance charges, sales tax, and transport fees; or
- HH. massage therapy, hypnosis, or biofeedback, regardless of whether the services are rendered or recommended by a licensed/registered medical professional for any and all causes; or
- II. genetic testing unless it is for the purpose of determining the appropriate treatment of a diagnosed illness and screening (including but not limited to amniocentesis and chorionic villus sampling, except as required by the Patient Protection and Affordable Care Act (PPACA); or
- JJ. treatment of conditions due to hair loss or replacement of hair even if it is a result of medical treatment except when law requires payment under this plan (i.e. Women’s Health and Cancer Rights Act of 1998); or
- KK. 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; or
- LL. stand-by charges of a physician unless medically necessary and physically present in the operating room; or
- MM. charges for services of a resident physician or intern rendered in that capacity; or
- NN. charges for services which any school system is required to provide under any law; or
- OO. charges for care, treatment, services or supplies that are not prescribed, recommended and approved by the covered person’s attending physician; or
- PP. claims not submitted with the Plan’s filing limit deadlines as specified in “When to File Claim” under Claim Procedures section;
- QQ. take home medication from the hospital;
- RR. Drugs or drug classes screened must reflect the member’s medical history. Screening should only test for the drugs likely to be present, based on the participant’s medical history or current clinical status. We will deny payment as not medically necessary if the drug screening does not reflect the participant’s medical history. We may audit claims for drug screening reimbursement to confirm the presence of written orders for each test. Routine drug screening is not considered medically necessary;
- SS. Any drug or biological that has received an “orphan drug” designation;
- TT. Genetic testing unless it is for the purpose of determining the appropriate treatment of a diagnosed illness and screening (including but not limited to amniocentesis and chorionic villus sampling). Alpha Feta Protein testing will be covered; except as required by the Patient Protection and Affordable Care Act (PPACA);
- UU. Specialty Drugs as defined by the PBM (unless mandated by a regulatory authority);
- VV. All medications included on True Rx Health Strategist’s medications list regarding True Codes;

Coordination with Other Plans

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

Definitions

- A. An "allowable expense" is defined as any necessary reasonable and customary expense covered, at least in part, by one of the plans or by third party liability (or arises from an incident making it an element of damage subject to third party liability). Not included are any expenses excluded by the Plan.
- B. "Third Party Liability" as used in this section is defined as the liability of some third person or entity for any damages suffered by an individual covered by this Plan and included in such damages "allowable expenses" as defined above. "Third Party Liability" as defined is intended to and shall include any situation where the covered individual is caused harm, injury, illness, or damage because of the wrongful, negligent, intentional, or tortuous act (including strict liability) of the third party, thus making the third party liable to the covered individual. Liability may also be contractual, but this Plan shall be excluded from the definition along with any plan considered for coordination as below delineated and which form a separate coordination basis. This definition as used in this section is also intended and shall encompass, all or most situations traditionally grouped under the heading of "subrogation" but in this Plan are dealt with as a coordination situation and governed by the express terms of this section even when advancements are made.

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

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

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

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

- A. a plan without COB provision will be primary to a plan with COB provision;
- B. a plan which covers an individual as an Employee will be primary to a plan which covers an individual as a dependent;
- C. a plan which covers an individual as a spouse will be primary to a plan which covers an individual as a dependent child;
- D. a plan which covers an individual as a spouse will be primary to a plan which covers an individual as a dependent;
- E. 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;
- F. 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; for children's expenses, a plan which covers an individual as a child will be primary to a plan which covers an individual as a dependent;
- G. if the birthday anniversaries are the same, then the plan which has covered the dependents the longest will be the primary plan;
- H. 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 always 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;
- I. in the case of separated or divorced parents, 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.

Third Party Liability – Plan Type C

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

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

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

- B. Monies Advanced - Monies may be advanced by this Plan for allowable expenses of individuals covered by this Plan Type C and/or third-party liability is available for those expenses. Advancement shall be at the sole discretion of the trustees of the Plan, but repayment of monies advanced shall be made in full under the terms of Agreement. Any advanced monies shall be subject to the following terms and any others the Plan trustees may impose in the discretion:
- a. any agreement must be signed by the covered individual, his spouse, parents, guardians, and his attorney;
 - b. the Plan administrator must be provided any and all information covered individual, or his attorney has concerning Plan Type C entitles; third parties who may be liable to the covered individual and/or is spouse, including name, address, and telephone number; and information concerning any insurance of the third party that may be a source of recovery. This duty shall be a continuing one. This obligation shall exist whether or not money is advanced;
 - c. the Plan, Plan administrator, and its representatives shall have the right to contract the third party, Plan Type C entitles, and the third party’s insurers for any reason, including but not limited to notifying them of the advancement of funds for allowable expenses and the interest of the Plan in any payments or recovery. This obligation shall exist whether money is

- advanced or not;
- d. any monies paid to or recovered by the covered individual and his spouse from the Plan Type C entity, and the third party's insurance, or any other source, shall be paid first directly to the Plan to extent of the Plan advancements for allowable expenses. If, for any reason, such payments cannot be made directly to the Plan, then the Plan shall be a payee along with the covered individual, his spouse, and counsel on any payment or recovery from the Plan Type C, third party, or third party's insurance, or any other source of payment;
 - e. if, for any reason, direct and full payment for advanced allowable expenses has not been made to the Plan, the covered individual, guardian for such individual, his estate, spouse, other derivative entities or individuals, and his counsel, shall be constructive trustees of any funds received by them as a result of recovery or payment from third parties, third party insurance, or Plan Type C payments because of the incident giving rise to such recovery or payment to the extent that the Plan has advanced money for allowable expenses. The recovery or payments received, to the extent advancements were made, shall be the money and specific property of the plan. If recovery or payment has been by joint check with the Plan or Plan Trust a joint payee, then all other payees shall endorse the check and give the check in total to the Plan Administrator; the check shall be deposited with the Plan, and another check issued by the Plan Administrator jointly to the other payees in the full amount of the original check less the full amount of all funds advanced by the Plan as below provided, which shall be retained by the Plan. If the payment or recovery otherwise reaches the covered individual, spouse, guardian, estate, counsel, or other derivative entities or individuals, and money advanced has not been fully reimbursed, then, to the extent that such funds have not been reimbursed, the covered individual, spouse, guardian, estate, counsel, or other derivative entities or individuals shall first pay from funds in their hands the amount of the unreimbursed advancements (unreduced as hereafter provided) before any other monies are paid out for any other purposes. It is understood that all the terms hereinabove and below provided shall include payments made in error by the Plan, which should not have been paid because of the coordination rules of the SPD;
 - f. in addition to all other rights to Plan shall have to full recovery of advanced funds, the Plan shall have the right of offset against any other allowable expenses to be paid, presently or in the future, by the Plan to the covered individual or his dependents which may be payable by the Plan, whether arising from the third-party liability incident or otherwise. Consequently, if for any reason, the covered individual or his dependents or counsel are deemed by the Plan to have improperly refused or failed to reimburse advancements, then the Plan shall have the right to offset the unreimbursed advancements made hereunder against other present or future allowable expenses which would otherwise be paid but for the nonpayment of the advancements hereunder. Such offset shall continue until the Plan's advancements are fully satisfied; and
 - g. the plan shall be made absolutely whole by the individual covered, his spouse, and his counsel, and the right to full return and repayment for monies advanced shall be unreduced and undiminished by:
 1. any reduction for litigation or other expenses incurred by the individual covered, his spouse, or counsel for any reason including expenses incurred for recovery Plan Type C payments or third-party recovery;
 2. any attorney fees of any nature charged by counsel for the covered individual or his spouse for the recovery of the Plan's money or recovery in general;
 3. normal "subrogation deductions" under the law of any state or other jurisdiction including, but not limited to, reductions in repayment of medical expenses because of comparative fault or uncollectability of the full value of the covered individual or spouses claim against a third party or Plan Type C entity because of limited liability insurance for any other cause (for Indiana law see IC 35-51-2-19); or reduction as stated for litigation costs and attorney fees (for Indiana see IC 34-53-1-2); and
 4. any violation of the agreement or the terms herein provided shall subject the individual covered by the Plan and his counsel and spouse to damages to the Plan, actions in replevin, and action for attorney fees and litigation expenses of every nature necessary for the Plan to recover the full funds advanced and any other damages suffered by the Plan including the right of offset as above provided.

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

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

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

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

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

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

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

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

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

Who is eligible to apply - Medicare provisions have been changed by recent government rulings. These provisions will continue to be amended as government regulations change. This Plan will adopt those changes as they are mandated by amendments to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Social Security Act and the Social Security Act and Age Discrimination in Employment Act (ADEA). The following briefly explains how the most recent changes have affected this Employer-sponsored Employee Benefit Plan. Effective January 1, 1987, the Consolidated Omnibus Budget Reconciliation Act (COBRA) mandated that employers remain the primary payers of medical care for disabled employees and their dependents from the time Medicare coverage begins until termination. However, only active employees and their dependents are included in the Medicare-as-secondary provisions. It does not apply to employees who become totally and permanently disabled and are terminated from employment. (See Termination of Coverage for further information.) In order to implement these amendments, regulations have been handed down by the Equal Employment Opportunity Commission (EEOC) and the Health Care Financing Administration (HCFA).

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

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

1. Medicare prescription drug coverage became available to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage in 2006. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage they offer is, on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Non-Creditable Coverage. This is important, because for most people enrolled in your employer's prescription drug plan, enrolling in Medicare prescription drug coverage means you will get more assistance with drug costs than if you had prescription drug coverage exclusively through your employer's plan.
3. You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll. Read this notice carefully - it explains your options.

Consider Enrolling in Medicare Prescription Drug Coverage - Because the coverage you have with your employer is on average for all plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay, consider enrolling in a Medicare prescription drug plan. Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. This may mean that you will have to wait to enroll in Medicare prescription drug coverage and that you may pay a higher premium (a penalty) if you join later, and you will pay that higher premium as long as you have Medicare prescription drug coverage. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your premium will go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. In addition, you may have to wait until the following October to join.

You Need to Make a Decision - When you make your decision, you should also 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.

For more information about this notice or your current prescription drug coverage - Contact our office for further information.

NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through your employer changes. You may also request a copy.

For more information about your options under Medicare prescription drug coverage - More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook from Medicare. You'll get a copy of the handbook

in the mail every year from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & Your handbook for their telephone number) for personalized help,
- 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 Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

An Employees coverage - The coverage of any employee will terminate on the end of the month following the date on which any of the following events first occurs:

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

"Ceasing active work" will be considered to be cessation of insurance. Employment may be deemed to continue for some of the coverages, up to the limits shown in the Schedule of Benefits, if the Employee is not at work due to approved FMLA leave. If any employee becomes totally disabled, then his eligibility date for termination of employment will be determined from the date his continual disability commenced as follows:

Employee Seniority	Continuation of Eligibility Before Termination
Up to 10 years	30 days
Over 10 years	90 days

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

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

- a. termination of eligibility as a dependent
- b. termination of the covered employee
- c. failure to make any of the required contributions
- d. when a dependent becomes covered for employee coverage

Dependents will continue to be covered for disabled employees as provided by the termination table.

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 full premium during the leave. The Employee will be responsible for the Employee and Employer portion of the premium during this leave. Upon an Employee's return to active employment following a leave of absence, coverage under this plan will begin following the plans 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 covered by the Plan will automatically receive a Certificate of Group Health Plan Coverage ("Certificate") when they lose coverage under the Plan and upon the loss of coverage should continuation of coverage under COBRA be elected. Additionally, all employees and their Dependents who lose coverage under the Plan may request a new Certificate at any time during the 24 months which follow loss of coverage. The Certificate will include information for both the covered employee and his Dependents unless the information for a Dependent is different from that of the covered employee, and in such case a separate Certificate will be issued for each such person. The Certificate will be issued free of charge to the employee or Dependent and will show a new Employer or group health plan the period that the Employee or Dependent was covered by the Plan, including the waiting period served prior to the effective date of coverage. A person who receives a Certificate must provide the Certificate to his new group health plan in order for the new group health plan to credit the period that the person was covered by the Plan against the pre-existing condition exclusion waiting period of the new group health coverage, if any.

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

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

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

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

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

Employees of a local unit public employer, as defined by Indiana Code 5-10-8, 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 twenty (20) years of creditable service with a public Employer, ten (10) years of which must have been completed with this employer 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 50;
- 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 Southeast Dubois County School 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.)

Dependent(s) of the Retired Employee may be enrolled for the continued health benefits for so long as the dependent(s) continue to meet all eligibility provisions of the Plan.

However, if a Retired Employee does not enroll his/her dependent(s) within ninety (90) days after date of retirement, the dependent may only be enrolled during an open or special enrollment period.

Employee coverage under this provision shall terminate on the earliest of the following dates:

- a. the date the covered person becomes eligible for Medicare;
- b. the date the covered person fails to pay the required premium when due;
- c. the date the employer terminates the health plan coverage; or
- d. the date group health plan coverage become available through a new employer;
- e. the date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact;

Dependent(s) of the Retired Employee will be eligible for the continued health benefits if they continue to meet all provisions of the school corporation. Coverage for spouse will be terminated on the earliest of the following events:

- a. when the Employer terminates the health insurance program;
- b. the date the dependent no longer meets the definition of a dependent (as stated in this Summary Plan Description/Master Plan Document);
- c. the date the spouse remarries;
- d. dependent becomes eligible for Medicare coverage; or
- e. the date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact;

At the time of retirement, you may elect not to enroll in COBRA in lieu of retiree coverage. If you elect COBRA in lieu of retiree coverage for yourself or your spouse or if you fail to make any election under the plan, you and/or your spouse will not be eligible to enroll in the retiree coverage under this plan at a later date.

If you elect retiree coverage in lieu of COBRA, the retiree coverage under the plan will be treated as alternative coverage and you will not be eligible to continue coverage under COBRA once retiree coverage under the plan has ended.

You are required to pay the entire cost of coverage for you and your spouse in accordance with the policies and procedures established by the plan. The amount of any required contribution will be communicated to you prior to your date of retirement.

Termination of Retiree Coverage - Coverage under the Plan will terminate for you on the earliest of the following dates:

- (1) The first of the month you become eligible for Medicare.
- (2) The date you (or any person seeking coverage on behalf of yourself) makes an intentional misrepresentation of a material fact. 24 12735-0711 v.0811

Termination of Retiree's Spouse or Surviving Spouse Coverage - Coverage under the Plan will terminate for your Spouse on the earliest of the following dates:

- (1) The date your Spouse becomes entitled to Medicare;
- (2) The date your Spouse becomes eligible for any other employer-sponsored group health plan;

- (3) The date your Spouse (or any person seeking coverage on behalf of your Spouse) makes an intentional misrepresentation of a material fact;
- (5) The date a surviving Spouse remarries;
- (6) For surviving Spouse ten (10) years after the death of the employee or Medicare eligibility whichever comes first.

Termination of Retiree's Dependent

- (1) the date the Dependent fails to meet the definition of a dependent.

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

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

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

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

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

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

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

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 decide 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 act 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 - This plan will not deny any claims due to a pre-existing condition. Proof of prior coverage is no longer required by this plan.

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

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

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

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

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

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

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

General Provisions

Amendments - The Plan Administrator reserves the right to amend the Plan in order to add or delete any Plan benefit, or otherwise change the terms of the Plan at any time without prior notice to Employees. The Employees will be notified in writing within 120 days of the change in compliance with 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 Errors/Misstatements - Neither clerical error in keeping records pertaining to the coverage, nor delays in making entries thereon, shall invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated, but upon discovery of such error or delay an equitable adjustment shall be made. If any facts relevant to the existence of amount of coverage shall have been misstated, the true facts will determine whether or not, and how much, coverage is in force. Any material misrepresentation on the part of the Employee in making application for coverage, or any application for reclassification of that coverage, or for benefits under this Plan shall render coverage voidable by the Plan Supervisor.

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

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

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

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

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

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

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

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

Not Liable for Acts of Health Care Providers - Nothing contained in this Plan, or its documents shall confer upon an Employee or Dependent any claim, right or cause of action, either at law or in equity against the Plan Administrator, the Employer, or the Plan

Supervisor for the acts of any health care provider in which he receives care or services under this Plan. Health care provider for the purposes of this provision includes but is not limited to hospitals, physicians, and pharmacies.

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

Pre-Existing Conditions - The pre-existing condition exclusion no longer applies to charges incurred on or after December 31, 2014.

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 regard to the maternity stay, this Plan authorizes a stay, for the mother and the child, of 48 hours for uncomplicated normal deliveries and a 96 hour stay for cesarean section. This stay may be changed only by the attending physician in consultation with the mother.

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

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

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

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

Compliance with HIPAA Nondiscrimination Provisions - HIPAA prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors. These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability. See *ERISA section 702; 29 CFR 2590.702*. Similarly Situated Individuals. It is important to recognize that the nondiscrimination rules prohibit discrimination within a group of similarly situated individuals. Under 29 CFR 2590.702(d), plans may treat distinct groups of similarly situated individuals differently, if the distinctions between or among the groups are not based on a health factor. If distinguishing among groups of participants, plans and issuers must base distinctions on bona fide employment-based classifications consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is based on relevant facts and circumstances, such as whether the employer uses the classification for purposes independent of qualification for health coverage. Bona fide employment-based classifications might include: full-time versus part-time employee status; different geographic location; membership in a collective bargaining unit; date of hire or length of service; or differing occupations. In addition, plans may treat participants and beneficiaries as two separate groups of similarly situated individuals. Plans may also distinguish among beneficiaries. Distinctions among groups of beneficiaries may be based on bona fide employment-based classifications of the participant through whom the beneficiary is receiving coverage, relationship to the participant (such as spouse or dependent), marital status, age or student status of dependent children, or any other factor that is not a health factor.

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

Plan Status - The Trust believes this plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a non-grandfathered health plan means that plan may include certain consumer protections of the Affordable Care Act, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Dunn & Associates. [you may also contact the

Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.]

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

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

OTHER FEDERAL PROVISIONS

Family and Medical Leave Act (FMLA)

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

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

Coverage will be continued for up to the greater of:

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

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

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

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

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

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

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

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent Children in cases of adoption or Placement for Adoption as required by 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.

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

Plan Sponsor - means Your employer.

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

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

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

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

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

When to Appeal

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

Appeal Process

To appeal a denied claim (in whole or in part), send a written request to the Plan Supervisor along with the reason you think claim should be reviewed. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. Appeals will be handled by an appropriate person who is neither the person who made the original claims decision nor subordinate to that original decision maker. If a claim involves a medical judgment (including whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in that judgment, but not the same person (or a subordinate of the person) who has consulted on the initial decision. You will be notified of the decision not later than 30 days (for pre-service claims) or 60 days (for post-service claims) after the appeal is received. You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

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

Notice of Appeal Determination

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

- a. the specific reason(s) for the adverse claim decision;
- b. a reference to pertinent Plan provision, internal rules, guidelines, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- c. if the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment used in making the decision (or a statement that an explanation will be provided free of charge upon request);
- d. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all other relevant documents; and
- e. a statement informing the claimant about the right to bring a civil action under section 502(a) of ERISA.

Legal Action

A claimant who disagrees with the decision after an appeal may have the right to bring a civil action under section 502(a) of ERISA. No action at law or in equity may be brought to recover under this Plan: (1) if the claimant fails to exhaust the Claims Appeal and Review Procedure; or (2) before final denial of a claim in accordance with that procedure; or (3) later than three years after the date the claim is finally denied.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

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

Help manage the health care treatment you receive

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

Run our organization

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

Pay for your health services

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

Administer this plan

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

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Dunn and Associates Benefit Administrators, Inc.

P.O. Box 2369 - Columbus, IN 47202-2369

(812) 378-9960 or (800) 880-9960

Fax: (812) 378-9967

www.dunnbenefit.com