

Summary Plan Description

for

Barr-Reeve Community Schools Employee Benefit Trust



This booklet describes the benefits in effect on March 1, 2016

TABLE OF CONTENTS

General Information	1
Claim Procedures	3
Preferred Provider Organizations	5
The Pre-Utilization Program	6
Eligibility	8
Schedule of Benefits	10
Definitions	17
Basic Life Insurance Benefit	25
Basic Accidental Death & Dismemberment Benefit	26
Long Term Disability Benefits	27
Comprehensive Medical Benefits	28
Comprehensive Medical Exclusions and Limitations	37
Comprehensive Dental Benefits	39
Comprehensive Dental Exclusions and Limitations	40
Comprehensive Vision Benefits	41
Coordination with Other Plans	42
Medicare Provisions	46
Termination of Coverage	48
USERRA Rights and Coverage	51
Continuation of Coverage (COBRA)	52
General Provisions	54
Privacy Provisions	57
Claims Appeal and Review Procedures	59

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

NAME OF PLAN Barr-Reeve Community Schools Employee Benefit Trust
TRUST I.D. NUMBER 501
PLAN NUMBER 35-2062236
PLAN EFFECTIVE DATE December 1, 1998
PLAN REVISION DATE March 1, 2016

PARTICIPANTS INCLUDED

This Summary Plan Description is for all full time Employees of the Barr-Reeve Community Schools, Inc.

NAME AND ADDRESS OF EMPLOYER/PLAN SPONSOR/PLAN ADMINISTRATOR

Barr-Reeve Community Schools, Inc.
P.O. Box 97
Montgomery, IN 47558
Phone: (812) 486-3220

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 December 1 and ending on each November 30.

Deductible and co-insurance information is kept on a Calendar Year basis.

TYPE OF ADMINISTRATION

The Plan is administered by the Employer with the following coverages:

- Basic Life and Basic Accidental Death and Dismemberment are fully insured. The premiums for this coverage are paid by the Trust.
- Medical benefits are self-insured by the Employer. Re-insurance policies have been obtained for specific and aggregate coverage on behalf of the Employer. The re-insurance premiums are paid by the Trust.
- Dental and vision benefits are self-insured by the Employer.
- Long Term Disability benefits are fully insured. The premiums for this coverage 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:

Basic Life Benefits
Basic Accidental Death & Dismemberment Benefits
Long Term Disability (Non-Certified and/or Administrative Employees Only)

For Covered Employees and Dependents:

Comprehensive Medical, Dental, and Vision Benefits

Life, AD&D and LTD benefits are fully insured. Each covered Employee will receive an individual certificate with the details of each policy. The information provided in this Summary Plan Description is a brief summary of each policy.

This Plan is the result of any 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 of Barr-Reeve Community Schools, Inc.
P.O. Box 97
Montgomery, IN 47558

President of Barr-Reeve Community Schools, Inc. Teachers Association
P.O. Box 97
Montgomery, IN 47558

President of Barr-Reeve Community Schools, Inc. Board of Directors
P.O. Box 97
Montgomery, IN 47558

CLAIM PROCEDURES

WHEN TO FILE CLAIM

Report claims promptly. *Claims should be filed with the Plan Supervisor within 90 days of the date charges were incurred* by you or through an authorized representative. Claims filed later than that day will not be covered unless:

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

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 need to 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 will 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 must 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 **do not** provide enough information for the Plan Supervisor to process a claim. Attach originals of itemized bills and keep copies for Employee records.

PRESCRIPTION DRUG CLAIMS

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 must 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

- d. 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

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.

CLAIM 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 ORGANIZATIONS

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

The use of providers in the Plan's primary PPO is not required; however, the negotiated reasonable and customary fees available through these providers are many times substantially less than the fees billed by other providers. The lower the fee, the lower the Plan participant's out-of-pocket cost will be for the services.

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

Additional Preferred Provider Organizations may be utilized in order to optimize coverage areas.

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

THE PRE-UTILIZATION PROGRAM

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

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).

HOW TO OBTAIN PRE-UTILIZATION REVIEW

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

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

For planned (elective) inpatient admissions, call at least 7 days prior to admission, for emergency admissions, call within 48 hours following admission, and for obstetrical care, call during the 1st trimester. For all other services requiring pre-utilization review, call prior to scheduling the procedure/care or obtaining equipment.

Confidential voice mail is available 24 hours per day. If voice mail left, remember to leave information above.

If the covered person believes this request is “urgent” (see “Urgent Claim” in Definitions section), he should indicate this to the case manager. A health care provider may call on behalf of the covered person, and the provider also may indicate urgency to the case manager.

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

NOTIFICATION OF PRE-UTILIZATION DETERMINATION

If a request for pre-utilization review is “urgent”, the case manager will advise whether the request is approved or denied within 72 hours.

If a request for pre-utilization review is not “urgent”, the case manager will advise whether the request is approved or denied within 15 days.

The case manager will approve a requested procedure, service or supply only if it finds it to be medically necessary and medically appropriate, based on the severity and complexity of the covered person's illness or injury, the covered person's age and general health, and medical necessity/appropriateness guideline. ***However, a determination by the case manager that a requested procedure, service or supply is medically necessary and/or medically appropriate does NOT mean that the procedure, service or supply is a covered expense under this Plan.***

CONTINUED CONFINEMENT

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

CONCURRENT REVIEW

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

DISCHARGE PLANNING

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

CASE MANAGEMENT

CLINIX will review the medical care provided to covered persons and may recommend alternative, cost-efficient programs of treatment. Such programs will be implemented only with the consent of the covered person, his physician, and the Plan Supervisor 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 will not be covered under the Plan. If a claim is identified as a potential large claim expense by Clinix, the individual identified is expected to cooperate with the Plan's Case Management efforts.

IF THERE IS A DISAGREEMENT / APPEALS

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

BENEFIT REDUCTION

If the procedures for Pre-utilization Review of Hospital Admissions are not followed, covered charges will be subject to a \$250 per admission penalty. This penalty will not count toward any deductible or co-insurance maximums.

■ ■ ■ R E M E M B E R ■ ■ ■

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

ELIGIBILITY

ELIGIBILITY FOR EMPLOYEES

All full-time Employees will be eligible for coverage. Full-time is defined as Employees who are scheduled to work 17 1/2 hours per week at the usual place of business or the location to which you are required to travel. No person may be both an Employee and a dependent of this Plan.

WAITING PERIOD

All eligible Employees will commence coverage on the first day of continuous service for this Employer for all other Employees. 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 date. 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. The cost of the premium for this coverage is the Employee's responsibility. All dependents must meet the criteria listed in the definitions section to be eligible for coverage.

All eligible dependents will commence coverage on the day the Employee does, if written application has been made 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.

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 purposes 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 if the enrollment is completed prior to marriage or the first day of the first pay period following the Plan Administrator's receipt of the completed enrollment form;
- 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 state 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 of this Plan, such employee or eligible dependent may enroll within 60 days of losing the Medicaid or CHIP coverage or becoming eligible for such premium assistance, as applicable. Coverage will become effective as of the first day of the month after the plan is notified.

OPEN ENROLLMENT PERIOD

An open enrollment period shall be held annually during the month of November. During this open enrollment period, Employees who have not previously elected coverage under the Plan and who do not qualify for a Special Enrollment Period as described herein, may enroll for coverage for themselves and/or any eligible Dependents. Coverage shall be effective on December 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.

The Barr-Reeve Community Schools shall provide the following choice of one only: The Corporation shall pay Eight-Thousand Five-Hundred Dollars (\$8,500.00) annually towards the cost of the single hospital plan premium. (***Teachers will pay no more than two-thousand dollars (\$2,000) towards the cost of a single plan premium.***) The Corporation shall pay Ten-Thousand Dollars (\$10,000.00) toward the premium of a spouse/children/family hospitalization plan.

It is understood that when a husband and wife are both Teachers in the school district that they may either choose to take two (2) single plans with the Corporation paying Eight-Thousand Five-Hundred Dollars (\$8,500.00) annually for each employee towards the cost of the two (2) single hospital plan premiums. or they may choose to have a spouse/children/family plan, with the Corporation paying up to a Maximum of Eighteen-Thousand Five-Hundred Dollars (\$18,500) or the total cost of the spouse/children/family hospitalization plan premium (whichever is the lesser amount).

SCHEDULE OF BENEFITS

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

LIFE/AD&D COVERAGE

BENEFIT DESCRIPTION

Basic Life Benefit	
Class I – Administrative	\$110,000
Class II – All Other Eligible Employees	\$105,000
<hr/>	
Basic AD&D Benefit	
Class I – Administrative	Same as Life
Class II – All Other Eligible Employees	Same as Life

Life and AD&D benefits will continue at the same level for all active Employees until they terminate or become eligible for Medicare. Upon retirement, the same Life and AD&D benefits will apply until the Employee is eligible for Medicare. If the Employee is eligible for Medicare at the time of retirement, Life and AD&D benefits will terminate at retirement.

LONG TERM DISABILITY BENEFITS

BENEFIT DESCRIPTION

Monthly Benefit	66 2/3% of your monthly compensation immediately prior to period of disability
Maximum Monthly Benefit	\$6,000
Elimination Period	90 days (Benefits are not payable for the elimination period)

COMPREHENSIVE MEDICAL BENEFITS (Employee and Dependents)

BENEFIT DESCRIPTION	PLAN C (Orange Plan) Traditional Plan		PLAN B (Red Plan) High Deductible Health Plan (HDHP)		PLAN B & C
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Annual Maximum (per individual)	Unlimited	same maximum for in-network applies to out-of-network (combined maximum)	Unlimited	same maximum for in-network applies to out-of-network (combined maximum)	Some covered expenses have separate annual and/or lifetime maximums as stated under Special Conditions.
Pre-utilization	See pre-utilization section	See pre-utilization section	See pre-utilization section	See pre-utilization section	A \$250 reduction in benefits will apply if pre-utilization requirements not met.
Deductible (per calendar yr)	Individual Family \$1,000 \$2,000	\$2,500 \$5,000	\$2,500 \$5,000 <i>Embedded Deductible</i>	\$5,000 \$10,000 <i>Embedded Deductible</i>	Common in- and out-of-network deductible. Deductible applies to all covered expenses unless otherwise stated under Special Conditions.
Covered Expenses	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Unless otherwise stated under Special Conditions.
Coinsurance Limit (per calendar yr)					In- and out-of-network coinsurance limits accumulate separately. Does not included deductible
Medical Coinsurance					
Individual	\$2,500	\$5,000	\$0	\$0	
Family	\$5,000	\$10,000	\$0	\$0	
Rx Coinsurance					
Individual	\$1,500	\$1,500			
Family	\$3,000	\$3,000			
Total Coinsurance					
Individual	\$4,000	\$6,500			
Family	\$8,000	\$13,000			

SPECIAL CONDITIONS					
	PLAN C (Orange Plan) Traditional Plan		PLAN B (Red Plan) High Deductible Health Plan (HDHP)		PLAN B & C
BENEFIT DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Prescription Drug Benefit <u>Retail Store</u> (30-day supply) Generic Drugs All Other <u>Retail Store</u> (90-day supply) Generic Drugs All Other	<u>Copay Employee Pays</u> \$6 no deductible \$12 no deductible <u>Copay Employee Pays</u> \$6 no deductible \$12 no deductible	Covered person must pay for the entire cost of prescriptions at the time filled and file a claim for reimbursement.	<u>Copay Employee Pays</u> 100% after deductible 100% after deductible <u>Copay Employee Pays</u> 100% after deductible 100% after deductible	Not covered. Discounts are available through pharmacies participating in Preferred network.	Includes prescription contraceptives and Ritalin. 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.
Outpatient Surgery	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Includes facility and all professional fees.
Voluntary Second Surgical Opinion	100% no deductible	50% after deductible	100% no deductible	50% after deductible	
Preadmission & Preoperative Testing	80% after deductible	50% after deductible	100% after deductible	50% after deductible	
Hospital Room & Board Intensive Care	80% after deductible 80% after deductible	50% after deductible 50% after deductible	100% after deductible 100% after deductible	50% after deductible 50% after deductible	Limited to semi-private room rate; limited to 4 times semi-private room rate.

	PLAN C (Orange Plan) Traditional Plan		PLAN B (Red Plan) High Deductible Health Plan (HDHP)		PLAN B & C
BENEFIT DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	PLAN LIMITATIONS
Mental Health/Substance Abuse Care	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Annual maximums do not apply. All claims subject to precertification requirements and utilization review. Call Dunn & Associates for additional information.
Home Health Care	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to an ANNUAL individual maximum of 100 visits, maximum of 4 hours per visit.
Hospice Care	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Inpatient treatment at Hospice facility limited to 30 days (including any respite days).
Physiotherapy Outpatient Care	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to an ANNUAL individual maximum of 20 visits.
Preventative Health Care	100% no deductible	100% no deductible	100% no deductible	100% no deductible	
Routine Colonoscopy	100% no deductible	100% no deductible	100% no deductible	100% no deductible	
<p><u>Preventative health care services include:</u></p> <ul style="list-style-type: none"> ➤ Evidence-based items or services that have a rating of “A” or “B” and are currently recommended by the U.S. Preventive Services Task Force ➤ Immunizations that are currently recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (CDCP) ➤ Evidence-informed preventive care and screenings (as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents ➤ Additional preventative care and screenings (as provided for in the comprehensive guidelines supported by the HRSA) for women ➤ Colonoscopy charges for individuals 50 and over will be considered routine according to the AMA recommended guidelines. <p>Pediatric oral and vision exams will be covered under the preventative benefit in accordance to the recommendation in the PPACA.</p>					
Extended Care/Skilled Nursing Facility	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to an ANNUAL individual maximum of 90 days.

BENEFIT DESCRIPTION	PLAN C (Orange Plan) Traditional Plan		PLAN B (Red Plan) High Deductible Health Plan (HDHP)		PLAN B & C
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	BENEFIT DESCRIPTION	IN-NETWORK
Temporomandibular Joint (TMJ)	80% after deductible	50% after deductible	100% after deductible	50% after deductible	
Laboratory Expenses Through Designated Facility All Other Facilities	100% no deductible 80% after deductible	 50% after deductible	not available 80% after deductible	 50% after deductible	Call Dunn and Associates for information on designated facilities in your area.
Medical Supplies	80% after deductible	50% after deductible	100% after deductible	50% after deductible	
Organ Transplants	80% after deductible	50% after deductible	100% after deductible	50% after deductible	
Fully-Insured Transplant Policy Donor/Organ/Tissue Procurement All Other Services	100% of actual network cost for solid organs; Bone Marrow allogenic is limited to \$30,000. 100% of actual network cost	\$15,000 for solid organs; Bone Marrow allogenic is limited to \$30,000. 80% network cost in the nearest network hospital where the transplant is performed	100% of actual network cost for solid organs; Bone Marrow allogenic is limited to \$30,000. 100% of actual network cost	\$15,000 for solid organs; Bone Marrow allogenic is limited to \$30,000. 80% network cost in the nearest network hospital where the transplant is performed	No Lifetime maximums. See comprehensive medical benefits section of this booklet for additional information. Pre-utilization requirements must be followed and met or there will be a penalty applied.
Transportation Expenses	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to an ANNUAL individual maximum of \$5,000 per ground trip and \$10,000 per air trip.

BENEFIT DESCRIPTION	PLAN C (Orange Plan) Traditional Plan		PLAN B (Red Plan) High Deductible Health Plan (HDHP)		PLAN B & C
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	BENEFIT DESCRIPTION	IN-NETWORK
Cardiovascular Care Through Designated Facility All Other Facilities	100% no deductible 80% after deductible	not available 50% after deductible	100% no deductible 100% after deductible	not available 50% after deductible	Call Dunn and Associates for information on designated facilities in your area.
Dialysis	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Limited to 40 treatments per episode of care. Treatment will be considered a separate episode of care if more than 180 days have lapsed since the last treatment.
Cash Reward Billing errors found by Employee	50% of actual savings	not available	50% of actual savings	not available	Limited to a per occurrence maximum of \$500.
Emergency Care	80% after deductible	80% after deductible	100% after deductible	100% after deductible	

DENTAL BENEFITS (Employee and Dependents)

BENEFIT DESCRIPTION	BENEFIT	PLAN LIMITATIONS
Annual Individual Maximum (per calendar year)	\$1,000	
Deductible (per calendar year)		
Individual	\$25.00	
Family	\$50.00	
Covered Expenses		
Preventative Care Expenses	100% no deductible	
Basic Services	80% after deductible	
Major Services	50% after deductible	
Orthodontic Benefits		
Covered Expenses	50% after deductible	
LIFETIME Individual Maximum	\$1,500	

VISION BENEFITS (Employee and Dependents)

BENEFIT DESCRIPTION	BENEFIT	PLAN LIMITATIONS
Annual Maximum (per individual)	\$150	
Covered Expenses	100% no deductible	

DEFINITIONS

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.

ACTIVE WORK, ACTIVELY WORKING, ACTIVELY AT WORK – A requirement that an Employee be actively at work on full-time basis at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

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

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.

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.

COINSURANCE – Coinsurance describes how the cost of health expenses is shared between the Employer and the Employee. For Plan A and Plan C the Employee portion of this Plan, the Employer pays 80% (Plan A and Plan C) and 100% (Plan B) of the covered expense while the Employee is responsible for the remaining 20% (Plan A and Plan C) and 0% (Plan B). This is sometimes called a "co-payment."

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

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

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

CONVALESCENT FACILITY – An institution or a distinct part of an institution meeting all of the following tests:

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

COORDINATION OF BENEFITS (COB) – Coordination of Benefits, also called COB, describes how expenses covered by two separate health programs are shared.

When an individual is covered for health benefits under two separate plans, coordination of benefits rules define the order in which the plans will make payment. More information, including the order of benefit payments for Dependents, is provided under the section called "Coordination of Benefits".

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

COSMETIC SURGERY – Surgery is cosmetic if it is intended to change:

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

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

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

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

CREDITABLE COVERAGE – Creditable Coverage includes coverage of an individual under a group health plan (including COBRA), individual health insurance coverage, Medicare, Medicaid, military sponsored health care, a program of the Indiana Health Service, a state health benefits risk pool, the Federal Employees Health Benefit Program, a public health plan as defined in regulations and any health benefit plan of the Peace Corps Act, a State Children's Health Insurance Program (effective February 28, 2005), or any other creditable coverage required by regulations issued by the Secretary for the Department of Health and Human Services. Creditable Coverage also includes short term, limited coverage. For eligible employees who became employed on or after the beginning of 2008/2009 school year (August 11, 2008), the following will also constitute Creditable Coverage: comprehensive health care coverage provided through a mutual aid society or a health care cost sharing organization.

CUSTODIAL CARE – Care is custodial if it is comprised of services and supplies, including room and board and other institutional services, which are provided to an individual whether disabled or not, primarily to assist this patient in the activities of daily living.

Such services and supplies are custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

Such care includes, but is not limited to, helping a patient walk, get into or out of a bed and take normally self-administered medicine. The Plan Supervisor will determine, based on reasonable medical evidence, whether care is custodial.

DEPENDENTS – Shall be any of the following:

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

The term "children" will include:

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

MICHELLE'S LAW

If a dependent child withdraws from regular full-time attendance at an accredited educational institution due to a medically necessary leave of absence, 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 if the dependent child had maintained status as a full-time student, whichever is earlier. A medically necessary leave of absence occurs when a dependent child who is a full-time student at an accredited education institution takes a leave of absence from his/her educational institution or otherwise changes his/her enrollment status with the educational institution, provided such leave or change is medically necessary and begins while the dependent child is suffering from a serious illness or injury. Documentation from the treating physician of the serious illness or injury and the need for the leave or enrollment change must be provided. Graduating students will be covered through the end of the month in which they graduate.

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

Proof of incapability must be submitted to the Plan Supervisor within 120 days of the child's 19th birthday. The child must have been incapacitated prior to age 19 and covered as a dependent under this Plan. The Plan Supervisor also has the right to require, at reasonable intervals, proof that an Employee's child has been fully handicapped continuously since the last proof was submitted.

After a child's coverage has been continued under this section for two years, the Plan Supervisor will not require this proof more often than once a year. If an Employee fails to submit any required proof, or refuses to permit a medical examination of the child as requested, he/she will be considered no longer fully handicapped.

No person may be covered as a Dependent of more than one Employee of this Employer.

No person who is a full-time member of the Armed Forces may be considered a Dependent, except as otherwise required under USERRA.

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

EMERGENCY CARE –Emergency care is the first treatment given in a hospital's emergency room or emergency care facility after the sudden and unexpected onset of symptoms or an accident causing injuries which are severe enough to require immediate hospital level care.

Hospital level care will be deemed to be required only if care could not safely and adequately have been provided other than in a hospital or adequate care was not available elsewhere in the area at the time and place it was needed.

EMPLOYEE – An Employee is a person employed by this Employer and assigned to, and regularly working for the required number of hours, and who is included in a class or group of Employees to which the Plan has been and continues to be extended.

For the purposes of brevity and clarity in this document, any references to the Employee will be in the male pronoun, his, which will in no way exclude any female Employee.

EXPERIMENTAL OR INVESTIGATIONAL

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

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

All phases of clinical trials shall be considered Experimental.

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

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

Reliable evidence shall mean:

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

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

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

Routine patient care costs for clinical trials include:

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

Routine costs for clinical trials do not include:

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

EXTENDED CARE/SKILLED NURSING FACILITY – An extended care/skilled nursing facility is a legally operated institution which:

- a. for a fee provides convalescents with room, board and 24-hour care by one or more professional nurses and other nursing personnel needed to provide adequate medical care;
- b. is under full-time supervision of a doctor or registered graduate nurse (RN);
- c. keeps complete medical records on each patient;
- d. if not operated by a doctor, has the services of one available under an established agreement; and
- 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;
- f. has an effective utilization review plan.

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

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

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

HOME HEALTH CARE AGENCY – An agency that meets all of these tests: 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 these tests: it must be a formal written plan made by the patient's attending physician which is reviewed at least every 30 days; it must state the diagnosis; certify that the home health care is in place of Hospital confinement; and it must specify the type and extent of home health care required for the treatment of the patient.

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

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

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

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

For the services covered under this Plan and for no other purpose, inpatient services for treatment of mental illness or substance abuse that are provided by a community mental health center or by a psychiatric hospital licensed by the state Board of Health or the Department of Mental Health will be considered services rendered in a hospital as defined above.

The term "hospital" will not include, nor will the term "covered charges" include charges incurred in connection with confinement to any institution or part thereof used principally as a rest or nursing facility or a facility for the care of mental disorders, the aged, chronically ill, convalescents, drug addicts or alcoholics, or as a facility providing primarily custodial, educational or rehabilitative care.

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

- a. sterilization including vasectomy and tubal ligation;
- b. alcoholism and drug addiction (substance abuse);
- c. the condition of being pregnant and all conditions and/or complications resulting from the pregnancy.
 1. Pregnancy is covered the same as any other illness for female Employees and 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.

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

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.

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

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

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

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

MORBID OBESITY – Morbid Obesity shall be defined as twice the ideal body weight (IBW) or 100 pounds over the IBW according to the reinsurance company's table of desirable weights.

NON-OCCUPATIONAL ILLNESS OR INJURY – An illness or injury is considered non-occupational if it is not connected with an injury or illness covered by any workers compensation, occupational illness law, or similar legislation.

OPEN ENROLLMENT – The open enrollment period shall be held during the month of November of each year.

OUTPATIENT SUBSTANCE ABUSE FACILITY – This means an institution which:

- a. provides a program for diagnosis, evaluation and effective treatment of substance abuse;
- b. provides detoxification services need with its effective treatment program;
- c. provides infirmary-level medical services or arranges with a hospital in the area for any other medical services that may be required;
- d. is at all times supervised by a staff of physicians;
- e. provides at all times skilled nursing care by licensed nurses who are directed by a full-time registered graduate nurse;
- 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.

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.

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 same as described herein.

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

PLAN DOCUMENT/MASTER PLAN DOCUMENT – The Document held by the Employer which describes the terms and conditions of the benefits of the Plan.

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

POST-SERVICE CLAIM – A claim for a benefit under the Plan that is not a pre-service claim or urgent care claim.

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

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

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

- a. the medical child support order clearly specifies the following:
 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; and
 4. the Plan to which such order applies.
- b. the medical child support order does not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act, as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993.

REASONABLE AND CUSTOMARY – A "reasonable and customary" charge shall be the Maximum Allowable charge made by a physician or supplier of services, medicine or supplies. This Maximum Allowable Fee is determined by comparing similar services or procedures to a national data base. This is adjusted to the locality where services or procedures were performed. The term "area" as it would apply to any particular service, medicine or supply means a county or such greater areas as is necessary to obtain a representative cross section of level of charges. This Plan will utilize the ADP reasonable and customary databases for medical, dental, and anesthesia services.

The allowable amount for assistant surgeon services will not exceed 20% of the maximum allowed amount for the surgery. Reasonable and customary limits for anesthesia charges will be based on the most recent guidelines provided by the American Society of Anesthesiologists (ASA). If multiple, bilateral, or incidental surgical procedures, which add significant time or complexity to patient care, are performed during the same operative session, the total value shall be the value of the major procedure plus 50% of the value of the lesser procedure(s).

The Maximum Allowable Charge limit is a cost control feature of this Plan. It is not intended to control or limit a patient's choice, or a provider decision, for necessary medical care.

Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which requires additional time, skill or expertise.

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

ROOM AND BOARD CHARGES – Charges made by an institution for room and board and other necessary services and supplies must be regularly made at a daily or weekly rate.

Semi-private rate is the charge which an institution applies to the most beds in its semi-private room with 2 or more beds. If there are no such rooms, it will be the rate most commonly charged by similar institutions in the same geographic area.

Private room charges will not be covered unless certified as medically necessary by the attending physician and approved by the Plan Supervisor. For the purposes of this benefit, "medically necessary" means the facility has no semi-private or less expensive accommodations, or all such accommodations are occupied and the patient needs hospitalization immediately and such inpatient treatment cannot be deferred until less expensive accommodations become available.

If the patient's condition requires isolation for his/her own health or that of others, a private room may be medically necessary when treating a number of physical and mental conditions. These include communicable diseases which require isolation of the patient for certain periods.

Miscellaneous charges are charges made by the hospital at a daily or weekly rate for other hospital services and supplies, or which are regularly made by the hospital as a condition of occupancy of the class of accommodations occupied

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

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

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

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

SPECIAL ENROLLEE – An Employee or Dependent who is entitled to and who requests special enrollment (as described in the Eligibility section) within thirty (30) days of losing health coverage; within thirty (30) days of marriage, birth, adoption, or placement for adoption (for newly acquired dependents; or within sixty (60) days after losing coverage under Medicaid or CHIP

program or becoming eligible for a subsidy for this Plan through a Medicaid or CHIP program.

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 by this Plan.

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, electrocauterizing, 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.

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

- a. an Employee from engaging in any and every business or occupation and from performing any and all work for compensation or profit;
- b. a dependent from performing the normal activities of a person of like age and sex.

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

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

URGENT CARE CLAIM – A claim for medical treatment which, if the regular time periods observed for claims were adhered to:

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

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

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

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

BASIC LIFE INSURANCE

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

Life Insurance for active Employees will continue at the same level until they are eligible for Medicare or terminate. Life Insurance for retired Employees will depend on eligibility for Medicare. If the retired Employee is eligible for Medicare, Life Insurance benefits will terminate. If the retired Employee is NOT eligible for Medicare, Life Insurance benefits will continue at the same level until they are eligible for Medicare. When the retired Employee becomes eligible for Medicare, Life Insurance benefits will terminate.

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

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

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

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

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

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

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT

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

Loss Of...	Insurance Benefit
Life	Full Amount
One Hand, One Foot, or One Eye	One-half the full amount
More than one of the above through one accident	Full amount

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

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

Benefits will terminate when Employee becomes eligible for Medicare or terminates as described under the Basic Life Benefit.

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

- a. suicide, attempted suicide, or whenever an Employee injures himself on purpose while sane or insane;
- b. voluntary taking of poison or ptomaines, or voluntary use of any controlled substance unless prescribed for the Employee by a licensed physician and taken in the dosage or manner instructed by a licensed physician;
- c. voluntary inhalation of gas;
- d. participation in, or as a result of having participated in, the committing of an assault or felony;
- e. insurrection or active participation in civil commotion, war or acts of war, whether or not declared;
- f. disease or bacterial infection other than infection occurring with and as a result of an accidental cut or wound;
- g. travel, flight, or getting in or out of an aircraft being used for test or experiments that an Employee is flying, is learning to fly, or is part of the crew of which does not have a valid FFA normal or transport type certificate of airworthiness; or that is not flown by a pilot with a valid license.

BENEFICIARY – Unless an Employee specifically designate otherwise, the one designation of Beneficiary shall apply to both Life Insurance and Accidental Death and Dismemberment benefits.

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

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

LONG TERM DISABILITY BENEFIT

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

WHAT IS TOTAL DISABILITY? – You will be considered “totally disabled” if:

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

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

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

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

- a. benefits from a personal individual disability income policy; or
- b. benefits from any of the following:
 1. an individual deferred compensation agreement; or
 2. any Employee savings plan; or
 3. an individual retirement account (IRA or 401K Plan); or
 4. a profit sharing savings plan maintained in addition to an Employer-sponsored defined benefit or defined contribution pension plan.

WHEN DO PAYMENTS BEGIN? – Monthly benefits will accrue from the first day after the qualifying period and will be payable while you continue to be “totally disabled”, if due proof of the disability is given to the insurance company. However, benefits will not be payable beyond the date you attain age 65, if disability occurs prior to age 60. For disabilities commencing on or after age 60, benefits are payable for period of up to 2 years, but not beyond age 70.

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

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

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

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

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

NOT COVERED DISABILITIES – No benefits are payable for disability due to self-inflicted injuries, due to war, or due to participation in or as a result of participation in, the commission of a felony. Benefits are limited for disability resulting from mental or emotional disease or alcoholism or drug abuse.

COMPREHENSIVE MEDICAL BENEFITS

ANNUAL MEDICAL MAXIMUM

The annual maximum payable under the Medical portion of the Plan is shown in the Schedule of Benefits.

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

LIFETIME MEDICAL MAXIMUM

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

LARGE CLAIM MANAGEMENT

This Plan allows the Employee and covered dependents access to cost-effective alternative treatment. The purpose of "alternative treatment" is to reduce cost and provide quality care if an Employee or a covered family member is 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 reinsurance carrier will be reimbursable under this provision.

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

DEDUCTIBLES

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

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

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

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

Basic Embedded Deductible Explanation

A health plan with an embedded deductible actually has two deductible amounts. In a family plan, for example, the embedded deductibles may start meeting expenses for an individual after the individual has 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.

BENEFITS

Certain medical expenses incurred after any Deductible are payable at the rate of 80% for Plan A/C and 100% for Plan B and the Employee is responsible for paying the remaining 20% for Plan A/C.

COINSURANCE LIMIT

Individual Limit: When 20% for Plan A/C and 100% for Plan B 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 80% for Plan A/C, except where maximum benefits have been met.

Family Limit: For a family unit, when 20% for Plan A/C 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 80% for Plan A/C, 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, and charges in excess of the reasonable and customary amount or negotiated rate will NOT go toward satisfying the coinsurance limit.

The copayments or coinsurance that an Employee pays for prescription drugs at the time of purchase through the drug store or mail-order program will not 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 (including prescription contraceptives and Ritalin);
 - b. diagnostic x-ray, laboratory and microscopic examinations including allergy testing and any medically necessary pre-operative or pre-admission testing -- routine ultrasound charges for covered pregnant Employees and dependents will be Covered Medical Expenses for one test during a normal pregnancy -- any ultrasound charges beyond the first test will be covered only if proof of medical necessity is provided to the Plan Supervisor;
 - 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 wheel chairs or hospital-type beds and other mechanical equipment for the treatment of respiratory paralysis required for temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less;
 - 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 hearing aids 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 non-service 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. contraceptive devices and birth control pills;
 - o. insulin, insulin syringes and clintests;
 - 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 up to the limits shown in the Schedule of Benefits for Preventative Health Care Expense;
 - s. routine pap smears and prostate exams up to the limits shown in the Schedule of Benefits for Preventative Health Care Expenses; and
 - 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.
- E. charges for the services of a certified nurse-midwife in accordance to the Plan definition.

SPECIAL CONDITIONS COVERAGE

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

Generic Drugs -- It is the responsibility of the claimant to have the pharmacist mark the drug as GENERIC on any prescription receipt (label). The receipt (label) must also show the name and cost of the drug, the date issued and the name of the patient for whom the drug was prescribed.

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/she needs to provide the identification card which indicates that the Employee and dependents are covered under this Employer Benefit Plan to receive the discounted price at the time of purchase. After the initial visit, the Network Store computer will identify the Employee and covered dependents.

If this Plan is primary, the Employee will pay only the copayment portion on brand name drugs or generic drugs when the prescription is filled. Generic drugs will be filled for a flat rate of \$6.00 (or less if the Employee's actual cost is less than \$6.00). All other drugs will be filled for a flat rate of \$12.00.

Mail Order Drugs - There will be a Mail Order Drug program for Employees or dependents who are on maintenance drugs. For a 3-month supply of any maintenance drugs, the cost will be \$12.00 for brand name drugs and \$6.00 for generic drugs. This program is through Script Care. Obtain an original order blank from the Human Resources Department of this Employer for further information.

If an insured elects not to purchase a generic drug when available and approved by the physician, the Employee will be responsible for the generic copayment plus the difference in the cost of the generic and the brand name drug.

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.

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.

- B. **Outpatient Surgery** - All expenses incurred for medically necessary surgery performed as outpatient surgery will be paid as shown in the Schedule of Benefits for all reasonable and customary charges made in connection with the surgery. "Surgery" is further described under the "Definitions."
- 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:
- for which the charges are a Covered Medical Expense;
 - which is recommended by the first physician who proposed to perform the surgery; and
 - 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.

A benefit is also paid for charges made for a third surgical opinion. This will be done when the second opinion does not confirm the recommendation of the first physician.

Additional information is detailed under the "Pre-Utilization Program" provision.

- D. **Preadmission/Preoperative Testing** - Charges made by a physician, hospital, surgery center, or licensed diagnostic lab facility to test a person while an outpatient before scheduled surgery or inpatient admission will be paid as shown in the Schedule of Benefits.

- E. **Hospital Care** - Intensive care charges will be covered expenses up to 4 times the semi-private rate of that institution.

Charges made by a hospital for routine care of a newborn will be paid at 80% after any required deductible for the baby. Also covered are professional fees during the initial hospital confinement for circumcision and in-hospital visits. These charges are covered separately from the mother.

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

- F. **Mental and Nervous Disorders** - if a person is an inpatient in a hospital, the covered expenses will be paid in the same way as for any other illness up to the Annual Limit shown in the Schedule of Benefits. The Pre-Utilization procedures must also be followed for this type of inpatient care.

- G. **Substance Abuse Treatment** - If a person is confined as an inpatient in either a qualified hospital or treatment facility, the covered charges are as follows:

Hospital or Qualified Treatment Facility:

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

The Pre-Utilization procedures must also be followed for this type of inpatient care.

Treatment must be ordered in writing by a qualified physician for the entire length of time the patient is confined.

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

Minimum 48-hour Requirement - Benefits for hospital charges and physicians treatment of substance abuse will not be provided for in-patient admissions of less than 48 hours.

The maximum number of authorized days for all inpatient and outpatient mental nervous disorders and substance abuse care is shown in the Schedule of Benefits.

If a person is not confined in a hospital for substance abuse treatment, the Schedule of Benefits shows the maximum number of sessions per year for each individual for this coverage.

Intensive Outpatient Substance Abuse Care - Intensive outpatient programs for treatment of substance abuse will be paid as shown in the Schedule of Benefits:

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

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

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

- H. **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.

The most visits covered in a calendar year is shown in the Schedule of Benefits. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

- I. **Hospice Care Expenses** - Covered Medical Expenses in connection with an approved Hospice Care Program will be paid as shown in the Schedule of Benefits. 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.

- J. **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 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 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.

- K. **Preventative Health Care Expenses** - Expenses incurred for routine health examinations, lab tests, physician check-up charges (not associated with any illness, injury or condition), well-baby exams, sport physicals, inoculations and immunizations will be covered for each eligible individual up to the limits shown.

This benefit also consists of lab work or physician charges for checkups for the detection of cancer. This includes, but is not limited to, annual exams, pap smears, mammograms, blood tests, colon and prostate screenings.

Expenses under this benefit are not subject to the deductible.

- L. **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 convalesce 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.
- d. physical, occupational or speech therapy.
- e. oxygen and other gas therapy.
- f. other medical services usually given by a convalescent facility. This does not include private or special nursing, or physicians services.
- g. medical supplies.
- h. 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.

- M. **Temporomandibular Joint Disorders** - The following charges for treatment of temporomandibular joint (TMJ) disorders will be considered covered medical charges up to a lifetime maximum shown in the Schedule of Benefits for a covered individual. This maximum includes all professional and facility fees. The following charges will be considered medical in nature whether performed by a medical doctor, a dentist or an oral surgeon:
 - a. physical medicine (heat, massage, ultrasound)
 - b. history/consultations/examinations
 - c. diagnostic x-rays
 - d. prescription medications; muscle injections
 - e. appliance therapy (bite splint) - no more than one every three years with adjustments as necessary
 - f. joint surgery

TMJ Exclusions

- a. alteration of occlusion (orthodontics)

- N. **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.

- O. **Organ Transplant Expenses** - Charges incurred for organ transplant surgery will be considered under the following categories to allow for reasonable and medically necessary care and treatment.

The following transplants will be considered covered expenses:

- a. artery or vein transplants;
- b. bone marrow transplants;
- c. heart valve replacements;
- d. implantable prosthetic lenses in connection with cataracts;
- e. joint replacements;
- f. prosthetic by-pass or replacement vessels;
- g. heart transplants (mechanical, artificial or other than human transplants are not covered);
- h. heart and lung transplants;
- i. liver transplants;
- j. pancreas transplants;
- k. liver and Pancreas transplants;
- l. kidney transplants;
- m. kidney and pancreas transplants

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

This Plan will work with Large Case Management to provide care in the most cost-effective setting. To be eligible for benefits, provider facilities must offer:

- a. advanced open heart surgery;
- b. the services of professionals such as neurologists, neurosurgeons, thoracic surgeons and intensive care, and
- c. technological and support facilities.

The benefits of this transplant provision will begin five days before the date of the transplant and end when the maximum benefit is reached.

Covered Organ Transplant Expenses will include:

- a. hospital inpatient care
 1. room and board
 2. miscellaneous charges
- b. physician services
 1. surgery
 2. assistant surgery
 3. anesthesia
 4. inpatient medical visits
 5. intensive medical care
 6. consultations
 7. home and office visits
- c. diagnostic services
 1. radiology, ultrasound and nuclear medicine
 2. laboratory and pathology
 3. EKG, EEG and other electronic machine tests
 4. psychological testing
 5. neuropsychological testing
- d. therapy services
 1. radiation therapy
 2. physical therapy
 3. respiratory therapy
 4. occupational therapy
 5. speech therapy
- e. skilled nursing facility (SNF) care
 1. no benefits are payable after the patient has reached the maximum level of recovery possible for his or her condition and requires only supportive care
- f. home health care
 1. services must be prescribed by the physician before discharge from a hospital or a Skilled Nursing Facility
- g. prescription Drugs
- h. transportation and lodging
 2. transportation, lodging and meals for the patient and one other person to and from the site of the transplant surgery are covered (if the patient has not reached his or her 18th birthday five days before the transplant, transportation, lodging and meals for two other people will be covered)
 3. these services are covered only if the patient must travel at least 50 miles to the transplant site
 4. benefits are paid as any other Major Medical expense subject to a maximum of \$10,000 per type of transplant
- i. donor Organ Procurement
 1. evaluation and surgical removal of donor organ
 2. transportation of the donor organ
 3. storage costs

If the scheduled transplant is canceled due to the patient's condition or death, and the organ cannot be used by another patient, procurement benefits will still be paid. Benefits are paid as any other Major Medical expense subject to a maximum of \$10,000 per type of transplant.

Organ Transplant Exclusions

The Plan will not pay:

- a. services and supplies which are not directly related to the receipt of the organ;
- b. artificial or animal organs;
- c. the cost of the organ itself;
- d. private duty nursing, except as specifically stated as covered;
- e. expenses the Employee incurs before his coverage begins or after it ends;
- f. services or supplies to the extent that the Employee have no legal obligation to pay for them;
- g. services or supplies furnished by any provider acting beyond the scope of his license;
- h. personal hygiene and convenience items, even if prescribed by a physician.
- i. any expenses when approved alternative remedies are available;
- j. any financial consideration to the donor other than for a covered expense which is incurred in the performance of or in relation to transplant surgery.

Fully-Insured Transplant Policy

Benefits for the treatment of Transplants of the following human to human organ transplants:

Heart;	Heart/kidney
Heart/Lung(s);	Lung(s);
Liver;	Liver/cadaveric;
Liver/kidney;	Liver/live donor;
Pancreas;	Kidney;
Kidney/Pancreas (simultaneous);	Pancreas (after kidney);
Small Bowel;	Bone Marrow

A covered transplant procedure will include only the following human to human transplant procedures when the procedure is used to treat leukemia, lymphoma, blood and genetic diseases and solid tumors: 1) allogeneic related; 2) allogeneic unrelated; 3) autologous; 4) synogeneic; 5) cord blood; 6) peripheral stem cells will be covered under a separate insurance policy through United States Fire Insurance Company, managed by Fairmont Specialty. For specific benefit questions or to access a covered Provider or Facility, please call the Pre-Certification number on your ID Card.

Lifetime Maximum Transplant Benefit under this policy is unlimited.

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

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

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

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

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

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

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

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

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

P. **Transportation Expenses** - 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.

Q. **Cardiovascular (Heart) Care**- Medically necessary cardiovascular (heart) care that is under the direction of a physician licensed in the state practicing will be covered as stated in the Schedule of Benefits.

Designated Cardiovascular Program: Having cardiovascular care rendered at a Designated Cardiovascular Facility is voluntary; however, for certain cardiovascular related procedures, it can produce substantial savings to the Employee. For information on this program, call Dunn and Associates. Dependents must have primary coverage through this Plan to be eligible for the Designated Cardiovascular Program. Only adult dependents may be eligible.

Notify Dunn and Associates before scheduling services you may wish to receive through the Designated Cardiovascular Program. If urgent care is necessary, please go directly to the nearest facility. It is important for the patient to be seen by a physician immediately. After the patient is stabilized and a procedure is decided upon, Dunn and Associates can be called.

R. **Dental Work and Oral Surgery**

Expenses for dental work and oral surgery are covered expenses only for the following:

- a. impacted teeth; and
- b. if they are for the prompt repair of natural teeth and other body tissue needed as a result of an injury. The expenses must be incurred within 90 days of the injury. Removal of tumors within the oral cavity will also be covered under the medical portion of the Plan.
- c. Surgery to correct a mandibular musculoskeletal deformity (orthodontics are not covered under the medical plan).

S. **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 surgery necessary for the prompt treatment of a diseased condition, or previous therapeutic process treated while covered under this Plan or correction of congenital defects of covered dependents born under this Plan will be Covered Medical Expenses if they are recommended and performed by a licensed physician. This includes reconstructive breast surgery following a radical mastectomy, whether or not recommended as medically necessary.

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.

COMPREHENSIVE 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;
- B. experimental or investigational services, procedures, or substances which have not been recognized by established medical review boards as accepted standard of medical practice by the Federal Drug Administration or the American Medical Association;
- C. cosmetic, elective, plastic, reconstruction or restorative surgery, except as specifically provided for in this Plan. This exclusion includes but is not limited to rhinoplasty, stomach stapling, breast reductions or enlargements, and face lifts, whether or not recommended by a physician as medically necessary; and
- 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, 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, hearing screenings above the maximum amount allowed under Preventative Health Care Expenses; or
- E. charges for the treatment of refractive errors, including but not limited to eye exams, glasses, contact lenses (or their fitting) in excess of the allowed maximum under Vision Benefits. 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 are also excluded; except vision exams for covered participants up to age 21 will be covered under the medical plans preventative coverage; 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. 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
- I. any treatment of obesity or weight reduction due solely to overeating, except as required by the Patient Protection and Affordable Care Act (PPACA) under the medical plan preventative coverage.
- J. rest or custodial care; or
- K. 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; or
- L. 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
- M. acting as pilot or copilot of an ultralight airplane; or
- N. repair or replacement of prosthetic devices except as detailed under "Covered Medical Expenses"; or
- O. travel, except as allowed under Ambulance coverage, whether or not recommended by a physician; or
- P. 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

- Q. 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
- R. marital counseling, recreational, educational or social therapy or training services;
- S. services related to sex transformations, sexual dysfunctions or sexual inadequacies; or
- T. any form of non-medical self-care or self-help training and any related diagnostic testing; or
- U. 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
- V. personal comfort items such as television, telephones, extra food trays, air conditioners, humidifiers, hot tubs, whirlpools, physical exercise equipment, etc.;
- W. 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
- X. expenses incurred after termination of coverage under this Plan; or
- Y. illness or injury paid or payable under Workmen's Compensation;
- Z. 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
- AA. 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
- BB. programs or confinements resulting from an arrest or citation for substance abuse and their related use; or
- CC. supportive devices of the feet; care of flat feet, fallen arches, weak feet, chronic foot strain, and toenails; and treatment of corns, bunions, and callouses. However, care of corns, bunions, callouses, or toenails is covered when medically necessary because of diabetes or circulatory problems;
- DD. services or supplies related to the treatment of abuse of nicotine from tobacco or other sources, except for nicotine substitutes which require a prescription under federal law, except as required by the Patient Protection and Affordable Care Act (PPACA);
- EE. services or supplies used to treat conditions related to autism, learning disabilities, behavior problems, mental retardation or senile deterioration beyond the period necessary for diagnosis.
- FF. Drugs or drug classes screened must reflect the members medical history. Screening should only test for the drugs likely to be present, based on the participants medical history or current clinical status. We will deny payment as not medically necessary if the drug screening does not reflect the participants 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.

This plan's intent is to comply with all necessary provisions of the Patient Protection and Accountable Care Act.

COMPREHENSIVE DENTAL BENEFITS

BENEFIT

Covered Dental Expenses include the charges of a dentist or duly qualified physician for services and supplies required in connections with the dental care and treatment of any illness, defect or accidental bodily injury, or in connection with preventative dental care, except charges in excess of reasonable and customary.

The Covered individual may choose any licensed dentist practicing within the scope of his/her profession or any physician furnishing dental services for which he/she is licensed.

DEDUCTIBLE

The annual dental deductible amount is the total amount of covered expenses a covered individual must satisfy in each calendar year before he/she is eligible for the Comprehensive Dental Benefits.

MAXIMUM BENEFITS

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

The maximum lifetime benefit shown for orthodontia is applicable for you and each of your covered dependents.

COVERED EXPENSES

- A. Preventative services and supplies - covered at 100%-no deductible
 - a. Oral Exams and Prophylaxis, but not more often than every 6 months;
 - b. Fluorides, but not more often than one each 12 months;
 - c. Sealants;
 - d. Diagnostic and therapeutic services
 - 1. Full-mouth x-rays, but not more than every 3 years or
 - 2. Bite-wing x-rays, but not more than every 6 months
- B. Basic Restorative Treatment - covered at 80% after deductible
 - a. Emergency palliative (dental pain) treatment;
 - b. Extractions and oral surgery, but additional charge for removal of stitches or post-operative examination in connection with the procedure shall not be included;
 - c. Periodontics for treatment of the gums and supporting structures of the teeth;
 - d. Endodontics;
 - e. Anesthetics, fractures and dislocations;
 - f. Injectable antibiotics administered by a dentist or physician;
 - g. Amalgam, silicate, plastic or composite restorations;
 - h. Space maintainers for missing primary teeth and habit breaking appliances;
 - i. Diagnostic x-ray and laboratory procedures required in relation to dental surgery;
 - j. Consultations required by the attending Dentist;
 - k. Repair, relining or rebasing of an existing full or partial denture if such denture has not been replaced by a denture covered under this Plan.
- C. Major Services and Supplies - covered at 50% after deductible
 - a. Crowns, implants and gold restorations, except that
 - 1. Crown, implant or gold restorations will be limited to the charge for an amalgam, silicate, plastic or composite restoration unless the tooth structure cannot be restored with such other material;
 - 2. Replacements of crown or gold restoration will be covered only if it is over five years old;
 - 3. Precision attachments, personalization, characterizations or specialized techniques shall not be covered.
 - b. Full dentures, removable partial dentures, fixed bridges (including crowns and inlays) or adding/replacing teeth to an existing prosthesis if they are lost while covered under this plan;
- D. Orthodontic services and supplies - charges made for services and supplies in connections with orthodontic treatment for the Employee and dependents are covered at 50% with no deductible.
 - a. This Plan will pay that portion that incurs after eligibility commences if there was a written signed contract at the time the orthodontic work started indicating date and amount of charges.
 - b. This plan will not cover that portion of charges for orthodontic services that incur prior to the time the individual becomes covered.

COMPREHENSIVE DENTAL EXCLUSIONS AND LIMITATIONS

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

- A. Charges for treatment by other than a dentist or physician except treatment performed under the supervision and direction of a dentist or physician, by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations;
- B. Services or supplies partially or wholly cosmetic in nature;
- C. Education or training in personal oral hygiene or dental plaque control;
- D. Any services or supplies reimbursed under the medical portions of this plan;
- E. Procedures, restorations, and appliances used to increase vertical dimension or to restore occlusion beyond the orthodontic benefit;
- F. Charges for crowns and restorations other than those listed in the subsections captioned "Restorative Services and Supplies";
- G. Services and supplies not specifically covered under the plan or not incurred during a period of coverage;
- H. Dental care or supplies for which no charge was made, or no payment would be required if the covered individual did not have this coverage;
- I. Illness or injury covered by Workmen's Compensation

COMPREHENSIVE VISION BENEFITS

BENEFITS

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

DEDUCTIBLE

There is no annual vision deductible. All expenses are paid at 100% up to the annual maximum shown in the Schedule of Benefits.

MAXIMUM BENEFITS

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

COVERED EXPENSES

- A. Preventative services and supplies
 - 1. examinations for pathology or anomalies;
 - 2. refractions; limited to one exam/refraction per year payable under type I charges.

- B. Diagnostic and therapeutic services
 - 1. coordination tests and measurements;
 - 2. near point visual function analysis;
 - 3. visual field charting when indicated;
 - 4. prescription of proper lenses, if indicated;
 - 5. color discrimination;
 - 6. tonometry - glaucoma test, if indicated;
 - 7. prescribing and ordering proper frames, assisting in selection of frames, verifying accuracy of the finished glasses and proper fitting;
 - 8. safety glasses (limit of two pairs in any 4 year period);
 - 9. contact lenses.

VISION EXCLUSIONS

Charges for the following services or supplies are not covered under this benefit:

- A. cosmetic or color frames or lenses not requiring a prescription;
- B. any vision or related expenses covered under the medical benefits;
- C. any charges above the maximum annual limit shown in the Schedule;
- D. for or in connection with a condition for which the Covered Person is entitled to benefits under any Worker's Compensation or similar law.

COORDINATION WITH OTHER PLANS

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

DEFINITIONS

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

PLANS AND THIRD PARTY LIABILITY CONSIDERED FOR COORDINATION

"Plans" means these types of covered or benefits of an individual covered by this Plan:

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

ORDER OF BENEFIT DETERMINATION

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

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

- A. a plan without COB provision will be primary to a plan with COB provision;
- B. a plan which covers an individual as an Employee will be primary to a plan which covers an individual as a dependent child;
- 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. 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;
- 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. if the birthday anniversaries are the same, then the plan which has covered the dependents the longest will be the primary plan;
- G. third parties, under third party liability situations, as defined above and elaborated on below, and the Plan Type C's under "Plans and Third Party Liability Considered for Coordination" are 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;

- H. 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 or domestic partner of the parent with custody
 3. the plan of the parent without custody; and
 - d. An obligation to carry coverage/insurance shall always be considered controlling and primary, above any other health obligation.

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

THIRD PARTY LIABILITY – PLAN TYPE C

- A. Plan Obligation – If recovery is obtained from a third party and/or Plan Type C, there shall continue to be no obligation on the part of the Plan to pay allowable expenses, as defined by this Plan and SPD, to or for the benefit of, any individual covered by this Plan until the amount of allowable expenses equals the gross amount paid by, or recovered from, a third party and a Plan Type C who or which is liable for those expenses because of third party liability, or under the terms of the Plan Type C contract. The obligation of this Plan to pay allowable expenses in such event shall begin with, and be limited to, those expenses exceeding Plan Type C and third party liability gross payments and gross recovery, up to the maximum allowed under this Plan. This shall be the case even if the allowable expenses are less than Plan Type C gross payments and third party liability gross recovery at the time of final resolution with Plan Type C entities and third parties. This shall also be the case if the Plan has made payment under agreement as below provided in this Section, and at the time of final settlement with Plan C entities and gross recovery from third parties, the allowable expenses are below Plan Type C payment and third party recovery.

It shall also be of no consequence that parts of gross recovery or gross payment shall be designated as payment for past, present, or future health expenses or receive any other designation (such as pain and suffering). All amounts paid, no matter how designated, shall be included in gross recovery or gross payments. Likewise, any amounts paid to or recovered by a spouse of the individual covered by this Plan (who has Plan C and/or third party liability recovery rights), as consortium or on any other basis derivative of the covered individual, shall be attributed to the covered individual and combined with and included in the terms “gross payments” and “gross recovery” for the purposes of determining the timing of and level of payments to the covered individual for allowable expenses under this Plan. For clarification, the following example should be instructive.

An individual covered by this Plan is 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 though 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.

If the allowable expenses are recoverable from a third party and/or Plan Type C and the allowable expenses do not exceed \$500 per accident injury or illness, the Plan may choose to accept responsibility for the expenses and make payment without regard to the third party and/or Plan Type C's potential payment. If the covered person receives payment from a third party and/or Plan Type C for the expenses reimbursed by this Plan, the Plan retains Subrogation Third Party Liability reimbursement rights as outlined in this section.

- 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 right 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.

MEDICARE PROVISIONS

WHEN TO APPLY

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

WHO IS ELIGIBLE TO APPLY

Medicare provisions have been changed by recent government rulings. These provisions will continue to be amended as government regulations change. This Plan will adopt those changes as they are mandated by amendments to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Social Security Act and the Social Security Act and Age Discrimination in Employment Act (ADEA).

The following briefly explains how the most recent changes have affected this Employer-sponsored Employee Benefit Plan.

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

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

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

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

This notice applies to all employees and dependents that are Medicare eligible or are preparing to become Medicare eligible.

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

You may have heard about Medicare's new prescription drug coverage and wondered how it would affect you. Your employer has determined that your prescription drug coverage with them is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare can enroll in a Medicare prescription drug plan from October 15th through December 7th. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between October 15th through December 7th.

If you do decide to enroll in a Medicare prescription drug plan and drop prescription drug coverage sponsored by your employer, be aware that you may not be able to get this coverage back.

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

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

You should also know that if you drop or lose your coverage sponsored by your employer and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage

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

For more information about this notice or your current prescription drug coverage...

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

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

For more information about your options under Medicare prescription drug coverage...

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

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

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

TERMINATION OF COVERAGE

AN EMPLOYEE'S COVERAGE

The coverage of any Employee will terminate on the date on which any of the following events first occurs:

- a. the day of which employment terminates;
- b. transfer to a class of Employees not covered by the Plan;
- c. the last day in which any required contributions are not paid;
- d. the date the Plan terminates;
- e. the date on which the Employee reaches retirement age and chooses Medicare as primary coverage;
- f. the date the participant enters the Armed Forces, except when covered by USERRA.

"Ceasing active work" will be considered to be cessation of employment. 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 illness or injury.

If an Employee becomes totally disabled, then his eligibility date for termination of employment will be determined from the date his continual disability commenced as follows:

<u>Employee Seniority</u>	<u>Continuation of Eligibility before Termination</u>
Up to 10 years	3 months
Over 10 years	6 months

At the end of the period, 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 on the day of the month on which any of the following events first occurs:

- a. termination of eligibility as a dependent;
- b. termination of the covered Employee's coverage for reasons other than attainment of the Lifetime Maximum Benefit;
- c. failure to make any of the required contributions;
- d. when a dependent becomes covered for Employee coverage;
- e. the date on which the dependent reach age 65 and chooses Medicare as primary 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 may continue coverage under the Plan for up to one month starting with the date the leave begins. The Employer will not continue to pay his portion of the premium amount for the Employee. The Employee will be responsible for the entire premium during this leave.

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

It is the intent of this Plan to follow all federal regulations in regards to the Family Medical Leave Act where applicable.

CERTIFICATES OF PRIOR COVERAGE UNDER THE PLAN

In 1996 the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") was passed by Congress. Under HIPAA, all Employees and their Dependents who are actually covered by the Plan will automatically receive a Certificate of Group Health Plan Coverage ("Certificate") when they lose coverage under the Plan and upon the loss of coverage should continuation of coverage under COBRA be elected. Additionally, all employees and their Dependents who lose coverage under the Plan may request a new Certificate at any time during the 24 months which follow loss of coverage. The Certificate will include information for both the covered employee and his Dependents unless the information for a Dependent is different from that of the covered employee, and in such case a separate Certificate will be issued for each such person.

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

TEACHERS -- EARLY RETIREMENT AND/OR DISABILITY

Teachers retiring early and/or who are disabled may be eligible to continue coverage. The requirements and benefits are as follows:

- A. Any teacher retiring who is at least 55 years of age with at least 10 years of service in the school corporation may purchase, at their own expense, single or family health insurance until the teacher is eligible for Medicare. It is understood and agreed to that a teacher's spouse is allowed to continue on the Health Insurance Plan until the spouse is eligible for Medicare, even if the retired teacher has already dropped off the plan due to age or death. Said coverage for the spouse will be at the spouse's expense. Said retiring teacher shall also receive fully paid single vision insurance, fully paid single or family dental insurance, and fully paid life insurance plus AD & D until eligible for Medicare.
- B. Teachers retiring before age 55 for disability reasons who have 10 years of service in the school corporation shall be allowed to remain in the school corporation insurance programs at their own expense until age 55 at which time the school corporation will begin to pay for the vision insurance, dental insurance and life insurance plus AD & D as stated under A above. The teacher's disability must be verified by at least one (1) physician depending upon the circumstances. If the school corporation needs more than one (1) verification, the corporation shall pay for such verification(s).
- C. A retiring teacher shall also receive either single or family dental insurance until eligible for Medicare with the school corporation paying the same amount toward said insurance as is paid for teachers currently teaching in the system

REDUCTION IN FORCE

It is hereby recognized that the Trustees of the Plan has the right under applicable law to reduce the number of teaching personnel whenever enrollments, educational programs, curriculum or economic necessity dictates. For additional information regarding reduction in force, refer to the board policy between the Board of Trustees of the Barr Reeve Community Schools, Inc and the Barr Reeve Classroom Teachers Association.

RECISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuation of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuation of coverage is NOT a rescission if:

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

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand a Covered Person's COBRA rights and obligations.

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

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

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA. Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

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

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

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

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

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

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

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

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

USERRA RIGHTS AND COVERAGE

CONTINUATION COVERAGE

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

COST

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

COORDINATION WITH COBRA

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

WAITING PERIODS AND EXCLUSIONS UPON REEMPLOYMENT

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

RIGHTS, BENEFITS, AND OBLIGATIONS

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

CONTINUATION OF COVERAGE (COBRA)

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

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

A **Qualified Beneficiary** is an Employee or Employee's spouse or dependent child who, on the day before a qualifying event, is covered by the Employer's group health plan. A qualified beneficiary also includes a covered Employee's newborn child or children placed for adoption with the covered Employee during the continuation period.

As an Employee covered by your Employer-sponsored group health plan, you have the rights to choose this continuation of coverage if you lose your group health coverage because of voluntary or involuntary termination of employment (except for termination for "gross misconduct") or reduction of hours to fewer than the number required for plan participation.

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

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

As a retiree (or a retiree's spouse or child) you have the right to continuation coverage if you have a substantial loss of coverage within one year before or after the Employer becomes subject to a Title XI bankruptcy proceeding.

Benefits may be continued for up to 18 months for termination of employment or reduction of hours. For all other qualifying events, benefits may be continued for up to 36 months.

SOCIAL SECURITY DISABILITY/RAILROAD DISABILITY

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

The premiums during the extended 11 months would be at a substantially higher rate than for the initial 18-month period.

COST OF COVERAGE

This "Continuation of Coverage" will be effective upon application and payment of the required premium. Premium is due on a month-to-month basis and should be paid on the first day of the month for which coverage is requested. The premium must be received within a 30-day grace period or coverage will be canceled. Once the coverage is canceled, it cannot be reinstated. If continuation of coverage is elected, payment for continuation coverage provided during the period preceding the election must be made within 45 days of the date of election. The premium is based on the average monthly cost of providing the identical benefits to any active employee. Each year when the Plan renews coverage, your premium will be adjusted for any changes in cost for active employees. Information can be obtained from the Employer concerning application procedures and amount of premium.

If you do not choose continuation of coverage, your group health insurance coverage will end. If you choose continuation of coverage, the Employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated active employees and family members. The coverage will begin on the date the group health coverage would otherwise have ended.

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

As of December 1, 2014, this plan will not deny any claims due to a pre-existing condition.

Proof of prior coverage is no longer required by this plan. This Employer will provide individuals with a "Certificate of Coverage" which shows *all* coverage provided during the 24-month period prior to a cessation of coverage. The Certificates of Coverage will be provided through December 31, 2014 and as requested thereafter.

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 you 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 spouses have changed addresses, please notify your Employer or Dunn and Associates. All notices will be sent to the last known address.

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.

ASSIGNMENTS

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

CESSATION OF BENEFITS

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

CHANGE OR DISCONTINUANCE OF PLAN

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

CLERICAL ERROR/MISSTATEMENTS

Neither clerical error in keeping records pertaining to the coverage, nor delays in making entries thereon, shall invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated, but upon discovery of such error or delay an equitable adjustment shall be made.

If any facts relevant to the existence of amount of coverage shall have been misstated, the true facts will determine whether or not, and how much, coverage is in force.

Any material misrepresentation on the part of the Employee in making application for coverage, or any application for reclassification of that coverage, or for benefits under this Plan shall render coverage voidable by the Plan Supervisor.

COMPLIANCE WITH CONTRACT PROVISIONS

Failure of the 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 feature of the Plan's coverage. Employees will all receive identification cards showing the Plan Supervisor's address and phone to provide coverage and benefit information.

FACILITY OF BENEFIT PAYMENT

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

FREE CHOICE OF PHYSICIAN/EXAMINATION

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

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

Covered individuals who are eligible for benefits as of December 1, 2014 shall be entitled to benefits for expenses incurred as a result of a "pre-existing condition." The pre-existing condition exclusion no longer applies to charges incurred on or after December 1, 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 regards to the maternity stay, this Plan will authorize a hospital stay, for the mother and the child, of 48 hours for uncomplicated normal deliveries and a 96 hour stay for cesarean section. The length of the stay will be decided 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.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision of the Plan or any provision of similar purpose of any other plan, the Plan Supervisor (under the direction of the Plan Administrator) may, without the consent or notice of any person, release to or obtain from any other insurance company or other organization or person, any information, with respect to any person, which the Plan Supervisor deems to be necessary for such purposes.

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

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.

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.

the Plan to the Plan Sponsor.

- D. **Disclosure of PHI to Obtain Stop Loss or Excess Loss Coverage** – The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Plan Supervisor, to disclose PHI to stop loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.
- E. **Other Disclosures and Uses of PHI** – With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

CLAIM APPEAL AND REVIEW PROCEDURES

WHEN TO APPEAL

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

APPEAL PROCESS

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

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

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

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

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

NOTICE OF APPEAL DETERMINATION

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

- a. the specific reason(s) for the adverse claim decision;
- b. a reference to pertinent Plan provision, internal rules, guidelines, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- c. if the denial is based on medical necessity or experimental treatment, an explanation of the scientific 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

LEGAL ACTION

A claimant who disagrees with the decision after an appeal may have the right to bring a civil action. 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.

.....

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