HEALTH BENEFITS PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

CITY OF AUBURN

Restated July 1, 2020

PREFACE

This Plan Document and Summary Plan Description for the **City of Auburn** HEALTH BENEFITS PLAN, hereinafter referred to as the "Plan," defines the benefits that shall be paid to or on behalf of a Covered Person during the continuance of this Plan in the event he or she incurs Eligible Expenses as defined herein. The Plan as described herein is intended to comply with Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (the "Code"), and is to be interpreted in a manner consistent with the requirements of Code Sections 105 and 106. The Plan is subject to all the terms, provisions and limitations stated herein and shall become effective as of 12:01 a.m. Standard Time on **July 1, 2020** at **Auburn, Indiana.**

Este sumario tiene un resumen en inglés de sus derechos y beneficios con el plan de salud de este empresario. Si tenga dificultades de compreción de este sumario, llama (260) 925-6450 el administrador de este plan, a su departamento de beneficios. Los horas del oficina son los 8:30 de la mañana d las 5 de la tarde los lunes a viernes. También pueda llamar el administrador del plan a su oficina a (260) 925-6450 para ayuda.

This summary has an English summary of their rights and benefits under the health plan of the employer. If you have difficulties comprehending this summary, call (260) 925-6450, the administrator of this plan, your benefits department. The office hours are 8:30 am - 5 pm Monday through Friday. Also you can call the plan administrator at his office at (260) 925-6450 to help.

This plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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 the plan administrator. 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.

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SECTION 1. GENERAL PROVISIONS

EFFECTIVE DATE

The Effective Date of the Plan is July 1, 2020 as of 12:01 a.m. in the time zone of the Plan Administrator, Standard Time at Auburn, IN. Eligibility for, and the amount of benefits, if any, payable with respect to Employees of the Employer or their Dependents prior to the Effective Date shall be determined in accordance with any applicable group benefit plan maintained by the Employer at that time. As of the Effective Date, eligibility for and the amount of benefits, if any, payable with respect to an Employee and his or her Dependents shall be determined pursuant to the terms and conditions of this Plan Document and Summary Plan Description.

PURPOSE

The City of Auburn, hereinafter referred to as the "Employer," has established and maintains the self-funded employee benefit plan contained herein to provide for the payment or reimbursement of specified medical and prescription drug expenses incurred by its Eligible Employees and their Covered Dependents. The name of the Plan is the City of Auburn HEALTH BENEFITS PLAN (the "Plan"). The purpose of this Plan Document and Summary Plan Description is to set forth the provisions of the Plan that provide and/or affect such payment or reimbursement.

AMENDMENT OR TERMINATION OF THE PLAN

Although it is the intention of the Employer to maintain the Plan indefinitely, the Employer, acting through its Board of Directors or any other person or committee to whom the Employer delegates such authority, has the sole and absolute right to amend or terminate the Plan at any time without the consent of any Covered Person. All amendments shall be communicated to Participants as soon as practical after adoption of the amendment. In addition, any amendment that decreases coverage or restricts eligibility shall be communicated to the Participants in a reasonable period of time before the amendment takes effect.

CONFORMITY WITH LAW/COLLECTIVE BARGAINING AGREEMENT

If any provision of the Plan is contrary to any law or regulation to which it is subject, such provision is hereby amended to conform thereto. Additionally, to the extent any provision in this Plan is contrary to any Employer obligation under any valid Collective Bargaining Agreement, the Plan is hereby amended to comply with such obligation.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations not warranties. No such representations will be used to void coverage or be used in defense to a Claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan.

No failure to enforce any provision of the Plan shall affect the Plan or Employer's right thereafter to enforce such provision, nor shall such failure affect the Plan or Employer's right to enforce any other provision of the Plan.

NOTICE AND PROOF OF CLAIM

Written proof of Eligible Expenses must be furnished to the Plan Administrator within one year after the claimed Eligible Expenses were Incurred, unless the claimant was legally incapacitated. Failure to furnish written proof of Eligible Expenses within that time will neither invalidate nor reduce any claim if it can be

shown that it was not reasonably possible to furnish written proof of Eligible Expenses within that time, and that written proof of Eligible Expenses was furnished as soon as was reasonably possible.

PAYMENT OF BENEFITS

The Employer will pay, or cause to be paid, all benefits payable under the terms and conditions of the Plan. The Employer assures the Covered Persons that all benefits provided under the Plan will be paid promptly upon receipt of proof that Covered Expenses have been incurred.

The Plan reserves the right to make payments for Covered Expenses either to you or directly to the provider of the services. The Plan Administrator is specifically authorized by you to determine to whom a benefit payment should be made. A provider that accepts such payment made by the Plan agrees to accept payment as consideration in full for services, supplies, and treatment rendered. Any such payment is not an assignment, and the provider does not have any right to receive any benefits due under the Plan greater than those of any Covered Person under the terms of the Plan. Notwithstanding any other provision of the Plan, if a provider refuses to accept such payment as payment in full, the Plan Administrator, in its sole discretion, may refuse to make payments for Covered Expenses directly to such provider, and any payment due by the Plan will be provided directly to the Participant.

EFFECT OF MEDICARE ON BENEFITS

An Actively at Work Participant and his or her spouse age 65 or older will receive the same benefits under this Plan as shown for persons under age 65.

In the event any Participant or Dependent is eligible for coverage under Medicare due to a disability which qualifies the individual for benefits under Section 226(b) of the Social Security Act, as amended, and the individual is a Dependent of an active Employee of the Employer, or is an Employee, then Medicare will not be the primary payer and this Plan will be the primary payer.

In the event any Participant or Participant's spouse is age 65 or older and covered by Medicare while the Participant is employed by the Employer, then this Plan will be the primary payer and Medicare will be the secondary payer for so long as the coverage and employment relationship giving rise to eligibility for coverage continues.

In the event any Covered Person is afflicted with end-stage renal disease ("ESRD") and becomes eligible for Medicare coverage as the result of ESRD, this Plan will be the primary payer and Medicare will be the secondary payer for the duration of the 30 month period beginning with the first month the Covered Person is entitled to receive Medicare benefits, or if earlier the first month the Covered Person would have been entitled to Medicare benefits if such Covered Person had applied for such benefits.

EXAMINATION

The Employer shall have the right and opportunity to have a Covered Person examined by a Physician as often as is reasonably necessary while a Claim is pending for an Injury or Illness. The Employer shall also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount permitted under this Plan, whether payable to the Participant or under any preferred provider contract (or other contractual arrangement), the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments, regardless of whether it was due to the Plan's or Employer's own error. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

CONTINUED GROUP HEALTH PLAN COVERAGE

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

PLAN ADMINISTRATOR DISCRETIONARY AUTHORITY

The Plan Administrator or its designee will have full discretionary authority and all power necessary to discharge its duties hereunder including, but not by way of limitation, the following:

1. to construe and interpret the Plan, decide all questions that pertain to eligibility, and determine the amount, manner and time of payment of any benefits hereunder;
2. to resolve and clarify any ambiguities, inconsistencies, and omissions arising under the Plan or plan documents;
3. to prescribe procedures and forms applicable to the filing for benefits;
4. to prepare and distribute information explaining the Plan in a manner that the Employer determines to be appropriate;
5. to require information from Participants as necessary for the proper administration of the Plan including, but not limited to, applications for participation and forms for filing a claim for benefits (the Plan Administrator may rely upon the accuracy of all information furnished by a Participant including the Participant's current mailing address); and
6. to appoint or employ individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal and actuarial counsel.

NONGUARANTEE OF EMPLOYMENT

Nothing contained in this Plan will be construed as a contract of employment between the Employer and any Employee, as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

NONALIENATION OF BENEFITS

Except as permitted by law, benefits payable under this Plan will not be subject in any manner to assignment, anticipation, alienation, sale, transfer, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary. Any attempt to assign, anticipate, alienate, sell, transfer, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder, shall be void. The Plan shall not, in any manner, be liable for or subject to the debts, contracts liabilities, engagements or torts of any person entitled to benefits hereunder.

SECTION 2. SCHEDULE OF MEDICAL BENEFITS

This section is a Summary of Benefits under this Plan.
The following sections will provide further detail of coverage.

MAJOR MEDICAL BENEFITS

Plan Year: July 1 through June 30

Open Enrollment: annually from Dec. 1 through Dec. 31 – coverage is effective Jan. 1 of the following year

Eligibility
Employees who are classified as "Full-Time" by the Employer and regularly employed by the Employer in the usual course of business and work at least 30 hours per week (or the minimum as required by *The Affordable Care Act*).

Waiting Period

The first day of the month following 30 days of full-time employment.

Penalty for Failing to Obtain Precertification for Hospital Expenses

Hospital per Admission $250

Benefit Level Description

EPO (Tier 1) EPO facilities and PPO Professional/Ancillary Providers in the Signature Care EPO network (select counties).

PPO (Tier 2) PPO facilities that include all others. (Excludes Signature Care EPO facilities)

Non-Preferred Providers – Providers of service not in the Signature Care EPO or Signature Care PPO Network.

Provider Network: www.ParkviewTotalHealth.com; (260) 266-5510; (800) 666-4449

Deductible (calendar year)

	Tier 1 EPO Facilities/ PPO Providers	Tier 2 Signature Care PPO Facilities	Tier 3 Non-Preferred Providers
Individual	$500 EPO	$1,500 PPO	$3,500 Non-Preferred Providers
Family	$1,500 EPO	$4,500 PPO	$10,500 Non-Preferred Providers

- The EPO & PPO deductibles accrue to each other.
- The Plan has Deductible Carry Over. Eligible charges incurred during the period Oct. 1 through Dec. 31, which are applied to the deductible for that calendar year, these charges are also applied toward satisfaction of the deductible for the next following calendar year.
- The family deductible is stated as a dollar amount. If any family member reaches the individual deductible then the deductible is satisfied for that family member. If any combination of family members reach the family deductible, then the deductible is satisfied for the entire family.

Co-Insurance

In those instances where Co-insurance applies, the percentage of Covered Expenses that the Plan covers is indicated.

Co-Payment

In those instances where a Co-Payment applies, the amount is indicated. Prescription Drug Co-Payments do not apply to the Deductible.

Maximum Out-of-Pocket Expense
Includes Deductible, Co-Payments and Coinsurance and shall not exceed the following:

	Tier 1	Tier 2	Tier 3	
In Network	EPO	PPO	Non-Preferred	
Individual:	$2,000	$5,000	Individual:	No Limit
Family:	$6,000	$12,900	Family:	No Limit

Maximum Out-of-Pocket excludes:

- penalty amounts;
- preventative & routine charges;
- prescription drug co-pays
- amounts not covered by the Plans

The EPO & PPO Out-of-Pocket Expenses accumulate towards each other.

Preferred Provider Network (PPO) and Exclusive Provider (EPO)

The Preferred Provider Organization being accessed is shown on your Identification Card. You can choose an EPO (Exclusive Provider), a PPO (Preferred Provider), or Non-PPO (Non-Preferred Provider) whenever medical attention is needed.

SPECIAL NOTES

The following Covered Expenses incurred for services, supplies, or treatments rendered by a Out-of-Network Provider shall be payable at the In-Network level of benefits.

1. Hospital Services: Subject to Tier 2 Deductible & Out-of-Pocket.
2. Non-Hospital Services: Subject to Tier 1 Deductible & Out-of-Pocket.
3. Services of an Out-of-Network Provider anesthesiologist if the operating surgeon in an In-Network Provider.

4. Durable Medical Equipment, Radiologist or pathologist services to interpret x-rays and laboratory tests rendered by an Out-of-Network provider when the facility rendering, or physician ordering, such services is an In-Network Provider.
5. Consultations with an Out-of-Network Provider that are ordered by an In-Network Provider Physician, while you are confined to an In-Network Provider Hospital.
6. Services provided to Covered Dependents who reside outside the service area of the In-Network Provider Organization.
7. Services provided to Covered Persons who do not have access to In-Network Providers within the PPO service area.
8. Emergency Treatment rendered while traveling outside the PPO service area, or services while temporarily traveling or residing outside the PPO service area (other than for purpose of seeking medical care).
9. Treatment received from Out-of-Network Providers for Emergency Care.
10. Specialty services from an Out-of-Network Provider, when an In-Network provider of that specialty is not available in the network service area (unless "continuity of care" or "emergency care" principles are applicable).
11. Lactation counseling from an Out-of-Network Provider, when a lactation counseling In-Network Provider is not available in the network service area.

Benefit Maximums:

Supplemental Accident (within 90 days of accident)	$500 per injury at 100%; then deductible & coinsurance
TMJ:	$2,000 per Calendar Year
Wigs:	Not Covered

Benefit Visits/Day Limitations:

Chiropractic	20 visits per Calendar Year
Skilled Nursing Facility:	90 days per Calendar Year
Home Health Care (professional visits)	60 visits per Calendar Year
Occupational Therapy (Per Therapy)	No Limit
Physical Therapy (Per Therapy)	No Limit
Speech Therapy (Per Therapy)	No Limit

The DEDUCTIBLE applies except where indicated with an asterisk (*).

Benefit Percentage:

Charges are paid at the Benefit Percentage shown:

	Tier 1	Tier 2	Tier 3
Inpatient Hospital Expenses	80%	80%/60%(1)	40%
Inpatient Physician Expenses	80%	80%	40%
Outpatient Hospital Expenses	80%	80%/60%(1)	40%
Outpatient Physician Expenses	80%	80%	40%
Skilled Nursing Facility	80%	80%/60%(1)	40%
Office Visit/Urgent Care Includes: Diagnostic Testing (except MRI, CT & PET Scans) injections, allergy testing, allergy serum, allergy injections and surgery	80%	80%	40%
Emergency Room Charges (Includes all related expenses)	80%	80%/60%(1)	40%
Diagnostic Testing (includes MRI, CT & PET)	80%	80%/60%(1)	40%
Laboratory Expenses – Specialty Lab (2)	100%*	100%*	N/A
Non-Specialty Lab	80%	60%	40%
Surgery Expenses (Inpatient)	80%	80%/60%(1)	40%
Chiropractic Care	80%	80%	40%
Home Health Care	80%	80%/60%(1)	40%
Hospice Care	80%	80%/60%(1)	40%
Physical, Speech, Occupational Therapy	80%	80%	40%
Ambulance	80%	80%	40%
Durable Medical Equipment & Supplies	80%	80%	40%
TMJ	80%	80%	40%
Preventive Care (see Covered Medical Expenses, Section 5, #25)	100%*	100%*	100%*
Human Organ & Tissue Transplant	80%	80%	40%
All Other Eligible Major Medical Charges	80%	80%/60%(1)	40%

		Notes:
Prescription Drugs – Retail (34 days)		
Co-Payment	$10 Generic $30 Brand Formulary $45 Brand Non-Formulary $45 Specialty Medications	Maintenance retail fills limited to 3 refills. The 4th refill is subject to co-pay of: $20 Generic $60 Brand Formulary $90 Brand Non-Formulary
Prescription Drugs – Mail Order (90 days)		
Co-Payment	$20 Generic $60 Brand Formulary $90 Brand Non-Formulary $90 Specialty Medications	Mandatory Generic Substitution. If Brand requested when Generic is available, the member will be charged the difference in cost, plus the brand co-pay. Applicable to Retail & Mail.

(1) Applies to facility fees not affiliated with the EPO Network. All professional fees remain at 80% unless otherwise specified by the Plan up to the Maximum Allowable Amounts.

(2) Specialty Lab refers to services performed through DeKalb Memorial Hospital, d/b/a DeKalb Health or Lab Corp.

(3) Covered Out-of-Network Behavioral Health Services are subject to deductible and 60% coinsurance.

SECTION 3. ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY FOR COVERAGE

Coverage provided under the Plan for Eligible Employees and their Dependents shall be in accordance with the Eligibility, Effective Date, and Termination provisions of this section.

If an Employee's coverage is continued during disability, approved leave of absence or temporary lay-off or as approved under the Family Medical Leave Act or in accordance with the Plan Sponsors Employee Handbook, the amount of coverage shall be the amount as it was on the last day of active work. In no event will coverage be continued more than outlined under Continuation of Coverage.

DATE OF EMPLOYEE ELIGIBILITY

An Employee eligible for coverage under the Plan shall include only Employees who meet all of the following conditions:

1. Is Actively-at-Work on the first day of employment provided, however, that an Employee not Actively-at-Work on the first day of employment shall become covered on the first day the Employee returns to work (provided the applicable Waiting Period has been satisfied);

2. Is employed by the Employer on a Full-Time Employment basis;

3. Is a Retiree (outlined below).

With respect to an eligible Employee employed by the Employer on the Effective Date of the Plan, the date of his eligibility shall be the Effective Date of the Plan.

With respect to an eligible Employee who becomes employed by the Employer after the Effective Date of the Plan, the date of his eligibility shall be the day he first comes within a Coverage Classification (if any) shown on the Schedule of Benefits.

Retiree Eligibility

Retired Employee Coverage Continuation Provision – Public Safety Employees

A covered employee who retires from employment and any eligible dependents, are eligible to continue coverage under the Plan provided the retired employee has elected to receive his/her pension benefit. The employee and his/her eligible dependents may remain covered under the Plan until he or she attains age 65, or becomes eligible for Medicare. A retired employee must make election to continue coverage within 90 days from the date of retirement. The continued coverage will become effective on the date such employee retired. The employee may elect to continue coverage for his or her spouse and dependents who were covered by the Plan the date of the employee's retirement.

In the event of the death of the retired employee, the spouse and dependents who were covered by the Plan on the employee's retirement date may remain covered by the Plan until the lesser of: (1) the date on which the spouse or eligible dependents become eligible for Medicare; (b) the date on which the spouse remarries; (c) the date on which the spouse or eligible dependent cease to meet the definition of an eligible dependent as specified by the Plan; or (d) the date (2) two years after the date of the death of the retired employee. Upon termination of coverage, the dependent children may, in certain instances, be eligible to continue coverage through the COBRA Continuation Coverage provision. This period of extended coverage shall run concurrently with, and not in addition to, the COBRA Continuation Coverage provision.

Retired Employee Coverage Continuation Provision – Civilian Employees

A covered employee who retires from employment and is collecting his/her pension, is eligible to continue coverage under the Plan. The employee may remain covered under the Plan until he or she attains age 65, or becomes eligible for Medicare. A retired employee must make election to continue coverage within 90 days from the date of retirement. The continued coverage will become effective on the date such employee retired.

The retired employee's dependent spouse and children may continue coverage under the COBRA Continuation Coverage provision.

DATE OF DEPENDENT ELIGIBILITY

A Dependent is eligible for coverage under the Plan on the latest of the following dates:

1. the date the Employee becomes eligible for coverage; or

2. the date on which the Employee first acquires a Dependent if the Employee is covered on that date (or, if not covered, is eligible and simultaneously enrolling in coverage with the Dependent);

If both the Employee and spouse are employed by the Employer, then either (but not both) are eligible for Dependent coverage and either (but not both) may elect Dependent coverage for their eligible Dependents.

A Dependent shall be considered eligible for coverage on the date the Employee becomes eligible for Dependent coverage, subject to all limitations and requirements of the Plan, and subject to the following rules and limitations:

1. A newborn child of a covered Employee will be covered from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent of the Employee within 30 days of the child's date of birth. However, enrollment is not required, and a newborn child will be automatically covered, if the Employee is already enrolled in family coverage, and there is no additional cost to add this Dependent. A newborn child will also be automatically covered if Dependent coverage is non-contributory.] This provision shall not apply, nor in any way affect, the normal maternity provisions applicable to the mother.

2. A spouse of a Covered Employee will be considered a Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent of the Employee within 30 days of the date of marriage.

3. If a Dependent is acquired, other than at the time of his or her birth, due to a court order, decree, or marriage, that Dependent will be considered a Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled as a Dependent of the Employee within 30 days of the court order, decree or marriage.

4. A child placed with an Employee for adoption will be an eligible Dependent. Coverage for that child will begin on the date the child is placed with the Employee for adoption. Coverage for the child will end on the date the child is no longer in the Employee's custody for adoption.

5. A Dependent shall also include a child under a Qualified Medical Child Support Order (QMCSO). A QMCSO is defined as a medical support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or beneficiary is eligible under the Plan. A child who is identified in such an order is designated an "alternate recipient" and has the same status and rights as any other child covered

under the Plan. Alternate recipient is defined as any child of a Covered Employee who is recognized under a medical child support order as having a right to be enrolled under the Plan. The Plan Administrator must perform the following duties in conjunction with the QMCSO:

a. notify the Covered Employee and alternate recipient(s) that an order has been received;

b. inform the Covered Employee and alternate recipient(s) of the Plan's procedures used in determining if the order is qualified as a QMCSO. Such procedures must be in writing and provide for prompt notification of all interested parties, including the Claims Adjudicator; and

c. determine, within a reasonable amount of time, if the order is a QMCSO and notify all interested parties, including the Claims Adjudicator.

It is the Employee's responsibility to notify the Plan within 30 days of a change in any Dependent's eligibility status. With respect to a working spouse, the Employee may be required to provide an annual certification of a working spouse's eligibility for coverage under this Plan.

EFFECTIVE DATE OF COVERAGE

The Effective Date is the date that coverage under the Plan starts for an Employee or Dependent. The Effective Date may occur on or after the date on which the Employee or Dependent becomes eligible for coverage, as provided above. Persons who meet the eligibility requirements will be considered Covered Persons only if the Employee timely submits a completed enrollment form to the Employer and makes any required contribution for coverage. In addition, the Employer may require the Employee to provide documentation to support the eligibility of a Dependent upon enrollment, such as a birth certificate to enroll a newborn child or a marriage certificate to enroll a spouse.

EFFECTIVE DATE OF COVERAGE FOR EMPLOYEE

If the Employee timely enrolls, his or her coverage shall become effective, as applicable, on:

1. The date the Employee becomes eligible under the Plan.

2. The effective date under a special enrollment event.

3. In the event of a change in status or other applicable event that permits an Employee to make a mid-year election change under Code Section 125, the date of the status change or other applicable event.

4. The date established as the Open Enrollment effective date.

EFFECTIVE DATE OF COVERAGE FOR DEPENDENTS

If the Employee timely enrolls a Dependent, his or her coverage shall become effective, as applicable, on:

1. The Employee's Effective Date.

2. The effective date under a special enrollment event.

3. In the event of a change in status or other applicable event that permits an Employee to make a mid-year election change under Code Section 125, the date of the status change or other applicable event.

4. The date established as the Open Enrollment effective date.

MID-YEAR CHANGES IN COVERAGE

Changes in enrollment (both to enroll in coverage and to terminate coverage) may not be made until the next Open Enrollment period for the next Plan Year unless the Employee is changing coverage due to a special enrollment event or a change in status or other applicable event that permits an Employee to make a mid-year election change under Code Section 125.**]** In such case, the Employee must make a request for coverage within 30 days of the event (60 days in the event of a status change related to a loss of eligibility for Medicaid or CHIP or eligibility for premium assistance under Medicaid or CHIP). If a request it not made timely, an Employee must wait until the next Open Enrollment effective date to make any desired changes.

Please refer to the Employer's Code Section 125 Plan for more information on permitted change in status events other than special enrollment events.

SPECIAL ENROLLMENT EVENTS

- **Addition of Dependents**. If you are a Covered Employee or an Eligible Employee under the Plan but previously waived coverage for any reason, and if you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll yourself, your new Dependent child, any existing Dependent children, and/or your spouse in coverage under the Plan. To enroll in coverage, you must: (1) complete the enrollment form; (2) certify the date the Dependent was acquired and provide any required supporting documentation; (3) agree to make the required contributions; and (4) make this election within 30 days after the date your new Dependent was acquired. In no event may you enroll a Dependent if you are not already a Covered Employee or if you are not contemporaneously enrolling yourself as a Covered Employee. If you acquire a Dependent through birth or adoption or placement for adoption, coverage will be effective as of the date of the birth or adoption or placement for adoption, as applicable. If you acquire a Dependent through marriage, including a stepchild, coverage will be effective no later than the first day of the first calendar month beginning after the date the Plan receives the request for special enrollment.

- Loss of Other Coverage. If you are otherwise eligible for coverage under the Plan, you may enroll yourself and/or your eligible Dependents if:

  (i) you previously declined coverage under the Plan for yourself and/or your Dependents because either you or your Dependents had coverage under another group health plan or other health insurance;

  (ii) you and/or your Dependents actually had other coverage at the time coverage under this Plan was declined; and

  (iii) the other coverage is lost due to exhaustion of the COBRA continuation period, loss of eligibility under the other coverage, or cessation of employer contributions to the other coverage.

  To enroll under these circumstances, you must (1) complete the enrollment form; (2) certify the date the other coverage was lost and provide any required supporting documentation; (3) agree to make the required contributions; and (4) make this election within 30 days after the loss of other coverage due to exhaustion of the COBRA continuation period, loss of eligibility, or cessation of employer contributions. To enroll a Dependent, you must already be a Covered Employee or you must enroll yourself at the same time. Coverage will be effective as of the first day of the first calendar month beginning after the date the Plan receives the request for special enrollment.

- **Eligibility Under Medicaid.** To the extent required by HIPAA, if you and/or your Dependent are otherwise eligible for coverage under the Plan, you may enroll yourself as a Covered Person if (1) you or your Dependent are covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health plan under Title XXI of the Social Security Act, and (2) medical coverage

under such plans is lost due to a loss of eligibility for such coverage. In addition, you and/or your Dependent may be enrolled in coverage under this Plan as a Covered Person if you or your Dependent become eligible for premium assistance, with respect to coverage under the Plan, under such Medicaid plan or state children's health plan (including any waiver or demonstration project conducted under or in relation to such plan). In such a situation, you must (1) submit a completed enrollment form within 60 days after the loss of other medical coverage or the date you or your Dependent are determined to be eligible for premium assistance; and (2) agree to make the required contributions. To enroll a Dependent, you must already be covered or you must enroll yourself at the same time. Coverage will be effective as of the date the other medical coverage is lost, provided the Plan timely receives the completed enrollment form.

TERMINATION OF COVERAGE

Subject to the exceptions below, coverage under the Plan shall terminate on the earliest of the following dates:

1. The Covered Employee's last day of employment which may be extended by unused vacation.

2. The date the Employee ceases to be an Eligible Employee.

3. The date on which the Covered Employee voluntarily cancels coverage while remaining an Eligible Employee with respect to himself or herself and/or any Covered Dependents, either in connection with an Open Enrollment period, special enrollment event, or a permitted change in status or other applicable event under Code Section 125.

4. The date on which a Covered Employee's unpaid leave of absence (other than FMLA or any other leave which mandates continuation under law) begins, except to the extent that such Covered Person continues to be treated as a Full-Time Employee for the period of the leave.

5. The last day of the pay period for which the Employee fails to make any required contribution for coverage.

6. The date the Plan is terminated.

7. The date of the Covered Employee's death.

8. The date the Employee or covered Dependent becomes a full-time member of the armed forces of any country.

9. The date the Dependent fails to qualify as an eligible Dependent. In the case of a spouse, this means the date on which the spouse is divorced from the Employee, or becomes eligible for his or her employer's health plan, in which case the spouse may be required to enroll in that health plan and is not eligible to maintain secondary coverage under this Plan (see the definition of "Dependent" for exceptions). In the case of a child, this means the end of the month in which the child reaches age 26 or is no longer disabled as described in the definition of "Dependent."

10. The date the Employee commits an act of fraud or intentional misrepresentation of a material fact with respect to the Plan. A failure to notify the Plan Administrator of any changes that impact Dependent eligibility specifically constitutes fraud and an intentional misrepresentation of material fact and may result in a retroactive cancellation of coverage under the Plan.

Depending on the circumstances of your termination of coverage, you and/or your Dependents may have rights to continue coverage under the Plan as described in Section 5.

CONTINUATION OF ACTIVE COVERAGE DURING LEAVES OF ABSENCE

Notwithstanding the general termination provisions above, if an Employee's coverage is continued during an Employer-approved leave of absence or other temporary event listed below, or in accordance with the Plan Sponsor's Employee Handbook, then the Employee and his or her Dependents may remain covered at the same level as in effect on the last day the Employee was Actively at Work, at active rates.

Notwithstanding anything in this Plan to the contrary, in no event will coverage end while the Employee is treated as a Full-Time Employee under Appendix A**.**

Approved Medical Leave of Absence – Firefighters and Police Officers

Providing approved leave of absence is due to disability or illness, and wages are continued: 365 days from date leave began.

Approved Paid Leave of Absence

Providing approved personal leave of absence is due to disability, a personal leave, or a layoff: 180 days from last day of the month the leave began.

Approved Unpaid Leave of Absence

Providing approved leave of absence is due to disability, a personal leave, or a layoff: 30 days from the last day of the month in which the leave began.

Family and Medical Leave Act

Providing approved leave: 12 weeks.

REINSTATEMENT OF COVERAGE UPON REEMPLOYMENT

A former Covered Employee who terminates employment with the Employer and then returns to employment with the Employer as an Eligible Employee within 62 days will not be subject to any Waiting Period, and will be reinstated in the Plan. If a former Covered Employee returns to employment with the Employer as an Eligible Employee more than 30 days following his or her termination, he or she must again satisfy the Waiting Period specified in the Schedule of Benefits unless such Employee is determined to be a Full-Time Employee under Appendix A, in which case the Employee shall be eligible for coverage upon the determination that he or she is a Full-Time Employee.

SECTION 4. CONTINUATION OF COVERAGE AND OTHER FEDERAL COVERAGE MANDATES

COBRA GENERAL NOTICE

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this Section 5 or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pockets costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as your spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "Dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- The death of the Employee; or
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer in writing within 60 days after the qualifying event occurs. Review this entire section for specific rules.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified of the second qualifying event. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

In order to protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Employee Plans, LLC
1111 Chestnut Hills Parkway
Fort Wayne, IN 46814
(260) 625-7470

COBRA PROCEDURES

A. Qualifying Event Involving Divorce or Loss of Dependent Status

1. Notification to Plan Administrator

Qualified beneficiaries who lose coverage (or will lose coverage) because of a divorce or legal separation or because a Dependent no longer qualifies as a Dependent as (defined in the Plan), must notify the Plan Administrator, in writing, via either facsimile or U.S. Mail of the qualified beneficiary's desire to extend COBRA coverage after the date of the divorce or loss of Dependent status. Such notice must be sent to the Plan Administrator at the address specified in the Schedule of Benefits.

Notice may be made by the Employee/former Employee or any other qualified beneficiary that is a spouse or Dependent of the former Employee. Such notice may be given before the occurrence of the divorce or loss of Dependent status, but must, in all cases, be given no later than 60 days after the date of the

divorce or the loss of Dependent status. Oral notice or notice by e-mail is not sufficient under these Procedures.

2. Documents Required for Divorce/Separation

With respect to the information which must be given to the Plan Administrator, when divorce or legal separation is the qualifying event, the qualified beneficiary must provide the Plan Administrator with a copy of the Court Decree dissolving the marriage. If the divorce or legal separation has not yet been concluded, the qualified beneficiary must provide the Plan Administrator with any court documents that have been filed (such a Petition for Dissolution) and indicate the date that the divorce or legal separation is expected to be final.

3. Documents Required for Loss of Dependent Status

With respect to loss of Dependent status, a qualified beneficiary must provide to the Plan Administrator the reason the individual will no longer qualify as a Dependent.

B. Qualifying Events Involving Termination, Reduction in Hours, Death and Bankruptcy - Notification by Plan Administrator

Qualified beneficiaries who lose coverage because of a termination, reduction in hours, death or bankruptcy will receive a COBRA Election form which permits the Employee/former Employee (and Dependents) to elect coverage and indicates the premium for such coverage.

Election form shall be sent by U.S. Mail, postage pre-paid, to the last known address of the Employee/former Employee unless the Plan Administrator has been notified in writing to the contrary. The last known address shall be deemed to the most recent address contained in the Employee/former Employee's personnel file. In the event the Employee/former Employee changes address, it is his or her responsibility to notify the Plan Administrator of any change in address and the Plan Administrator shall not be responsible for notices sent to the wrong address if the more recent address was not provided in the above manner. Notification to an Employee/former Employee who elected spousal coverage shall be sent with an envelope marked "Mr. and Mrs. John Smith." Election forms sent to an Employee/former Employee that has one or more children/Dependents covered shall be addressed to the Employee (if the spouse was not covered) or to the Employee and spouse (if spousal coverage was elected), and each shall be deemed to include notification to any Dependent children, unless the Plan Administrator has actual knowledge of a different address for a Dependent child before the date the election form is mailed and provided further that any such notification to the Plan Administrator was in writing sent via either U.S. Mail or facsimile.

C. Errant Notices

In the event an individual receives a COBRA Election Form before the date the Plan Administrator determines that the individual is not eligible to elect COBRA (either because of an error concerning the individual's eligibility or because the individual was fired for gross misconduct), the Plan Administrator shall notify the individual of the errant notice within 14 days of the date that the individual was originally given the COBRA Election Form.

D. Early Termination of COBRA

COBRA continuation coverage will end earlier than the maximum coverage period described above (either 18, 29, or 36 months after the qualifying event), as of the first to occur of the following events:

1. The first day (including any grace period) for which COBRA premium payments are not made on a timely basis.
2. The date on which the qualified beneficiary first becomes covered under any other group health plan after electing COBRA coverage.
3. The date on which the qualified beneficiary first becomes entitled to benefits under Medicare after electing COBRA coverage.

4. The date on which the qualified beneficiary ceases to be disabled (if continuation coverage is due to a disability).
5. The Employer ceases to provide any group health plan to any employee.

The Plan Administrator shall notify the qualified beneficiary of the early termination date and the reason for early termination of COBRA coverage.

E. Postmark Date

All notifications, payments and other correspondence from a qualified beneficiary (or a possible qualified beneficiary) shall be deemed to have been received on the date that the item is postmarked, if sent by U.S. Mail. In the event communication or correspondence is sent via facsimile, the communication or correspondence shall be deemed to have been received on the date it is transmitted.

F. Eleventh Month Disability Extension

COBRA continuees who are determined by Social Security to be disabled within the first 60 days of COBRA continuation coverage (or earlier) may elect to extend the 18th month COBRA period by 11 months, provided the applicable premium is paid. The 11 month extension will only be given if the Plan Administrator is notified in writing, via either U.S. Mail or facsimile, of the Social Security determination. This written notification must also contain a copy of the Social Security determination. Qualified beneficiaries are required to request the 11 month extension within 30 days of receiving the Social Security determination and, in any event, must be provided to the Plan Administrator before the end of the 18 month COBRA continuation period. Any qualified beneficiary not meeting each of these rules will not be entitled to elect the eleven month extension. Qualified beneficiaries who were originally determined to be disabled but had that determination reversed must notify the Plan Administrator within 30 days of notification of the reversal. In the event the qualified beneficiary does not notify the Plan Administrator of any such reversal, the qualified beneficiary shall be required to repay the Plan for any Claims which were incurred after the date of reversal.

G. Multiple Qualifying Events

In the event a qualified beneficiary experiences a second qualifying event during the original 18 or 29 month period, who wishes to apply for an extension of the 18 or 29 months because of a second qualifying event, must notify the Plan Administrator via either U.S. Mail or facsimile, of the occurrence of the second qualifying event within 60 days after the event occurs. Any qualified beneficiary who fails to notify the Plan Administrator of the occurrence of the second qualifying event will not be entitled to extend coverage past the end of the 18 or 29 month period. COBRA coverage shall not extend beyond 36 months from the day of the original qualifying event, regardless of the occurrence of multiple qualifying events. Whether the subsequent qualifying event entitles a qualified beneficiary to extend coverage, under the applicable regulations, will be determined by the Plan Administrator.

H. Payment Requirements

COBRA payments must be paid monthly in the amount designated on the Election Form. The first COBRA payment is due within 45 days after the election form is executed. This payment covers the cost of the health care coverage provided from the date of the qualifying event (or loss of coverage, if later) through the date of the election. After the first payment, all subsequent COBRA payments are due on the first of each month for the applicable month. If no payment is received for a particular month, the qualified beneficiary shall be given a grace period of 30 days to pay the premium.

All payments of COBRA premiums should be made by check, money order or cashier's check. If payment is made by personal check, the qualified beneficiary shall be solely responsible for maintaining sufficient funds in his/her account so that the check will clear when presented. If a COBRA payment paid by personal check does not clear when first presented, the Plan Administrator shall make a second attempt to cash the check if the Plan Administrator has at least five (5) working days' notice before the end of the 30 day grace period. It is the obligation of the qualified beneficiary to confirm that his/her

COBRA personal checks have cleared the bank. The Plan Administrator shall not be under any obligation to notify the qualified beneficiary if a check does not clear. Additionally, if the Plan Administrator is presented with a personal check that does not clear, the Plan Administrator shall have the option of requiring all subsequent COBRA payments to be made by guaranteed funds (i.e. money order or cashier's check).

USERRA CONTINUATION COVERAGE

In any case in which an Employee (or the Employee's Dependent) has coverage under the Plan, and such Employee is absent from such position of employment by reason of service in the uniformed services, the Employee may elect to continue coverage under the Plan as provided in this section. The maximum period of coverage of an Employee and the Employee's Dependents under such an election shall be the lesser of the following:

1. The 24-month period beginning on the date on which the Employee's or Dependent's absence begins; or

2. The day after the date on which the Employee fails to apply for or return to a position of employment as determined under USERRA.

Any continuation coverage provided under this section will run concurrently with any other continuation coverage available, including COBRA continuation coverage.

An Employee who elects to continue Plan coverage under this section must pay 102% of his or her normal premium under the Plan; however, in the case of an Employee who performs service in the uniformed services for less than 31 days, such Employee will pay his or her normal contribution for coverage for the 31 days. All election procedures and time limitations for election of COBRA and payment of COBRA premiums applicable to COBRA shall apply to coverage under this Plan (refer to the COBRA Procedures provided above).

The preceding paragraph shall not apply to the coverage of any Illness or Injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Medical Benefits provided under the Plan will comply with the Newborns' and Mothers' Health Protection Act of 1996. As part of such compliance, the Plan may not 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 caesarian section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Medical Benefits provided under the Plan will comply with the Women's Health and Cancer Rights Act of 1998. As part of such compliance, if a Covered Person is receiving benefits in connection with a mastectomy and elects breast reconstruction with a mastectomy, the Plan will provide coverage in a manner determined in consultation with the Covered Person and the attending Physician, for:

- Reconstruction of the breast on which the mastectomy will be performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Federal law requires this coverage. In addition, the Plan will not:

- Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the Plan, solely for the purpose of avoiding this coverage; or

- Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce the provider to provide care in a manner inconsistent with the required coverage.

ELIGIBILITY FOR MEDICAID BENEFITS

Medical Coverage will be paid in accordance with any assignment of rights made by or on behalf of any Covered Person as required by a State plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, a Covered Person's eligibility for or receipt of medical benefits under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. The State will have a right to any payment made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make such payment.

MENTAL HEALTH PARITY ACT OF 1996

1. The Medical Benefits provided under the Plan will comply with the Mental Health Parity Act of 1996, as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan.

2. As part of such compliance, the financial requirements applicable to covered services for mental health and substance use disorder benefits will be no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all covered services for medical and surgical benefits, as such requirements and limitations are set forth in the Schedule of Benefits. A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of requirement or limit.

3. If the Plan provides coverage for medical or surgical benefits provided by Out-of-Network Providers, the Plan will provide coverage for mental health or substance use disorder benefits provided by Out-of-Network Providers in a manner consistent with this Section.

4. This Section will not apply to any Plan Year in which the Plan meets the cost exemption under applicable federal law and the Plan Administrator, in its sole discretion, chooses to apply such exemption.

5. The criteria for Medical Necessity determination made under this Plan with respect to mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential Covered Person, beneficiary, or contracting provider upon request.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The **[OPTIONAL:** Medical Benefits provided under the**]** Plan shall comply with HIPAA, as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan. As part of such compliance, the Plan provides the following rights:

1. Special Enrollment. Eligible Employees and their Dependents shall be entitled to enroll in the Plan upon a special enrollment event if they timely enroll within 30 days of the event.
2. Prohibition Against Discrimination Based On A Health Factor, The Plan will not exclude Eligible Employees or their Dependents from coverage based on a health status-related factor. The Plan

will also not charge any individual more for coverage, based on his or her health, than the amount charged to a similarly situated individual.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Medical Benefits provided under the Plan will comply with the Genetic Information Nondiscrimination Act of 2008 ("GINA"), as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan. As part of such compliance, the Plan may not adjust premium or contribution amounts for the group covered under the Plan on the basis of genetic information and will not request or require an individual or a family member of such individual to undergo a genetic test. The Plan also will not request, require, or purchase genetic information for underwriting purposes or with respect to any individual prior to such individual's enrollment under the Plan in connection with such enrollment.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The Medical Benefits provided under the Plan will comply with the Affordable Care Act, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan. As part of such compliance, the Medical Benefits provided under the Plan will meet the following coverage mandates:

1. Provide coverage of Dependent children to age 26;
2. Prohibit lifetime and annual dollar limits on Essential Health Benefits;
3. Prohibit pre-existing condition exclusions;
4. Prohibit Rescissions of Medical Benefits except in the case of fraud or an intentional misrepresentation of material fact;
5. Provide the same level of coverage for Emergency Care provided out-of-network as provided in-network,
6. Provide Preventive Care Benefits at no cost to the Participant,
7. Provide an External Review process for Covered Persons whose claims were Denied on Appeal;
8. Limit waiting periods to no longer than 90 days;
9. Limit Out-of-Pocket Maximums under the Plan to no greater than the ACA limits; and
10. Provide required coverage for Clinical Trials.
11. Allow Covered Persons to designate a participating primary care provider of choice for themselves, and a primary care provider who specializes in pediatric care for their child’s primary care provider.
12. Allow Covered Persons who are women to seek treatment for obstetrical and gynecological care without any requirement to obtain a referral.

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SECTION 4A. ESSENTIAL HEALTH BENEFITS

For purposes of compliance with the prohibition on annual and dollar lifetime limits on Essential Health Benefits, the Medical Benefits provided under this Plan consider the following benefits to be Essential Health Benefits:

1. Primary Care Visit to Treat an Injury or Illness
2. Specialist Visit
3. Other Practitioner Office Visit (Nurse, Physician Assistant)
4. Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
5. Outpatient Surgery Physician/Surgical Services
6. Hospice Services
7. Infertility Treatment
8. Urgent Care Centers or Facilities
9. Home Health Care Services
10. Emergency Room Services
11. Emergency Transportation/Ambulance
12. Inpatient Hospital Services (e.g., Hospital Stay)
13. Inpatient Physician and Surgical Services
14. Pre-natal and Post-natal Care
15. Delivery and All Inpatient Services for Maternity Care
16. Mental/Behavioral Health Outpatient Services
17. Mental/Behavioral Health Inpatient Services
18. Substance Abuse Disorder Outpatient Services
19. Substance Abuse Disorder Inpatient Services
20. Generic Drugs
21. Preferred Brand Drugs
22. Non-Preferred Brand Drugs
23. Specialty Drugs
24. Outpatient Rehabilitation Services
25. Habilitation Services
26. Chiropractic Care
27. Durable Medical Equipment
28. Imaging (CT/PET Scans, MRIs)
29. Preventive Care/Screening/Immunization
30. Routine Eye Exam for Children
31. Eye Glasses for Children
32. Dental Check-Up for Children
33. Laboratory Outpatient and Professional Services
34. X-rays and Diagnostic Imaging
35. Basic Dental Care – Child
36. Orthodontia – Child
37. Major Dental Care – Child
38. Off Label Prescription Drugs

SECTION 5. COVERED MEDICAL EXPENSES

GENERAL REQUIREMENTS

In order to be considered, expenses must be incurred by a Covered Person while the Plan is in force as the result of an Injury or an Illness, and meet all of the following requirements:

1. Must be related to treatment administered or ordered by a Physician or eligible provider;

2. Must be Medically Necessary for the diagnosis and treatment of an Illness or Injury;

3. Must not be excluded under any provision or section of the Plan;

4. Must be limited to the Usual, Customary and Reasonable Charge;

5. Must not exceed any applicable maximum benefit limitation set forth in the Schedule of Benefits; and

6. Must comply with nationally recognized coding standards including but not limited to: American Medical Association, Centers for Medicare Services, Health and Human Services – Office of Inspector General, National Library of Medicine, National Institute of Health and Specialty Societies, Current Procedural Terminology and CDC Guideline Recommendations.

COVERED EXPENSES

The following list of Covered Expenses is not intended to be exhaustive. Charges for treatments, services, and supplies that are not specifically excluded under the Plan may still be covered if they meet the general requirements above, even if they are not included on this list.

1. Charges made by a Hospital for:

    a. Daily Room and Board, general nursing services, or Confinement in an Intensive Care Unit not to exceed the Usual, Reasonable & Customary room charge.

    b. Necessary services and supplies other than Room and Board furnished by the Hospital will include inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions, emergency room use, Physical Therapy treatments, hemodialysis, x-ray and linear therapy.

2. Inpatient services in connection with Behavioral Health or Substance Abuse will be treated as an Illness.

3. Charges made by a Convalescent Hospital/Extended Care Facility for services and supplies furnished by the facility during any one convalescent period. Charges must commence within five (5) days following a Hospital Confinement of at least three (3) consecutive days and be for the same purpose and cause which created the Hospital Confinement. The confinement may not be for routine Custodial Care and the patient must be personally visited at least once each 30 days by a Physician. These expenses include:

    a. Room and board, including any charge made by the facility as a condition of occupancy such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average semi-private charges, or an average semi-private rate made by a representative cross section of similar institution in the area;

    b. Medical services customarily provided by the Convalescent Hospital/Extended Care Facility except for private duty or special nursing services and Physician's fees;

c. Drugs, biologicals, solutions, dressings and casts furnished for use during the convalescent period, but no other supplies.

4. Charges related to a Hospice:

   a. Nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a vocational nurse or a public health nurse who is under the direct supervision of a Registered Nurse (R.N.);

   b. Physical Therapy and Speech Therapy when rendered by a licensed therapist;

   c. Medical supplies, including drugs and biologicals and the use of medical Appliances;

   d. Physician's services;

   e. Services, supplies and treatments ordered by a Physician.

5. Physician services for medical care and/or surgical treatments including office and home visits, Hospital inpatient care, Hospital Outpatient visits/exams, clinic care.

6. Registered Nurses (R.N.) or Licensed Practical Nurses (L.P.N.) for private duty nursing services, treatment by a licensed physiotherapist or registered kinesiotherapist. Fees will not be paid to a nurse, physiotherapist or registered kinesiotherapist who ordinarily resides in the same household or is the Covered Person's spouse, child, parent, brother or sister.

7. Treatment or services by a licensed physical therapist or registered kinesiotheropist in a home setting or at a facility or institution for which the primary purpose is to provide medical care for an Illness or Injury.

8. Subject to any limitation set forth in the Schedule of Benefits, services of a Physician or qualified speech therapist for restorative or rehabilitative Speech Therapy for speech loss or impairment due to an Illness, Injury, other than a functional disorder, or due to surgery performed on account of an Illness or Injury.

9. Medically Necessary transportation of the Covered Persons by professional ambulance service, railroad, or regularly scheduled airline to the nearest Hospital or medical facility equipped to furnish treatment for the Injury or Illness, provided that the Covered Person's Injury or Illness cannot be adequately treated in the locale where the Injury or Illness occurs.

10. Drugs that require a written prescription from a licensed Physician and are necessary for treating a covered Illness or Injury.

11. X-rays, microscopic tests, and laboratory tests.

12. Radiation therapy or treatment.

13. Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.

14. Oxygen and other gases and their administration.

15. Electrocardiograms, electroencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

16. Anesthetic cost and administration.

17. Dressings, sutures, casts, splints, trusses, crutches, braces, ostomy supplies or other necessary medical supplies, with the exception of dental braces or corrective shoes.

18. Rental of a wheelchair, Hospital bed or iron lung or other Durable Medical Equipment required for temporary therapeutic use. At the option of the Plan Administrator, the equipment may be purchased.

19. Prosthetics. The initial purchase, fitting and repair of fitted Prosthetics to replace body parts, including replacements of prosthetic devices and supplies if permanently useless or malfunctioning body part.

20. Voluntary sterilization (reversal of any sterilization procedure is excluded from coverage).

21. Charges for treatment by an Ambulatory Care Facility or minor emergency medical clinic.

22. Home Health Care Agency charges for care in accordance with a Home Health Care Plan. Such expenses must be performed by Part-Time or intermittent nursing care by a Registered Nurse (R.N), Licensed Practical Nurse (L.P.N.), or a vocational public health nurse who is under the direct supervision of a Registered Nurse.

    Specifically excluded from coverage under the Home Health Care Plan are the following:

    a. Services and supplies not included in the Home Health Care Plan;

    b. Services of a person who ordinarily resides in the same household or is the Covered Person's spouse, child, parent, brother or sister;

    c. Services of a Social Worker;

    d. Transportation services;

    e. Meals and Custodial Care;

23. Subject to any limitation set forth in the Schedule of Benefits, chiropractic services may be covered only if all of the following requirements are met:

    a. The treatment is within the scope of a duly licensed chiropractor;

    b. The service would be covered by this Plan if it had been rendered by a Physician;

    c. The treatment is Medically Necessary as indicated for the diagnosis;

    d. The treatment is rehabilitative and not considered Preventive or maintenance;

    e. The frequency and/or duration of services are consistent with the diagnosis.

24. Insulin and necessary supplies used for the administration thereof.

25. Preventive Benefits are covered as shown on the Schedule of Benefits and includes examinations, pap smears, mammograms (one per calendar year), other related x-ray and laboratory services, immunizations and well-baby care; colonoscopies. Also, included under this benefit: examinations for covered employees of the Plan required as a condition of employment that are paid for by the employer.

26. Subject to any limitations set forth in the Schedule of Benefits, charges for Occupational Therapy and Physical Therapy.

27. Any Covered Person who is receiving benefits under this Plan in connection with a mastectomy and who elects breast reconstruction, the following procedures will be covered under the Plan, subject to the usual Co-payment and Deductible requirements.

    a. Reconstruction of the breast on which the mastectomy was performed;

    b. Surgery and reconstruction of the other breast for a symmetrical appearance; and

    c. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

28. Hospital expenses for mothers of newborn children who are covered under this Plan shall be covered for a minimum of two (2) days following a normal delivery and minimum of four (4) days following a caesarian delivery. No pre-certification is needed for coverage not in excess of the two (2) and four (4) day limitations. An attending provider, after consulting with the mother, may discharge the mother and/or newborn before the two (2) and four (4) day periods mentioned above. An "attending provider" means an individual who is licensed under applicable state law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child. Therefore, a plan, Hospital, managed care organization or other issuer is not an attending provider.

29. Multiple Surgical Procedures will be a Covered Charge subject to the following:

    a. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the UCR that is allowed for the primary procedures; 50% of the UCR will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedure.

    b. If multiple unrelated surgical procedures are performed by two surgeons on separate operative fields, benefits will be based on the UCR for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the UCR allowed for that procedure; and

    c. If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's UCR.

30. Case Management, Claim Edit, Fee Negotiation services and similar services shall be paid by the Plan at 100%.

31. Services and supplies in connection with covered transplant procedures are subject to the following conditions:

    a. A Second Surgical Opinion must be obtained prior to undergoing any covered transplant procedure. This mandatory Second Surgical Opinion must concur with the attending Physician's findings regarding the procedure being Medically Necessary. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training, or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery;

    b. If the recipient is covered under this Plan, then Eligible Expenses incurred by the recipient will be considered for benefits. In no event will benefits be payable in excess of the Maximum Benefit still available to the recipient;

    c. If both the donor and the recipient are covered under this Plan, then Eligible Expenses incurred by each person will be treated separately for each person;

d. Only the Usual, Customary and Reasonable Charge of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered a Covered Expense.

Charges due to tissue transplants, organ transplants, or replacement of tissue or organs, whether natural or artificial replacement materials or devices and all charges due to complications arising from such procedures or treatments.

The following procedures are payable on the same basis as any other Illness:

a. cornea transplants

b. artery or vein transplants

c. kidney transplants

d. joint replacements

e. heart valve replacements

f. implantable prosthetic lenses in connection with cataracts

g. prosthetic by-pass or replacement vessels

h. bone marrow transplants

i. heart transplants

j. lung transplants

k. heart and lung transplants

l. liver transplants

No other replacement of tissue or organs are covered under this Plan.

32. Charges for weight control or obesity, including diet control, diet supplements and Physician approved weight loss clinics are not covered except for the medical treatment of obesity which is a direct and immediate threat to life. An individual is Morbidly Obese if that individual's weight is in excess of 170% of standard weight tables.

33. Physician consultations provided in connection with Telemedicine Services contracted by the Employer.

34. Oral surgical procedures:

a. surgical extraction of impacted third molar teeth;

b. excision of exostosis of the jaw and hard palate;

c. excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

d. surgery to correct accidental injury of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

e. reduction of fractures and dislocation of the jaw;

f. external incision and drainage of cellulitis;

g. incision of accessory sinuses, salivary gland or ducts; and

h. frenectomy.

35. Charges for injectable and implantable contraceptives.

36. This provision is applicable to COVID 19 testing and is in accordance with the FFCRA. Diagnostic products, services and test furnished to an individual during a health care provider office visit, telehealth visit, urgent care center visits and emergency room visits, used to diagnose for a need to be tested or to be tested will not be subject to cost share, prior authorization or medical management requirements. This will apply to both in and out of network benefits.

PRESCRIPTION DRUG COVERAGE

The Plan provides prescription drug coverage as provided in the Schedule of Medical Benefits in Section 2. The prescription drug benefits coverage available to you under the Plan is managed by CVS Caremark, the pharmacy benefits management (PBM) company with which the Plan contracts to manage your prescription drug benefits. The PBM has a nationwide network of retail pharmacies, a specialty pharmacy, and a mail service program. It also provides clinical management services.

The PBM's role includes making recommendations and updates to the Plan's Formulary, which is a list of covered prescription drugs. The Formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary is not a guarantee of coverage under the Plan. The Formulary changes periodically and should be verified at the time a medication is prescribed to ensure it remains covered under the Plan. Prescription drugs must be Medically Necessary and not Experimental in order to be a Covered Expense.

The PBM also utilizes management tools when appropriate to encourage the use of cost effective generic drugs and to otherwise manage costs under the Plan. These programs may include dispense as written (DAW) policies, generic step therapy, maintenance drug programs, specialty and compound drug programs, opioid utilization management, diabetes care management, and others. Contact the Plan Administrator to learn more about the programs applicable to your prescription drug benefits.

SECTION 6. MEDICAL PLAN EXCLUSIONS

MEDICAL COVERAGE EXCLUSIONS

Notwithstanding any provision of this Plan to the contrary, the Plan excludes coverage of the following:

1. Charges incurred in connection with services and supplies which are not Medically Necessary for the treatment of an Injury or Illness or are not recommended and approved by a Physician.

2. Charges in excess of the Usual, Customary and Reasonable Charge.

3. Charges incurred prior to the Covered Person's Effective Date of coverage under the Plan, or after such coverage is terminated.

4. Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

5. Charges for services received as a result of Injury or Illness arising out of or in the course of employment for wage or profit, whether such employment is with the Employer, with another employer, or self-employment, provided the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law or any such similar law with respect to the Injury or Illness. This exclusion applies regardless of whether the Covered Person claims the benefits or compensation to which he or she may be entitled. If the Covered Person is not eligible for benefits under Worker's Compensation or Occupational Disease Law or any such similar law, this exclusion does not apply.

6. Care, treatment or supplies furnished or provided by any Federal, State or Local government, agency or instrumentality as prohibited by law.

   NOTE: *This Exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This Exclusion does not apply where otherwise prohibited by law.*

7. Charges incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

8. Charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation; or by committing or attempting to commit any assault crime or criminal act which constitutes a felony or assault, regardless of whether the individual is not charged with a crime or accepts a plea agreement to a lesser offense, if the Plan Administrator determines by a preponderance of the evidence that a crime was committed.

9. Charges incurred in connection with any intentionally self-inflicted Injury or Illness.

10. Treatment for care required as a result of Illness or Injury resulting from participation in high risk sports or hobby, including, but not limited to, sky diving, hang gliding, SCUBA diving, car racing in any professional or semi-professional sport, bungee jumping, motorcycle or ATV operating in any contest of speed.

11. Charges incurred for nutritional supplements or vitamins not Medically Necessary for the treatment of any Injury or Illness (except for prenatal vitamins).

12. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, hot tubs, saunas, whirlpools, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical

thermometers, scales, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

13. Charges for any treatment for Cosmetic Procedures, except as specifically covered for compliance with the Women's Health and Cancer Rights Act of 1998. In addition, and notwithstanding anything in the Plan to the contrary, the Plan will also pay for Cosmetic Procedures that are:

    a. due solely to an accidental bodily Injury;

    b. due solely to reconstructive surgery; or

    c. due solely to a birth defect of an individual who is less than 16 years old.

14. Charges incurred for services or supplies which are Experimental.

15. Charges for elective abortions, unless (a) the Physician certifies in writing that the pregnancy would endanger the life of the mother, (b) the expenses are to treat medical complications due to non-elective abortions, or (c) the pregnancy resulted from rape or incest.

16. Charges for services rendered by a Physician, nurse, or licensed therapist who is the Covered Person's spouse, child, parent, brother or sister, or resides in the same household as the Covered Person.

17. Charges incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical service, drugs, or supplies.

18. Charges for Hospitalization when such Confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care.

19. Charges for Room and Board incurred in connection with a Hospital admittance on Friday or Saturday unless the attending Physician states in writing that such admittance was an emergency Hospital admittance and was Medically Necessary.

20. Charges for a Physician's fees for any treatment that is not rendered by or provided under the supervision of a Physician.

21. Charges incurred in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses for Aphakia, Keratoconus or following cataract surgery, nor does it apply to the initial purchase of hearing aid if the loss of hearing is a result of a surgical procedure performed while coverage under the Plan is in effect. However, such expenses will be considered a Covered Expense only to the extent of the least expensive service, supply or procedure which will correct the condition.

22. Any surgical procedure for the correction of a visual refractive problem, including radial keratotomy, or Lasik surgery.

23. Charges incurred for treatment of or to the teeth, nerves, roots, gingival tissue or alveolar processes. However, benefits will be payable for charges incurred for: (1) oral surgery as shown in Covered Medical Expenses and, (2) for treatment to natural sound teeth due to accidental injury; other than those caused by chewing food or similar substances. Expenses must be incurred within 12 months from the date of injury. Item (2) of this exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture.

24. Charges related to sex transformation or sexual dysfunctions or inadequacies.

25. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility or reverse sterilization, including, but not limited to artificial insemination, or in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, zona drilling, any other surgical or non-surgical procedures or monitoring services (such as ultrasound or lab test) when related to treatment performed.

26. Physical, psychiatric or psychological examinations, testing or treatment not otherwise specifically listed in the Plan as a Covered Expense, for purposes:

    a. of obtaining or maintaining employment or insurance;

    b. relating to judicial or administrative proceedings or orders;

    c. which are conducted for purposes of medical research;

    d. to obtain or maintain a license or certification of any type;

    e. relating in travel;

    f. relating to marriage or adoption; or

    g. required physical examinations related to education or sports participation beyond grade 12.

27. Charges for callus or corn paring or excision; toenail trimming; any manipulative procedure for weak or fallen arches, flat or pronated feet, or foot strain; or orthopedic shoes or other devices for support of the feet, except for open cutting operations. This exclusion does not apply to diabetics.

28. Services for educational or vocational testing, training, or rehabilitation.

29. Charges for Cognitive Therapy (by any name called).

30. Speech Therapy, except, as specifically covered as a Covered Expense under this Plan.

31. Charges for Custodial Care or Long-Term Rehabilitation Services.

32. Charges for treatment of any Behavioral Health condition or learning disability not contained in the Diagnostic and Statistical Manual of Mental Disorders.

33. Charges for hypnotism, acupuncture, behavior or goal modification.

34. Charges incurred that resulted from (a) the voluntary taking of drugs except those taken as prescribed by a Physician, (b) the voluntary taking of poison, (c) the voluntary inhaling of gas, or (d) being under the influence of alcohol. A person will automatically be considered under the influence of alcohol while the level of their blood alcohol exceeds the legal limit of operating a motor vehicle in the jurisdiction where the Injury occurred, regardless of whether the individual is charged with a crime if the Plan Administrator determines by a preponderance of the evidence, that the person was intoxicated.

35. Charges for canceled appointments or completion of claim forms.

36. Behavior Training, Biofeedback and similar programs.

37. Marriage, relationship or behavioral counseling unless such counseling is necessary to treat an Illness or Injury covered under this Plan.

38. Charges which, although within this Plan's Reasonable and Customary limitations or which are within this Plan's network reimbursement, are excluded based on Referenced-Based Pricing by another employer health plan that pays primary to this Plan.

39. Prescription or Injectable drug charges (a) that have been reimbursed (or will be reimbursed) through coupons, rebates, etc.; or (b) for any Dependent who has primary drug coverage under another Employer sponsored group health plan; or (c) that are not specifically covered under the Prescription Benefit Program such as, but not limited to, growth hormones, infertility medications, or cosmetic drugs (other exclusions may apply).

40. Charges relating to non-human organ or tissue transplants, gene therapies, xenographs, or cloning.

41. Charges directly or indirectly related to Clinical Trials.

42. Charges for dependent child maternity.

43. The following Essential Health Benefits (as shown in Section 5A), are not covered under this Plan:

    - Infertility Treatment
    - Routine Eye Exam for Children
    - Eye Glasses for Children
    - Dental Check-Up for Children
    - Basic Dental Care – Child
    - Orthodontia – Child
    - Major Dental Care – Child

Notwithstanding any provision in this Section 6 to the contrary, no exclusion based on the source of an Illness or Injury shall be enforceable if the Illness or Injury results from a medical condition (either physical or mental) or results from domestic violence.

SECTION 7. CLAIM FILING, INTERNAL APPEAL AND EXTERNAL REVIEW PROCEDURES

The following Procedures explain the rules and time limitations that apply for:

- Filing a Claim for Medical Benefits under the Plan,
- Filing an appeal of a Claim for Medical Benefits that is wholly or partially denied, and
- Filing an external review.

These Procedures do not apply to the Dental Benefits and/or Vision Benefits offered under the Plan. Claims under those benefits are administered as provided in the applicable policy or certificate. **[REMOVE IF N/A TO THIS PLAN.]**

DEFINITIONS

For purposes of interpreting these Procedures, the following terms are defined as set forth below:

Adverse Benefit Determination means any Claim denial or partial denial, which shall include any denial, reduction, termination or failure to provide or make payment (in whole or in part) for a benefit, including determinations based on eligibility and utilization review, or a failure to cover a benefit because it is determined to be Experimental or not Medically Necessary. It also means a Rescission of coverage whether or not, in connection with the Rescission, there is an adverse effect on any particular Medical Benefit at that time.

Authorized Representative means an individual designated by the Claimant, in writing and communicated to the Plan Administrator, to exercise the Claimant's rights under this Section 8. An Authorized Representative cannot be any Employee of the Plan Administrator.

Claim means a request for a specific medical treatment or, for treatment which has already been rendered, a request for payment for medical services provided. For purposes of these Procedures, any interaction between a Claimant and a preferred or network provider shall not be treated as a Claim if the medical provider exercises no discretion. Similarly, any reply to a request for a precertification which does not deny coverage (or limit coverage) for medical services is not considered a "Claim." Additionally, a medical provider's refusal to render services without payment by the patient is not considered a Claim subject to these Procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered a Claim subject to these Procedures. Notwithstanding the foregoing, any action or inaction by a provider that is not treated as a Claim for these purposes will be treated as a Claim and be reviewed by the appropriate person or entity if a Claimant files a specific request with the Plan that any action or inaction by the provider be treated as a Claim under the Plan.

Claimant means any individual filing a Claim under the Plan pursuant to these Procedures. The rights of a Claimant under this Section 8 can be exercised by a Claimant's Authorized Representative.

Concurrent Care Claim means a Claim for a specific ongoing medical treatment of an Illness or Injury. Except as otherwise specifically noted, all time limitations and other rules and restrictions for Concurrent Care Claims are identical to those for Pre-Service Claims, unless the Concurrent Care Claim qualifies as an Urgent Care Claim, in which case the Urgent Care Claim time limitations apply.

Electronic Notification means the transmission of Claim or medical information via email, fax or any other means other than the delivery of written information via first class mail. Any information transmitted pursuant to these Procedures via Electronic Notification must be resubmitted in writing, sent to the appropriate party via first class mail, within 72 hours of the Electronic Notification.

Final Adverse Benefit Determination means a Claim that is wholly or partially denied after an Internal Appeal.

IRO means an Independent Review Organization that has contracted with the Plan or the Plan's Supervisor and has received the applicable accreditation to conduct external reviews under federal law.

Medical Judgment means Claims involving Medical Necessity, appropriateness of care, health care setting, level or care, effectiveness of a covered benefit and determination as to whether a treatment or procedure is Experimental.

Pre-Service Claims means a Claim for medical care that is required to obtain approval before obtaining care.

Post-Service Claims means a Claim for services already been rendered.

Urgent Care Claims are those Claims where failing to make a determination (about eligibility, Medical Necessity, etc.) quickly could seriously jeopardize a Claimant's life, health or ability to gain maximum function, or could subject the Claimant to severe pain that could not be managed without the requested treatment. Notwithstanding the preceding sentence, any Claim designated by the treating Physician as in "Urgent Care Claim" will be treated as such for purposes of these Procedures.

INITIAL CLAIM FILING REQUIREMENTS

1. **How to file a Claim**. All Claims must be filed with the Claims Adjudicator as designated on the Covered Person's Identification Card.

2. **Time Limits for Filing Initial Claims**. All Claims must be filed with the Claims Adjudicator within one (1) year after the expenses were incurred, unless the Claimant was legally incapacitated, in which case the Claim must be filed as soon as reasonably possible after such incapacitation ends.

3. **Time Limits for Review of Initial Claims**. The Claims Adjudicator shall review and process the following types of Claims within the following time limitations:

   Urgent Care Claims – Initial determinations on Claims considered Urgent Care Claims shall be made as soon as possible but no later than 72 hours after it is received. Initial determinations on Concurrent Care Claims which qualify as Urgent Care Claims shall be made within 24 hours after the Claim is received.

   Pre-Service Claims – Initial determinations shall be made within 15 days of the time the Claim is received. This time limitation may be extended by up to 15 days if the Claims Adjudicator determines that additional time is necessary due to matters outside the control of the Claims Adjudicator. The Claims Adjudicator will notify the Claimant of such extension before the end of the initial 15-day time period and the date on which the Claims Adjudicator expects to render a decision.

   Post-Service Claims – Initial determinations shall be made within 30 days from the date the Claim is received. This time limitation may be extended by up to 15 days if the Claims Adjudicator determines that additional time is necessary due to matters outside the control of the Claims Adjudicator. The Claims Adjudicator will notify the Claimant of such extension before the end of the initial 30-day time period and the date on which the Claims Adjudicator expects to render a decision.

   Incomplete Claims – For any Claim which does not provide information necessary for the Claims Adjudicator to make the initial determination, the Claimant will be notified that additional information is needed within 24 hours for Urgent Care Claims, and within five days for Pre-Service Claims. After receiving notification, the Claimant

must provide the missing information within 48 hours for Urgent Health Care Claims and within 45 days for Pre-Service and Post-Service Claims. Failure to provide the missing information within the time deadlines specified shall result in the Claim being denied.

4. **Response to Claim**. If a Claimant's Claim for benefits is wholly or partially denied, any notice of such Adverse Benefit Determination under the Plan will:

   a. State the specific reason(s) for the denial or partial denial;

   b. Reference the specific plan provisions on which the determination was based;

   c. Describe additional material or information necessary to complete the Claim and why such information is necessary;

   d. Describe Plan procedures and time limits for appealing the determination (as set forth below) and the right to obtain information about those procedures and the right to sue in federal court;

   e. Disclose any internal rule, guidelines, protocol or similar criteria relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

   f. If the denial is based on Medical Judgment, explain the scientific or clinical judgment for the determination (or state that such explanation will be provided free of charge upon request);

   g. Disclose information sufficient to identify the Claim, including the date of service, the health care provider, and the Claim amount (if applicable).

   h. State that, upon request, the Plan will provide all diagnostic or treatment codes given by a provider (and information involving interpretation of those codes) at no charge.

   i. Disclose, as applicable, the denial code and its corresponding meaning, as well as a description of the Claims Adjudicator's standard, if any, that was used in the denial of the Claim.

   j. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes.

   k. For Urgent Care Claims, provide a description of the expedited review process applicable to such claims.

   Notice of any Adverse Benefit Determination may be provided by the Plan via written or Electronic Notification, provided that a written notification will be sent via first class mail within 72 hours from the date an Electronic Notification is provided.

INTERNAL APPEAL PROCEDURES

1. **How to File an Appeal.** In the event a Claimant's Claim is wholly or partially denied, the Claimant has the right to appeal to the Plan for review of the Claim. All appeals will be decided by the Claims Adjudicator. Appeals may be made via Electronic Notification by contacting the Claims Adjudicator, but any appeal in Electronic form must be sent in writing within 72 hours via first class mail to the Claims Adjudicator at the following address:

2. **Time Limitation for Filing Appeal.** All Claims which are wholly or partially denied must be appealed pursuant to the Procedures set forth below. All appeals must be filed within 180 days of the date that the Claim was totally or partially denied. Failure to file an appeal of a Claim will result in the initial Claim decision becoming final and binding on all parties. Failure to file an appeal within the foregoing time limit will be deemed to void any right the Claimant may have to seek judicial review of the original Claim denial.

3. **Appeal Review Time Limitations.** The Plan Administrator shall review the initial determination and make a decision on any appeal of a Claim within the following deadlines:

   a. Urgent Care Claims within 72 hours from the time the appeal was communicated.

   b. Pre-Service Claims within 30 days from the date the Plan Administrator was notified of the appeal.

   c. Post-Service Claims within 60 days from the date the Plan Administrator was notified of the appeal.

4. **Your Rights During Appeal.** Any Claimant making an appeal will have the opportunity to submit written comments, documents or other information in support of his or her appeal. Additionally, any Claimant filing an appeal will have all access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the Adverse Benefit Determination will take into account all new information whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

   If the Claims Adjudicator has approved an ongoing course of treatment to be provided to a Claimant over a certain period of time or for a certain number of treatments, any reduction or termination of such course of treatment before the approved period of time or number of treatments end will constitute an Adverse Benefit Determination. The Claimant will be notified of the Adverse Benefit Determination in accordance with these Procedures before the reduction or termination occurs to allow the Claimant a reasonable time to file an appeal and obtain a determination on the appeal. Coverage for the ongoing course of treatment that is the subject of the appeal will continue pending the outcome of such appeal.

   Any Claimant initiating an appeal shall, within 10 days after the appeal is received, be provided with all information considered by the Plan when the Adverse Benefit Determination was made and such Claimant shall be given the opportunity to review their Claim file and present evidence and/or testimony as part of the appeal process.

   In the case of an appeal of a Claim denied or partially denied based on Medical Judgment, the Plan Administrator will consult with a health professional with the appropriate training and expertise. The health care professional who is consulted on appeal will not be the same health care professional who may have been consulted during the initial determination or a subordinate of that health care professional. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your Claim, the names of each such expert shall be provided upon request. This administrative appeal process must be completed before any legal action regarding your Claim can be taken. Additionally, if any such judicial proceedings are undertaken, the evidence presented shall be strictly limited to the evidence presented to the Plan Administrator pursuant to this Claim Appeal Procedures.

5. **Denial of Appeal.** If a Claim for Medical Benefits is denied on appeal, the notice will serve as the Final Adverse Benefit Determination. The Claims Adjudicator will provide the following information to the Claimant free of charge as soon as possible and sufficiently in advance of the date on which the notice of Final Adverse Benefit Determination is required, such that the Claimant has a reasonable opportunity to respond prior to that date:

   a. Any new or additional evidence considered, relied upon, or generated by the Claims Adjudicator (or at the direction of the Claims Adjudicator) in connection with the claim; and
   b. Any new or additional rationale that forms the basis of the Claims Adjudicator's Final Adverse Benefit Determination, if any.

   If any Claim is denied on appeal, the Claimant will be given notice which will contain a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claimant's claim, as well as items (a), (b), (e), and (f) – (k) under the "Response to Claim" section above. The Claimant will also receive:

   a. A description of the review procedures and time limits, including information on the external review process; and

   b. A discussion of the decision.

6. **Plan Administrator's Right to Construe and Interpret Plan.** The Plan Administrator has the discretion to construe and interpret the terms of the Plan and to determine eligibility for benefits in making any determination on a Claim or an appeal of an Adverse Benefit Determination. Except with respect to Medical Benefits that are eligible for external review, a decision on review will be final, conclusive, and binding on all persons.

7. **Time Limitation for Filing Claimant Action.** Subject to other limitations contained in these Procedures, in no event may any Claimant file a lawsuit seeking payment of wholly or partially denied Claims more than one year after the Claim is initially denied, or, if later, more than six months after the later of the date the Appeal decision of the Plan Administrator is rendered or the date the final external review decision of the IRO is rendered, if applicable. Any lawsuit seeking payment for wholly or partially denied Claims must be filed in state or federal court in the county (or federal district court) in which the Plan Administrator is located. Claimants and this Plan may have other voluntary alternative dispute resolution options, such as mediation. For available options, Claimants could contact their local U.S. Department of Labor Office and their State insurance regulatory agency.

8. **Exhaustion of Remedies.** If a Claimant fails to file a request for review of a Denial, in whole or in part, of benefits in accordance with these Procedures, such Claimant will have no right to review and no right to bring action, at law or in equity, in any court, and the Denial of the claim will become final and binding on all persons for all purposes.

   Unless the exception in the following paragraph applies, if the Claims Adjudicator fails to strictly adhere to all the requirements with respect to a Claim under these Procedures, the Claimant is deemed to have exhausted the internal Claims and appeals process with respect to such Claim. Accordingly, the Claimant may initiate an external review with respect to such claim, as outlined below. The Claimant also is entitled to pursue any available remedies under state law with respect to such claim.

   Notwithstanding the previous paragraph, the internal Claims and appeals process will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Claims Adjudicator demonstrates that the violation was for good cause or due to matters beyond the control of the Claims Adjudicator and that the violation occurred in the context of an ongoing, good faith exchange of information between the Claims Adjudicator and the Claimant. This exception is not available if the violation is part of a pattern or

practice of violations by the Claims Adjudicator. The Claimant may request a written explanation of the violation from the Claims Adjudicator, and the Claims Adjudicator will provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal appeals process outlined in this Section to be deemed exhausted. If the IRO or a court rejects the Claimant's request for immediate review due to deemed exhaustion on the basis that the Claims Adjudicator met the standards for the exception described in this paragraph, the Claimant will have the right to resubmit and pursue the internal appeal of the Claim. In such case, within a reasonable time after the IRO or court rejects the Claim for immediate review (not to exceed 10 days), the Claims Adjudicator will provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the Claim. Time periods for re-filing the Claim will begin to run upon the Claimant's receipt of such notice.

REQUEST FOR EXTERNAL REVIEW—APPLIES TO MEDICAL BENEFITS ONLY – *Not applicable to Grandfather Plan*

SECTION 8. UTILIZATION REVIEW AND PRECERTIFICATION

UTILIZATION REVIEW

Utilization Review is a program which reviews the setting, necessity and quality of health care. The Plan furnishes each Participant with Utilization Review through the Review Agent identified on the Covered Person's identification card.

The Covered Person is responsible for making sure the Review Agent is contacted prior to Hospital admission. Authorization from the Review Agent is required for:

1. Inpatient Hospital Stays and
2. Other Inpatient Facility charges.

Utilization Review is performed only for the purpose of reviewing the Medical Necessity of the above services for the care of an Illness. Authorization by the Review Agent does not guarantee that all charges are covered under this Plan. Charges submitted for payment are subject to all other terms and conditions of the Plan.

FAILURE TO CALL PENALTY

If the Covered Person fails to call the Review Agent as required under Precertification, the Precertification Penalty, as shown in the Schedule of Benefits, will apply. This penalty is in addition to any other Deductible or Co-payment under the Plan and does not accrue toward the Out-of-Pocket Maximum.

If Hospital Utilization Review is Not Used by the Covered Member, the Hospital charges incurred by a Covered Person for the part of a Hospital Confinement which was not authorized by the Review Agent shall not be considered to be Eligible Expenses. For example, if pre-admission review and concurrent review authorize three days and the Covered Person stays in the Hospital for four days, the additional day's charges will not be covered by the Plan.

PRECERTIFICATION

The following treatments and services require precertification in order to be Eligible Expenses:

1. Hospital Admissions.
2. Emergency/Urgent/Pregnancy Related/Hospital Admission:

   For an Emergency or Urgent Hospital Admission (including all pregnancy related events), the Covered Person is responsible for making sure the Review Agent is notified within 48 hours after admission. For admission on a holiday or after business hours, the Review Agent must be informed of the admission on the next business day. Benefits will be paid for authorized days only.

   "Emergency Hospital Admission" means an admission for Hospital Confinement, which, if delayed would result in a disability or death.

   "Urgent Hospital Admission" means admission for a medical condition resulting from Injury or Illness which is less severe than an emergency admission but requires care within a reasonably short time. This includes pregnancy related events.

CONCURRENT REVIEW

After admission to the Hospital, the Review Agent will continue to evaluate the patient's progress. If, after consulting with the Physician, the Review Agent determines that continued Hospital Confinement is no longer Medically Necessary, the Covered Person and the Physician will be advised. Benefits will be paid only for authorized days. No benefits will be paid for Hospital days not authorized.

The Review Agent will also evaluate the patient's progress under authorized healthcare services and supplies review. If, after consulting with the Physician, the Review Agent determines that continued treatment is no longer Medically Necessary, the Covered Person and the Physician will be advised. Benefits will be paid only for authorized treatment and services. No benefits will be paid for treatment and services not authorized.

APPEALS PROCESS

The Covered Person, Physician, Hospital or responsible party may request an appeal, when authorization is denied, by contacting the Review Agent. The appeal may be submitted in writing or by telephone as soon as possible but within sixty (60) days after the Denial. See Section 8 for more information about the Plan's claims and appeals process, including information on the Plan's external review process.

SECTION 9. LARGE CASE MANAGEMENT

The Plan Administrator may, at its option, provide a Large Case Management program to assist the Participant in obtaining needed medical care from the most appropriate source available. The Large Case Manager will have the option of suggesting methods and providers of care which may not be specifically covered by this Plan. The costs of these special care facilities and treatment will be covered as any other expense under this Plan.

Large Case Management is a voluntary program. It is designed to provide and promote an individualized program of care outside of the acute care Hospital setting to a Covered Person suffering from catastrophic Illness or Injury. These conditions include, but are not limited to:

1. terminal stage cancer, brain tumors, organic brain damage;

2. coronary heart disease, heart attack or stroke;

3. head Injuries, skull fracture, fracture of neck and/or trunk, spinal cord Injury;

4. neonatal conditions, prematurity, infantile cerebral palsy, and respiratory distress syndrome;

5. AIDS;

6. transplants.

Each case receives individual and ongoing attention. The Case Manager does not prescribe care, but works to coordinate viable care alternatives. The Case Manager consults with the patient, the family, the attending Physician and the Hospital in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1. personal support to the patient;

2. contacting the family to offer assistance and support;

3. monitoring Hospital or nursing home care;

4. determining alternative care options such as Home Health Care, Hospice Care, or rehabilitative care; and

5. assisting in obtaining any necessary equipment and services.

Note: Large Case Management is a voluntary service. There are no reductions of benefits, or penalties, if the patient and family choose not to participate.

SECTION 10. COORDINATION OF BENEFITS

NOTE: To the extent this Plan pays secondary to another employer plan that utilizes "Referenced-Based Pricing," then this Plan hereby adopts the identical price limitation used by the other plan for each such expense. Coverage paid by this Plan, as secondary, shall be limited to reimbursement of deductibles, co-payments or co-insurance applied to the other plan.

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed expenses. It applies when the Employee or any eligible Dependent that is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan pays a reduced benefit. This Plan will pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed the amount eligible for payment under this Plan.

No prescription drug coverage is provided for any Dependent who has primary drug coverage under another Employer sponsored group health plan.

Only the amount paid by the Plan will be charged against the Plan maximums.

DEFINITIONS

Allowable Expenses — The Usual, Customary, and Reasonable expense for medical or dental care or treatment. Part of the expenses must be covered under at least one of the plans covering a Covered Person.

Coordination of benefits: — The way benefits are payable under more than one health plan. Under coordination of benefits, a covered Employee or Dependent will not receive more than the allowed expenses for a loss.

Plan: — Applies to all covered benefits or services of:

1. This Plan.
2. Any group, blanket or franchise health insurance.
3. A group contractual prepayment or indemnity plan.
4. A Health Maintenance Organization (HMO), whether group practice or individual practice association.
5. A labor-management trusteed plan or a union welfare plan.
6. An Employer or multi-Employer plan or Employee benefit plan.
7. A government program. (Excluding Medicaid, TRICARE and VA)
8. Insurance required or provided by statute.
9. Any coverage for students which is sponsored by, or provided through a school or other educational institution

Plan does not include any individual or family policies or contracts or public medical assistance programs, including Medicaid.

Note: In the case of HMO (Health Maintenance Organization), PPO (Preferred Provider Organization), EPO (Exclusive Provider Organization) plans: This

plan will not consider any charges in excess of what an HMO/PPO/EPO provider has agreed to accept as payment in full. Also, when an HMO/PPO/EPO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO/PPO/EPO had the Covered Person used the services of an HMO/PPO/EPO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Primary plan/
secondary plan: When this Plan is primary, its benefits are determined before those of the other plan. The benefits of the other plan are not considered. When this Plan is secondary, its benefits are determined after those of the other plan. Its benefits may be reduced because of the other plan's benefits. When there are more than two plans this Plan may be primary as to one and may be secondary as to another.

ORDER OF DETERMINATION

If this Plan is the Covered Person's primary plan, the benefits of this Plan are provided without regard to the other plan, and the other plan then pays whatever may be covered under that plan. If this Plan is secondary, this Plan will pay only the amount of Allowable Expenses it would have paid if this Plan were the primary plan, reduced by the amount paid by the primary plan. In the event this Plan is not the primary plan, and if the primary plan has access to a Capitated Rate, this Plan, as a secondary plan, shall pay no benefits. For purposes of the preceding sentence "Capitated Rate" shall mean an arrangement whereby the provider of medical services or supplies receives a prearranged fee, regardless of utilization.

In determining which plan is the primary plan, the first following rules shall apply:

1. General - A plan that does not coordinate with other plans is always the primary plan.

2. Non-Dependent/Dependent - The benefits of the plan which covers the person as an Employee or member (other than a Dependent) is the primary plan; the plan which covers the person as a Dependent is the secondary plan.

3. Dependent Child/Parent Not Separated or Divorced - Except as stated in (4) below, when this Plan and another plan cover the same child as a Dependent of different parents:

   a. The primary plan is the plan of the parent whose birthday (month and day) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year, but

   b. If both parents have the same birthday, the benefits of the plan which covered the parent the longer is the primary plan; the plan which covered the parent the shorter time is the secondary plan.

4. Dependent Child/Separated or Divorced Parents - If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order.

   If the specific terms of a court decree state that one parent is responsible for the health care expense of the child, then that parent's plan is the primary plan; otherwise, the following will be the order of determination:

   a. First the plan of the parent with custody of the child;

   b. Second the plan of the spouse of the parent with custody;

   c. Third the plan of the parent without custody of the child.

5. Active/Inactive Employee - The primary plan is the plan which covers the person as an Employee who is not laid off, retired or a COBRA continuee (or as that Employee's Dependent). The secondary

plan is the plan which covers that person as a laid off, retired Employee or COBRA continuee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

6. Longer/Shorter Length of Coverage - If none of the above rules determines the order of benefits, the primary plan is the plan which covered an Employee or member longer. The secondary plan is the plan which covered that person the shorter time.

MEDICARE

This Plan shall pay secondary to Medicare whenever permitted by law.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Any Covered Person who claims benefits under this Plan must furnish information necessary to implement and apply this provision. This Plan may release or obtain information from any insurance company or health care carrier, or from any other organization or person without consent of the Covered Person.

FACILITY OF PAYMENT

This Plan has the right, at its sole discretion, to pay any amounts it determines to be warranted in order to satisfy the intent of this Section. Amounts so paid will be deemed to be benefits paid under this Plan, and, to the extent of such payments, this Plan will be fully discharged from liability under this Plan.

RIGHT OF RECOVERY

Whenever payments have been made by this Plan in excess of the maximum amount of payment required to satisfy the intent of this Section, this Plan will have the right to recover excess payments from any persons to whom such payments were made, or any other insurance companies or other organizations.

SECTION 11. THIRD PARTY RECOVERY PROVISION

When a Covered Person incurs expenses that were either the result of the alleged negligence, or which arise out of any claim or cause of action which may accrue against any third party responsible for Injury or death to the Covered Person by reason of his or her eligibility for benefits under the Plan, the Plan will advance benefits under the following terms and conditions.

The Covered Person will reimburse the Plan out of the Covered Person's recovery for all benefits paid by the Plan. The Plan will be reimbursed in full prior to the Covered Person receiving any monies recovered from any party of their insurer as a result of judgment, settlement or otherwise. The duty and obligation to reimburse the Plan applies even if the Covered Person is not fully compensated (or "made-whole") for their Injuries and damages. The Plan shall have a property right in the form of a constructive trust in the proceeds of any settlement. The Covered Person and/or his or her legal representative shall hold the Plan's interest in trust and shall distribute said interest on demand by the Plan. Furthermore, the Covered Person shall include the Plan's name as a co-payee on any settlement check. The Covered Person agrees that provision of the Third Party Recovery language to any applicable insurance carrier for the plan participant or for an at-fault party is sufficient to instruct the carrier to place the Plan's name on any settlement check.

The Covered Person shall fully cooperate with the Plan in any case involving the alleged negligence of a third party. In such cases, the Covered Person is obligated to provide the Plan with whatever information, assistance and records the Plan may require to enforce the rights in this Section. In the event the Plan has reason to believe that the Plan may have a lien, the Plan may require the Covered Person to complete a questionnaire, sign an acknowledgement of the Plan's right of recovery and an agreement to provide ongoing information before the Plan pays, or continues payments, of Claims according to its terms and conditions. Upon receipt of the requested materials, the Plan will commence, or continue, payments of Claims, according to its terms and conditions provided that said payment of Claims in no way prejudices the Plan's rights. Payment of claims before the signed forms are received does not modify or invalidate the Plan's subrogation rights.

The Plan may, but is not obligated to, take any legal action it sees fit against the third party or the Covered Person, to recover benefits the Plan has paid, including but not limited to filing suit against any responsible party in order to protect the rights of the Plan, intervention in any existing suit, and any other action that the Plan deems necessary in order to protect its interests. The Plan's exercise of this right will not affect the Covered Person's right to pursue other forms of recovery unless the Covered Person and his or her legal representative consent otherwise. In the event that a Covered Person fails or refuses to prosecute an action against a third party or any applicable insurer, the Plan shall have the right to commence its own independent action and the Covered Person agrees, by taking benefits, to cooperate with the Plan in the prosecution of said action.

In the event that the Plan Administrator determines that a recovery exists, the Plan Administrator retains the right to employ the services of any attorney to recover money due to the Plan. The Covered Person shall cooperate with the attorney who is pursuing the recovery. The compensation that the Plan's attorney receives will be paid directly from the dollars recovered for the Plan.

The Plan has no duty or obligation to pay a fee to the Covered Person's attorney for the attorney's services in making any recovery on behalf of the Covered Person.

The Covered Person is obligated to inform his or her attorney of the Plan's lien for reimbursement and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan.

The Covered Person shall not release any third party or its insurer without prior written approval from the Plan, and will take no action which prejudices the Plan's rights under this Section. If the Covered Person impairs the Plan's rights, or refuses to reimburse the Plan from any settlement or judgment received, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any Claims of the Covered

Person and to reduce future benefits payable under the Plan by the amount due as reimbursement by the Plan.

The Covered Person shall refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's lien or right to reimbursement.

In the case of a Michigan insured that is covered by Michigan No-Fault coverage, the Plan will not pay Claims until and unless all of the Michigan No-Fault coverage is exhausted first.

The Plan Administrator in its sole discretion may seek refund, offset or pursue any other means of recovery of the overpayment.

SECTION 12. FAMILY AND MEDICAL LEAVE ACT OF 1993 AND AMERICANS WITH DISABILITIES ACT

FAMILY AND MEDICAL LEAVE ACT OF 1993

In the event that the Employer approves a leave under the Family and Medical Leave Act of 1993 ("FMLA") for an Employee, that Employee may receive up to 12 work weeks of continued benefits in a 12 month period under this Plan while on such leave (provided that required contributions, if any, are made by or on behalf of that Employee) because of (i) the birth of a child and to care for such child, (ii) the placement of a child for adoption or foster care, and to care for such child, (iii) the need to care for a family member (child, spouse, or parent) with a "serious health condition" as defined under the FMLA, (iv) because of an Employee's own "serious health condition" which makes the Employee unable to do his or her job, or (v) a "qualifying exigency" (as defined under the FMLA) related to a covered family member's call to active duty in the military. In addition, any spouse, son, daughter, parent, or nearest blood relative ("next of kin") of a "covered service member" will be granted leave not to exceed a total of 26 work weeks during a single 12 month period to care for the "covered service member." During the single 12 month period described above, an Employee's leave entitlement is limited to a combined total 26 work weeks of FMLA for any qualifying reason. For purposes of this Section, the phrase "covered service member" means a member of the Armed Forces, including a member of the National Guard or Reserves, who is: (i) undergoing medical treatment, recuperation, or therapy; (ii) is otherwise in an "outpatient status" (as defined by regulations); or (iii) is otherwise on the temporary disability retired list, for a "serious injury or illness" (as defined by regulations), and the term "spouse" means a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides

The continuation of coverage provision outlined in the Section 4 of the Plan will apply on the earliest of:

1. the date that the Employee informs the Employer of his or her intent not to return from such leave;

2. the date that the Employee does not return from such leave and coverage for the Employee or Dependents would be lost were it not for continuation coverage; or

3. the date the Employee fails to make the necessary payment to continue coverage under this Plan as set forth in the Employer's FMLA policy.

An Eligible Employee returning from an approved leave under the Family and Medical Leave Act, who did not continue benefits under this Plan during such leave, will not be required to satisfy a new Waiting Period or provide proof of good health upon returning to Actively at Work status and meeting the definition of an Employee who is eligible to participate in this Plan. In addition, such persons will continue to be covered under the Plan as if there had been no break in service as long as the condition was covered prior to the approved leave.

AMERICANS WITH DISABILITIES ACT

The Plan has not been created to violate the Americans with Disabilities Act (ADA). Should it be determined that a provision could be in violation, the Plan will be amended.

SECTION 13. HIPAA PRIVACY AND SECURITY

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Standards") promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") govern the Plan's use and disclosure of protected health information ("PHI").

Pursuant to the Privacy Standards, the Plan may:

1. Disclose PHI to the Plan Sponsor to carry out plan administration functions that the Plan Sponsor performs only in accordance with the Plan documents and the restrictions on uses and disclosures set forth herein;

2. Not permit a health insurance issuer or HMO with respect to the Plan to disclose PHI to the Plan Sponsor except as permitted by the Privacy Standards;

3. Not disclose and not permit a health insurance issuer or HMO to disclose PHI to the Plan Sponsor unless a statement permitting such disclosure is included in the applicable Notice of Privacy Practices; and

4. Not disclose PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor is permitted to use and disclose the PHI disclosed to it for all purposes required or permitted by the Privacy Standards, including (without implied limitation) treatment, payment and health care operations.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Payment includes activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of Plan benefits or to provide reimbursement for the provision of health care that relates to an individual to whom health care is provided, except as may be prohibited with respect genetic information.

These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and Co-payments as determined for an individual's Claim);

2. Coordination of benefits;

3. Adjudication of health benefit claims (including appeals and other payment disputes);

4. Third Party Recovery of health benefit claims;

5. Establishing employee contributions and continuation coverage premiums;

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. Billing, collection activities and related health care data processing;

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

9. Obtaining payment under a contract of reinsurance (including stop-loss and excess of loss insurance);

10. Medical Necessity reviews or review of health care services for coverage under the plan, appropriateness of care or justification of charges;

11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

12. Disclosing the following information to consumer reporting agencies related to the collection of premiums or reimbursement: name, address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

13. Reimbursement to the Plan.

Health Care Operations include, but are not limited to the following activities:

1. Quality assessment and improvement activities;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;

3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities,

4. Except as prohibited with respect to genetic information, underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care Claims (including stop-loss insurance and excess loss insurance);

5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including, but not limited to, formulary development and administration, development or improvement of payment methods or coverage policies;

7. Business management and general administrative activities of the Plan, including, but not limited to: (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, (b) customer service, including the provision of data analyses for policyholders, Plan Sponsors or other customers, (c) resolution of internal grievances, and (d) the sale, transfer, merger or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

8. Creating de-identified health information or a limited data set.

Also as required by the Privacy Standards, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual about whom the PHI relates;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual about whom the PHI relates;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to an individual in accordance with the Privacy Standards' access requirements;

7. Make PHI available for Amendment and incorporate any Amendments to PHI in accordance with the requirements of the Privacy Standards;

8. Make available the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Standards;

9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining the Plan' compliance with the Privacy Standards;

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

11. Ensure that the adequate separation required pursuant to the Privacy Standards, if any, is established.

12. In accordance with the Privacy Standards, only the Privacy Officer and any other individual authorized by the Plan Sponsor shall be permitted to access Protected Health Information in the ordinary course of business and to perform duties for the Plan Sponsor.

If the Privacy Officer does not comply with the provisions of this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

HIPAA SECURITY STANDARDS

1. Definitions:

   a. Electronic Protected Health Information. The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

b. Security Incidents. The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2. Plan Sponsor Obligations

When Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;

b. Plan Sponsor shall insure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

c. Plan Sponsor shall insure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modifications, or destruction of the Plan's Electronic Protected Health Information; and

e. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

HIPAA BREACHES

Following the discovery of a breach of unsecured PHI, the Plan will notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired or disclosed as a result of a breach, in accordance with 45 C.F.R. Section 164.404 as amended, and will notify the Secretary of Health and Human Services in accordance with 45 C.F.R. Section 164.408 as amended. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan will notify the media in accordance with 45 C.F.R. Section 164.406 as amended. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

SECTION 14. FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. The Plan will pursue all appropriate legal remedies in the event of fraud.

The Plan is obligated to meet the requirements of Section 2712 of the Public Health Service Act, relating to the prohibition on Rescissions. As part of such compliance, the Plan will not Rescind health coverage, except in the case where a Covered Person (or a person seeking coverage on the Covered Person's behalf) has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact. In such case, the Plan will provide the Covered Person with 30 days advance written notice before coverage is Rescinded. A Rescission is a cancellation or discontinuance of coverage that has retroactive effect. The Plan may still cancel or discontinue coverage effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Nothing in this paragraph prohibits the Plan from cancelling or discontinuing coverage prospectively for any reason provided under the Plan.

Covered Persons must:

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

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

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

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should notify the Plan Administrator or Claims Adjudicator.

SECTION 15. DEFINITIONS

ACCIDENT

An unforeseen or unexplained sudden Injury occurring by chance involving an outside force, without intent or violation.

ACTIVELY AT WORK

The active expenditure of time and energy in the service of the Employer. An Employee will not be treated as Actively at Work on any regular working day that he or she is absent from work, except as required by HIPAA if the absence is related to the Employee's health status and occurs after the Employee's first day of work.

AFFORDABLE CARE ACT OR ACA

The Patient Protection and Affordable Care Act of 2010, as amended.

AMBULATORY SURGICAL CENTER

A Provider with facilities and equipment for performing medical and surgical procedures as an Outpatient. The Outpatient facility must be supervised by Physicians or a nursing staff. The facility must not be used as an office or clinic for the Physician's private practice, or provide for overnight stays.

APPLIANCES

Those devices that are necessary for the alleviation or correction of defects of diseases including arm and leg braces; artificial arms, legs and eyes; crutches; hospital beds; pressure machines; resuscitators; traction equipment; walkers; and wheel chairs. It does not mean air conditioners; air purifiers; arch supports; articles of special clothing, bed pans, corrective shoes, dehumidifiers, dentures, elevators, eyeglasses, hearing aids, heating pads, hot water bottles, or similar devices.

BENEFIT PERCENTAGE

That portion of Covered Expenses as defined in 2.1 to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the Deductible that are to be paid by the Participant.

BEHAVIORAL HEALTH

Mental and emotional disorders, mental and psychiatric Illnesses, and other psychiatric conditions (whether organic or non-organic, whether biological, non-biological, genetic, chemical or non-chemical origin), which include, but are not limited to, psychoses, neurotic disorders, bipolar disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems and disorders, conditions, and Illnesses.

BENEFIT PERIOD

The Calendar Year during which a Covered Person has coverage under the Plan. A Benefit Period will terminate on the earliest of the following dates:

1. The last day of each Calendar Year.

2. The day the Covered Person ceases to be covered under the Plan.

3. The day the Plan is terminated.

BIRTHING CENTER

A freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. The facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse midwife and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre or post-delivery confinement.

BRAND DRUG

A drug marketed under a proprietary, trademark-protected name.

CALENDAR YEAR

January 1 through December 31 of the same year.

CERTIFIED NURSE - MIDWIFE

A person who is:

1. licensed as such and acting within the scope of the license; and

2. acting under proper medical direction furnished in affiliation with a Free Standing Birthing Center.

CLAIMS ADJUDICATOR

Employee Plans, LLC, 1111 Chestnut Hills Parkway, Fort Wayne, Indiana 46814.

CLINICAL TRIAL – *not covered under this Plan*

A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. a federally funded or approved trial;

2. a clinical trial conducted under an FDA investigational new drug application; or

3. a drug trial that is exempt from the requirement of an FDA investigational new drug application.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. COBRA refers to continuation of coverage provisions that are mandated by Federal law.

CODE

The Internal Revenue Code of 1986, as amended.

COGNITIVE THERAPY

Treatment given to improve a Covered Person's thinking processes and intellectual capabilities.

CO-INSURANCE

The percentage of a Covered Expense that is the responsibility of the Covered Person after the Deductible is satisfied. The Co-insurance is the percentage remaining after the Plan pays the Benefit Percentage provided in the Schedule of Medical Benefits in Section 2.

COMPLICATIONS OF PREGNANCY

Those conditions, requiring Hospital Confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but adversely affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravidarum, pre-eclampsia and similar medical and surgical conditions or comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning Illness, gestational diabetes and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

CONTINUITY OF CARE

This provision is applicable when the Plan implements, or changes, the PPO network for the entire Plan or a specific group of individuals. In this instance, if there is a surgical procedure or treatment plan necessary to not disrupt “Continuity of Care”, and the following events occur:

1. The healthcare provider is participating in the current PPO network, and,

2. The healthcare provider is not a member of the new PPO network;

The following provision will apply: The Covered Expenses from the healthcare provider will be treated as “in-network” until that episode of care is complete, or six (6) months of the PPO implementation, whichever is first.

CONVALESCENT HOSPITAL/EXTENDED CARE FACILITY

An institution or part thereof constituted and operated pursuant to law which:

1. Provides for compensation, Room and Board and 24-hour skilled nursing service under the full-time supervision of a Physician or a Registered Nurse (R.N.). Full-time supervision means a Physician or Registered Nurse (R.N.) is regularly on the premises at least 40 hours per week;

2. Maintains a daily medical record for each patient;

3. Has a written agreement or arrangement with a Physician to provide Emergency Care for its patients;

4. Qualifies as an "Extended Care Facility" under the Health Insurance provided by Title XVIII of the Social Security Act;

5. For those which are not an integral part of the Hospital, has a written agreement with one or more Hospitals providing for the transfer of patients and medical information between the Hospital and Convalescent Hospital; and

6. Is licensed as such under all applicable local, state, and federal laws or regulations.

"Convalescent Hospital" includes that part or unit of a Hospital which is similarly constituted and operated to provide Room and Board and 24-hour nursing service for convalescent care. In no event, however, will a

Convalescent Hospital be deemed to include an institution which is, other than incidentally, a place of rest for the aged, the blind or deaf, Intellectually Disabled; or a place for Behavioral Health or Substance Abuse Treatment or Custodial Care.

CO-PAYMENT OR CO-PAY

A specified dollar amount that a Covered Person is required to pay for certain health services provided under the Plan. The Covered Person is responsible for paying the Co-Payment to the medical provider at the time of service. Co-Payments do not count toward satisfying the Deductible.

COSMETIC PROCEDURES

Those procedures which improve physical appearance, but which do not correct or materially improve a physiological function, and are not Medically Necessary.

COVERED EXPENSES

Refer to Section 6 for Covered Medical Expenses.

COVERED PERSON

A person who has met the eligibility requirements of this Plan as an Employee or is an eligible Dependent of such Employee and whose coverage has become effective.

CUSTODIAL CARE

Care that provides a level or routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a layperson that does not have professional qualifications, skills or training. Custodial Care includes, but is not limited to, help in walking and getting into or out of bed; help in bathing, dressing, and eating; help in other functions of daily living of similar nature; administration of or help in using or applying medications, creams and ointments; routine administration of medical gasses after regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings, diapers and protective sheets and periodic turning and position in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheostomy care; general supervision of exercise programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

DEDUCTIBLE

A specified dollar amount that a Covered Person is required to pay for most Covered Expenses before the Plan will reimburse additional Covered Expenses incurred during the Benefit Period, subject to the applicable Benefit Percentage. Certain benefits indicated on the Schedule of Medical Benefits are not subject to a Deductible, such as Preventive Care Benefits.

DEPENDENT

Dependent is any one of the following persons:

1. A covered Employee's spouse. The term "spouse" shall mean the Employee's legally recognized marital partner of the opposite sex and who lives in the same country as the covered Employee. The Plan Administrator may require documentation proving a marital relationship. If a spouse is eligible to enroll in his or her own employer's group medical plan, the spouse must enroll in such coverage (for at least "employee-only coverage") and is not eligible under this Plan for secondary coverage. Notwithstanding the preceding sentence, a Participant's spouse is eligible for primary coverage in this Plan if one of the following circumstances apply:

a. Both the Participant and the spouse work for the Employer;
b. The spouse is not currently employed;
c. The spouse is employed but not eligible for health coverage through his or her employer because the employer does not sponsor a health plan or because the spouse works in a non-benefits-eligible position;
d. The spouse is self-employed and is not eligible for group health coverage through such employment;
e. The spouse is retired and is not covered as a retiree under any employer-sponsored health plan; or
f. The spouse is retired and eligible for Medicare.

2. A covered Employee's child from birth to age 26. Coverage will end as of the end of the month of the child's 26th birthday. The term "child" (or "children") means the Employee's natural child, legally adopted child or child placed for adoption, stepchild, or child for whom the Employee has been granted legal guardianship who lives in the Employee's household, and for whom the covered Employee provides more than half of the financial support during a Calendar Year. A "child" also includes any child of a Participant who is an alternate recipient under a qualified medical child support order (QMCSO).

3. A covered Employee's child age 26 or older who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. Such child shall remain a Dependent while the incapacity and inability to be employed continues, provided:
   a. the covered Employee provides more than half of the financial support for the child during the Calendar Year;
   b. proof of the incapacity is furnished to the Plan Administrator within 120 days after the date coverage would otherwise terminate and at reasonable intervals thereafter during the first two years of the continued incapacity; and
   c. proof of continued incapacity following the first two years is furnished upon request. The Plan may request additional proof annually.

   The Plan Administrator reserves the right to have the Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of the continued incapacity.

The following persons are excluded as Dependents:

1. Any individual living in the covered Employee's home, but who is not eligible as defined above;
2. The legally separated or divorced former spouse of the Employee; and
3. Any person who is on active duty in any military service of any country.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Out of Pocket Maximums and all amounts applied to maximums.

If both spouses are Employees, they may be covered as either an Employee or as a Dependent. Eligible Dependent children will be covered as Dependents under either parent, but not of both.

DENTAL SERVICES

Procedures involving the teeth, gums or supporting structures.

DENTIST

A duly licensed individual practicing within the scope of the dental profession and any other Physician furnishing any Dental Services which such Physician is licensed to perform.

DISABILITY/PERIOD OF DISABILITY

In the case of a Covered Person, any period of Illness or Injury, or multiple Illnesses or Injuries arising from the same cause, including any and all complications therefrom, which are not separated by a complete recovery (as certified by the attending Physician) and return to active full-time employment; or in the case of a Dependent, return to the resumption of the normal activities of a person of the same age and sex in good health.

DURABLE MEDICAL EQUIPMENT

Medical equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an Illness or Injury, and is appropriate for use in the home.

ELIGIBLE EMPLOYEE

An Employee who is determined to be a Full-Time Employee pursuant to the Employer's policy for determining full-time employment status under Code Section 4980H, as attached hereto and incorporated herein under Appendix A, and as amended from time to time.

The following categories of Employees are not Eligible Employees under the Plan:

1. Any worker who has signed an employment agreement, independent contractor agreement, or other personal services contract with the Employer stating that he or she is not eligible to participate in the Plan.

2. Any worker that the Employer designates in good faith as an independent contractor, during the period that the worker is so designated, regardless of whether the Internal Revenue Service or a court of law later determines such individual to be a common law employee for tax purposes.

3. Any leased employee within the meaning of Code Section 414(n), or any person that would be a leased employee but for the fact that he or she is the common law employee of the Employer.

4. Any individual hired by the Employer who is an intern or seasonal employee.

Notwithstanding the above, if an Employee in one of the above categories is determined to be a Full-Time Employee pursuant to Appendix A, that Employee shall be an Eligible Employee for the period of time in which he or she is treated as a Full-Time Employee.

ELIGIBLE EXPENSE

Those expenses which:

1. Are Incurred expenses for services, treatment, or supplies;
2. Are Medically Necessary as defined herein;
3. Are Incurred expenses on the recommendation of a Physician;
4. Are not in excess of Usual, Customary and Reasonable charges, or not in accordance with the Fee Schedule;
5. Are not excluded under the terms of the Plan;
6. Do not exceed any amounts to be paid under this Plan; and
7. Are Incurred expenses while this Plan is in force for the Covered Person.

EMERGENCY CARE/EMERGENCY SERVICES

Services provided in connection with an emergency medical condition and include medical screening examinations within the capability of a hospital's emergency department, including ancillary services routinely available to evaluate an emergency medical condition and further examination and treatment as required to stabilize the patient. An emergency medical condition is evidenced by acute symptoms of sufficient severity so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy, or seriously impair bodily functions, bodily organs or parts.

Observation care or confinement in excess of 23 hours will be considered an inpatient hospital admission.

EMPLOYEE

A common law employee of the Employer.

EMPLOYER

City of Auburn

ESSENTIAL HEALTH BENEFITS

The benefits designated by the State of Alabama as "essential health benefits," as that term is defined in Section 1302 of the Affordable Care Act, which specific benefits are listed in Section 5A.

Essential Health Benefits include ambulatory patient services, chronic disease management services, emergency room services, inpatient hospital services, laboratory services, maternity and newborn care services, mental health and substance use disorder services, including behavioral health treatment, pediatric care services, including oral and vision care, prescription drugs, rehabilitative and habilitative Services and devices, preventive and wellness services and those other services that are defined by the Secretary of Health and Human Services as being essential health benefits in accordance with Section 1302 of the Affordable Care Act.

EXPERIMENTAL TREATMENTS, PROCEDURES, DRUGS AND DEVICES

A drug, device, treatment or procedure that satisfies one or more of the following:

1. a drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug or device is furnished; or

2. a drug, device, treatment or procedure which Reliable Evidence shows is the subject of an ongoing Phase I, II or III clinical trial or is under study to determine its maximum tolerated dose, its toxicity, or its efficacy as compared with standard means of treatment or diagnosis; or

3. the treatment or procedure is less effective than conventional treatment methods; or

4. the procedure or treatment is currently undergoing review by the Institutional Review Board (or similar body) for the treating health care facility; or

5. the language appearing in the consent form or in the treating Hospital's protocol for treatment indicates that the Hospital or the Physician regards the treatment or procedures as Experimental; or

6. a review of the number of patients who have received this treatment indicates that the patients who have received the treatment or procedure, received it during Phase I, II or III of the clinical trial of the development of the treatment or procedure; or

7. a drug or device that is used in a manner or as a treatment for which it was not approved by the Food and Drug Administration, except that expenses related to off-label drug use may be considered Eligible Expenses when all of the following additional criteria have been satisfied:

   a. The drug is not excluded under the Plan; and

   b. The drug has been approved by the FDA; and

   c. You can demonstrate to the satisfaction of the Plan Administrator that the off-label drug use is appropriate and generally accepted by medical practitioners specialized in the condition being treated; and

   d. If the drug is used for the treatment of cancer, the American Hospital Formulary Service Drug Information, or the Compendia-Based drug Bulletin, recognize it as an appropriate treatment for that form of cancer.

8. any drug, device, treatment or procedure that is considered Experimental or investigational under the Medicare Coverage Issues Manual.

   "Reliable Evidence" means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent form used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedures with respect to the condition of the Covered Person in question.

Note: For purposes of subparagraphs 2 and 5 immediately above, treatment for a Clinical Trial (as defined herein) shall not cause the treatment to be considered "Experimental;" however, treatment for a clinical trial that does not fall within the parameters of a "Clinical Trial," as defined herein, may cause the treatment to be considered "Experimental."

EXTENDED CARE FACILITY

A provider whose main purpose is to provide skilled nursing services to inpatients. The inpatients must require convalescent and rehabilitative care by or under the supervision of Physician. Eligibility for payment is based on care that complies with Medicare-established guidelines. It is not a place that primarily provides Custodial Care or Long-Term Rehabilitation Services.

FULL-TIME EMPLOYEE

An Employee employed by the Employer an average of at least thirty (30) hours of service per week, pursuant to the Employer's policy for determining full-time employment status under Code Section 4980H, as attached hereto and incorporated herein under Appendix A, and as amended from time to time.

GENERIC DRUGS

A drug product that is equivalent to a brand/reference listed drug product in active ingredients, dosage form, strength, route of administration, quality and performance characteristics and intended use.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended.

HOME HEALTH CARE AGENCY

A service or agency providing home health care and possessing a valid certificate of approval issued in accordance with Title XVIII of the Social Security Act, that is licensed as such under all applicable local, state and federal laws or regulations.

HOME HEALTH CARE PLAN

A program for care and treatment of a Covered Person that has been established and approved in writing by the Covered Person's attending Physician which states that the proper treatment of the Injury or Illness requires Confinement as a resident inpatient in a Hospital or an Extended Care Facility as defined in the Title XVIII of the Social Security Act.

HOSPICE

"Hospice" means an agency that provides counseling and medical services and may provide Room and Board to a terminally ill Covered Person and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service 24 hours a day, seven (7) days a week.
3. It is under the direct supervision of a Physician.
4. It has a nurse coordinator who is licensed.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of Hospice services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the patient.
9. It is licensed, if licensing is required.

HOSPICE BENEFIT PERIOD

A specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal Illness or Injury. The period shall end the earliest of six (6) months from such date or at the death of the Covered Person. A new Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof may be required before such a new Benefit Period can begin.

HOSPITAL

An institution which meets all of the following requirements:

1. Is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured sick persons;
2. Has organized departments of medicine and surgery;
3. Has a requirement that every patient must be under the care of a Physician or Dentist;
4. Provides 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.);
5. Is licensed as such under all applicable local, state and federal laws or regulations.

6. Is not a place for Custodial Care or Long-Term Rehabilitation Services;

7. Is accredited by the applicable accreditation agency

Services rendered in the infirmary or clinic of a college, university or private board school shall be Eligible Expenses. In such instances, if a Covered Person is confined in a school facility that does not meet the definition of a Hospital because it has no operating room, benefits may be paid, provided the charges for such Confinement do not exceed the Usual, Customary and Reasonable Charges.

HOSPITAL CONFINEMENT OR CONFINED IN A HOSPITAL

An individual will be considered confined in a Hospital if he is a registered bed patient in a Hospital upon the recommendation of a Physician, is a patient in a Hospital because of surgical operation, or is a patient receiving Emergency Care in a Hospital for an Injury within 48 hours after the Injury is received, or is an Outpatient in a Hospital because tests were ordered by a Physician within four (4) days prior to an admission on an inpatient basis to the same Hospital.

For the purpose of determining the benefits payable, two (2) partial Days of Confinement in a Hospital will be considered one Day of Confinement. Partial Confinement means continuous treatment for at least three (3) hours but not more than 12 hours in any 24-hour period.

HOSPITAL EMERGENCY ROOM VISIT

The Hospital's total, eligible charge for the emergency room treatment. Observation care or confinement in excess of 23 hours will be considered an inpatient hospital admission.

ILLNESS

A disorder of the body or mind, a disease, or pregnancy. All Illnesses which are due to the same cause or to a related cause or causes will be deemed to be one Illness.

INTELLECTUALLY DISABLED

Having a condition that has been diagnosed as “mental retardation” under the Diagnostic Statistical Manual IV-TR and subsequent revisions.

INCURRED EXPENSES

The charge for a medical treatment, service or supply rendered to a Participant. Such charge shall be considered to have been incurred on the date the treatment or service was provided or the supply purchased.

IN-NETWORK SERVICES

Services provided by a Network Provider.

INJURY

Accidental bodily Injury caused by unexpected external means which does not arise out of or in the course of employment and which results in a loss covered by the Plan.

INTENSIVE/CORONARY/ACUTE CARE CHARGE

A service which is normally reserved for critically and seriously ill patients requiring constant audio-visual surveillance; provides Room and Board; provides care by Registered Nurse (R.N.) or other highly trained Hospital personnel; has special equipment and supplies immediately available on a standby basis; and is

provided at a location segregated from the rest of the Hospital's facilities. This term does not include care in a surgical recovery or postoperative room.

LARGE CASE MANAGEMENT SERVICES

A program designed specifically to identify catastrophic or potentially catastrophic Claims while they are still being incurred and to investigate alternate treatment programs which offer both quality care and cost savings.

LEGEND DRUGS

Drugs or medications which require a Federal warning stating, "Caution: Federal Law prohibits dispensing without a prescription."

LICENSED PRACTICAL NURSE

An individual who has received specialized nursing training and practical nursing experience, and is duly licensed under all applicable local state and federal laws or regulations to perform nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LONG-TERM REHABILITATION SERVICES

Long-Term Rehabilitation Services are services for a condition where the condition is not expected to improve significantly within a reasonable period of time (based on the Illness or Injury); however, the reasonable period of time shall not exceed 90 consecutive days. Long-Term Rehabilitation Services include but are not limited to therapy for speech, physical, respiratory, occupational, vestibular and cardiac rehabilitation.

LIFETIME

Is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

MEDICAL BENEFITS

The medical and prescription drug benefits provided under this Plan.

MEDICAL EMERGENCY

The sudden onset of severe medical symptoms that:

1. could not have been reasonably anticipated; and

2. require immediate medical treatment.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

A service, drug, or supply if necessary and appropriate for the diagnosis or treatment of an Illness or Injury in accordance with generally accepted standards of medical practice in the U.S. at the time the service, drug or supply is provided. When specifically applied to a Hospital Confinement it further means that the diagnosis or treatment of the person's symptoms or condition cannot be safely provided to that person on an Outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:

1. is investigational, Experimental, or for research purposes; or

2. is provided solely for the convenience of the patient, the patient's family, Physician, Hospital or any other provider; or

3. exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or

4. could have been omitted without adversely affecting the person's condition or the quality of medical care; or

5. involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration; or

6. involves a service, supply or drug not approved for reimbursement by the Center for Medicare and Medicaid Services.

Benefits payment is subject to the determination of the Plan Administrator that the service, drug or supply is Medically Necessary.

MEDICARE

The program established by Title I of Public Law 89-97 (79 Statutes 291), as amended, entitled Health Insurance for the Aged Act, which includes Part A-Hospital Benefits for the Aged, Part B-Supplemental Medical Insurance Benefits for the Aged, Part C-Medicare Advantage and Part D-Voluntary Prescription Drug Benefit Program.

MENTAL HOSPITAL

An institution, other than a Hospital, which specializes in Behavioral Health diagnosis and treatment which is operated pursuant to law and meets all of the following requirements:

1. Is licensed to give medical treatment;

2. Is operated under the supervision of a Physician;

3. Offers nursing services by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);

4. Provides, on the premises, all the necessary facilities for medical treatment;

5. Is not providing Custodial Care or Long-Term Rehabilitation Services; and

6. Is licensed as such under all applicable local, state and federal laws or regulations.

NETWORK HEALTH CARE PROVIDER

A Health Care Provider who, at the time of providing or authorizing services to the Covered Person, has entered into a contract (or on whose behalf a contract has been entered into) with the Plan to accept Plan negotiated reimbursement for professional services provided to Members.

OCCUPATIONAL THERAPY

Treatment which primarily consists of instructing a covered person on performing normal activities of daily living.

OPEN ENROLLMENT

A specific period of time in which new elections or changes from previous elections may be made for a subsequent effective date, as specified in the Schedule of Benefits.

ORTHOTIC APPLIANCE

An external device designed specifically for the Covered Person and intended to correct a defection from or function of the human body.

OTHER MISCELLANEOUS HOSPITAL CHARGES

Includes any charges, other than charges for Room and Board, made by a Hospital on its own behalf for necessary medical services and supplies actually administered during Hospital Confinement. Necessary services and supplies will also include any charges, by whomever made, for professional ambulance service to or from the nearest Hospital where the medical care and treatment necessary for the individual can be provided, and any charges for the administration of anesthetics during Hospital Confinement, but will not include any charges for the special nursing fees, dental fees or medical fees.

OUTPATIENT

The classification of a Covered Person when that Covered Person received medical care, treatment, services or supplies at home, a minor emergency medical clinic, and Ambulatory Care Facility, a Physician's office, a Hospital, an Outpatient Psychiatric Facility or an Outpatient Substance Abuse Treatment Facility, if not a registered bed patient.

OUTPATIENT SUBSTANCE ABUSE TREATMENT FACILITY

An institution which provides a program for: diagnosis, evaluation, and effective treatment of Substance Abuse; detoxification services needed with such treatment program; infirmary-level medical services or arranges for a Hospital in the area for any other medical services that may be required; supervision at all times by staff of Physician; skilled nursing care at all times by Licensed Practical Nurses (L.P.N.) or Registered Nurses (R.N.) who are directed by a full-time Registered Nurse (R.N.); preparing and maintaining a written plan of treatment for each patient based on medical, psychological and social needs; and when meeting all applicable local, state and federal laws and regulations.

OUTPATIENT PSYCHIATRIC FACILITY

An administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient Behavioral Health services and a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

OUT-OF-NETWORK HEALTH CARE PROVIDER

Health Care Provider services not provided by a Network Provider.

OUT-OF-POCKET MAXIMUM

The maximum amount of Medical Benefits cost-sharing expenses that you and/or your covered Dependents may incur, after which the Plan will pay 100% of Covered Expenses for the remainder of the Plan Year, subject to any maximums stated in the Schedule of Benefits. For these purposes, "cost-sharing expenses" include the Deductible, Coinsurance, and Co-Payment amounts incurred to pay for Medical Benefits, but exclude premiums and payments for the following services, treatments, or medications:

1. Any penalty imposed under the Plan for failure to obtain required precertification;
2. Balance-billed charges by Out-of-Network Providers;

3. Non-covered services; and
4. Charges in excess of UCR.

The Out-of-Pocket Maximum is stated in the Schedule of Medical Benefits.

PARTICIPANT

An Eligible Employee who satisfactorily completes all enrollment procedures.

PHARMACY

A licensed establishment where prescription drugs are dispensed by a pharmacist.

PHYSICAL THERAPY

Treatment given to improve the physical capabilities of a covered individual in an attempt to restore such individual to a previous level of good health.

PHYSICIAN

A qualified, licensed doctor of medicine or osteopathy, and any other licensed health care provider that state law requires to be recognized as a Physician, and practicing within the scope of his license. This does not include the Participant, or his or her spouse, parent, son, daughter, brother or sister.

PLAN

The terms and conditions of the benefit plan described herein.

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

This document, which contains all the provisions of the Plan and govern its legal operations.

PLAN YEAR

The 12-month period specified in the Schedule of Medical Benefits.

PREFERRED PROVIDER ORGANIZATION (PPO)

The network with which the Plan Administrator has designated to provide quality Medical Care and services. The PPO Organization will deliver medical services at contracted fees for the Covered Person.

PREVENTIVE CARE BENEFITS – *See Covered Medical Expenses*

PRIVATE DUTY NURSING SERVICES

Skilled services which are furnished by or under the direct supervision of skilled personnel to assure the safety of the patient and achieve the medically desired result, and for which the planning and management of a treatment plan requires the continuing involvement of a licensed nurse.

PSYCHIATRIC SERVICES/TREATMENT

Behavioral Health Treatment including services provided by a Physician, and services provided by a Psychologist, certified Substance Abuse counselors, therapist or clinical Social Worker or other therapist under Physician supervision who is certified or licensed as such under all applicable local, state and federal laws or regulations, which services and treatment care relate to Behavioral Health or Substance Abuse.

PSYCHOLOGIST

An individual who is duly licensed or certified as a psychologist under all applicable local, state and federal laws and regulations.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

An order issued by a court that creates or recognizes the right of a Participant's child (alternate recipient) to receive benefits under the same Plan providing coverage to the Participant. To be a "qualified" order, the following information must be included:

1. The name and last known address of the Participant and each alternate recipient;

2. A "reasonable" description of the type of coverage to be provided by the Plan to each alternative recipient; or the manner in which type of coverage is to be determined;

3. The period to which the order applies; and

4. Each plan to which the order applies.

REFERENCED-BASED PRICING

Any fixed reimbursement or other limitation imposed by an employer health plan, including but not limited to any such limitation which limits the maximum covered charge to Medicare rates (or Medicare rates increased by a certain percentage) and that term as described in FAQs issued by the Departments of Labor, Health and Human Services and Treasury on May 2, 2014 and October 10, 2014.

REGISTERED NURSE

An individual who has received specialized nursing training, is authorized to use the designation "R.N.", and who is duly licensed under all applicable local, state and federal laws and regulations.

REHABILITATIVE CARE

Necessary inpatient medical care which is prescribed by a Physician, rendered in a Rehabilitation Hospital, excluding Custodial Care or occupational training.

REHABILITATION HOSPITAL/FACILITY

A facility which meets all the requirements of a Hospital, except that a surgery department is not required. In addition, it must meet the following criteria:

1. It must be accredited by the Joint Commission Accreditation of Hospitals (J.C.A.H.O.) and be approved for federal Medicare benefits as a qualified Hospital;

2. It must maintain transfer agreements with Hospitals to handle surgical and/or medical emergencies;

3. It must maintain a utilization review committee; and

4. Is licensed as such under all applicable local, state and federal laws and regulations.

RESCISSION OR RESCIND

A cancellation or discontinuance of coverage that has retroactive effect. A Rescission does not include the cancellation or discontinuance of coverage if it only has a prospective effect, or is effective retroactively, to

the extent it is attributable to the Participant's failure to timely pay required contributions toward the cost of such coverage.

REVIEW AGENT

The company appointed by the Plan Administrator to evaluate medical information against professionally endorsed standards of medical care.

ROOM AND BOARD

Refers to the expenses incurred by an Inpatient which are made by Hospital as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

ROUTINE NURSERY CHARGES

Hospital charges for nursery Room and Board, the initial pediatric examination made by a Physician, charges by a pediatrician for attendance at a cesarean section and circumcision performed while the newborn child is in the Hospital or Birthing Center at the time of birth, or for care other than treatment due to Illness or Injury.

SECOND SURGICAL OPINION

When surgery is prescribed, a Second Surgical Opinion is recommended. This Second Surgical Opinion is to determine the necessity of the proposed surgery and must be provided by a Board Certified Physician who is qualified to render such a service and who is not affiliated in any way with the Physician who will be performing the surgery.

SEMI-PRIVATE ACCOMMODATIONS

A room with two (2) or more beds in a Hospital or Skilled Nursing Facility approved by Plan. The difference in cost between Semi-private Accommodations and private accommodations is covered only when private accommodations are Medically Necessary.

SKILLED NURSING FACILITY

A lawfully operated institution, or its distinct part which:

1. Has the primary purpose of providing day and night lodging and skilled nursing care for persons recovering from an Injury or Illness;

2. Is supervised on a full-time basis by a Physician or Registered Nurse (R.N.);

3. Admits patients only upon the advice of a Physician, keeps clinical records on all patients and has the services of a Physician available;

4. Has established methods and procedures to dispense and administer drugs and biologicals;

5. Has a written agreement with one or more Hospitals;

6. Is licensed as such under all applicable local, state and federal laws and regulations and

In no event, however, will a Convalescent Hospital be deemed to include an institution which is, other than incidentally, a place of rest for the aged, the blind or deaf, Intellectually Disabled; or a place for Behavioral Health or Substance Abuse Treatment or Custodial Care.

SOCIAL WORKER

An individual who is duly licensed and holds a master's degree in social work from a university approved by the National Association of Social Workers (NASW) and who is practicing under the supervision of a Psychiatrist or Psychologist.

SPEECH THERAPY

Treatment administered to improve a Participant's speech capabilities after a decrease in those capabilities following an Illness.

SUBSTANCE ABUSE

The condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that result in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

SUBSTANCE ABUSE TREATMENT FACILITY

1. A public or private facility providing Substance Abuse detoxification or rehabilitation services; or

2. A comprehensive health service organization, community Behavioral Health center or clinic or day care center which furnishes Behavioral Health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the treatment of Substance Abuse and which is licensed for those purposes and which is licensed as such under all applicable local, state and federal laws or regulations.

TELEMEDICINE SERVICES

Physician consultations that are available to Covered Persons via telephone or secure mail, through a network of providers under contract to the Employer.

TERMINAL ILLNESS

An Illness where the medical prognosis is of a life expectancy of six (6) months or less if the Illness runs its normal course.

TOTAL DISABILITY

An Employee who is prevented, because of an Injury or Illness, from engaging in his regular or customary occupation and who is performing no work of any kind for compensation or profit or a Dependent of a Covered Person who is prevented, solely because of an Injury or Illness, from engaging in all of the normal activities of a person of like age and sex in good health.

URGENT CARE

Care for a medical condition resulting from Injury or Illness which is less severe than Emergency Care but requires care within a reasonably short time.

USUAL, CUSTOMARY AND REASONABLE (UCR)

Except as provided below with respect to implantable devices, charges made for medical services or supplies essential to the care of the individual if they are in accordance with:

1. the "usual" fee which is the fee an individual Physician most frequently charges the majority of his patients for the procedure performed; and

2. the "customary" fee which is the fee established by the Plan based on charges made by most Physicians of the same specialty in comparable geographical economic areas for the procedure performed; and
3. the "reasonable" fee which is the fee charged for unusual circumstances involving medical complications, requiring additional time, skill and experience; and
4. in no event will the amount allowed under the Plan exceed 200% of the Medicare allowed for professional, facility, emergency charge or similar service(s) for out-of-network claims.

Notwithstanding the above, UCR charges for implantable devices is the actual implant cost, as shown on the medical provider's invoice, increased by 150%. If the medical provider does not provide an invoice or the invoice does not reflect the implant cost, UCR charges will instead be determined by the one of the following factors, in the Plan Administrator's sole discretion:

- the implant cost obtained from a national database such as ImplantDx;
- the implant cost determined using normative data such as Medicare cost-to-charge ratios, average wholesale price, or manufacturer's retail pricing; and/or
- the cost of an equivalent implant (determined by using any method above) if the cost of the implantable device is unavailable.

The implant cost will not be paid if such implant is not considered separately payable by Medicare and/or CMS when billed in an Ambulatory Surgical Center setting.

The Plan Administrator has discretionary authority to determine the appropriate payment for implantable devices and may, upon review of additional documentation or extenuating circumstances and in its sole discretion, approve a higher allowable charge. However, in no event will UCR charges include any identifiable billing mistakes including, but not limited to, duplicate charges or identification of incorrect implantable devices. In making this determination, the Plan Administrator may consider all relevant facts in addition to findings and assessments of (but not limited to) national medical associations, societies, and/or organizations, and the Food and Drug Administration.

Note: Charges in excess of UCR shall not apply to the Out-of-Pocket Maximum.

VOCATIONAL REHABILITATION

Teaching and training which allows a Covered Person to resume his or her previous job or to train for a new job.

WAITING PERIOD

The number of days stated in the Schedule of Medical Benefits as provided in Section 2 that Eligible Employee must be employed by the Employer before he or she can enroll in the Plan as an Eligible Employee.

SECTION 16. PLAN INFORMATION

Plan Name and Identification Number	City of Auburn HEALTH BENEFITS PLAN
Employer Identification Number:	35-6000943
The Plan Number assigned by the Employer:	501
Plan Sponsor and Plan Administrator:	City of Auburn 210 E. 9th Street Auburn, IN 46700 Telephone: (260) 925-6450 The Plan Administrator is liable for all benefits under the Plan.
Claims Adjudicator:	Employee Plans, LLC 1111 Chestnut Hills Parkway Fort Wayne, Indiana 46814 Telephone: (260) 625-7470
Agent for Service of Legal Process:	City of Auburn 210 E. 9th Street Auburn, IN 46700 Telephone: (260) 925-6450
Plan Year	The financial records of the Plan are kept on a 12 month period specified in the Schedule of Medical Benefits.
Funding of Plan and Payment of Benefits	The level of any contributions will be set by the Plan Administrator. Contributions will be used to fund the costs of the Plan as soon as practical after they have been received from the Employee or withheld from the compensation otherwise payable to the Employee. Benefits are paid directly from the Plan. The Plan Sponsor has purchased reinsurance to reimburse the Plan for certain large Claims.
Plan original Effective Date:	July 1, 2003
Plan Restatement Date:	January 1, 2009 July 1, 2011 July 1, 2014 July 1, 2015 July 1, 2020

SECTION 17. SIGNATURE PAGE

APPROVED AND ACCEPTED

IN WITNESS. Whereof, this document is executed at:

_____, _____ on _____
(City) (State) (Date)

By: _____
(Name)

_____
(Title)

ON BEHALF OF:

City of Auburn
(Name of Plan)

_____
(Witness)

APPENDIX A

POLICY FOR DETERMINING FULL-TIME EMPLOYMENT STATUS UNDER INTERNAL REVENUE CODE SECTION 4980H

I. PURPOSE

This Appendix A sets forth the City of Auburn Policy for Determining Full-Time Employment Status Under Internal Revenue Code Section 4980H ("Policy"). This Policy is intended to set forth the methods by which the City of Auburn ("Employer") will determine whether an Employee is a Full-Time Employee under Internal Revenue Code ("Code") Section 4980H for purposes of:

(i) meeting the Employer's reporting obligations under Code Section 6056; and

(ii) determining eligibility under the City of Auburn Health Benefits Plan ("Health Plan") that is established and maintained by the Employer.

The determination that an Employee is a Full-Time Employee under this Policy is for these two purposes only and does not affect the Employer's determination of full-time employee status for any other purpose, including for purposes of eligibility for dental or vision coverage.

This Policy is part of, and incorporated by reference into, the Health Plan. This Policy controls to the extent that there are conflicts with the Health Plan.

II. POLICY

An Employee who is determined by the Employer to be a Full-Time Employee during a Measurement Period shall be reported as a Full-Time Employee during the corresponding Stability Period for the applicable periods under Code Section 6056. Such Full-Time Employee will also have an opportunity to elect, change, or decline Health Plan coverage for himself or herself and his or her dependents during the related Administrative Period.

This Policy is intended to satisfy the rules under Treasury Regulation Section 54.4980H-3, will be interpreted consistently therewith, and will be revised to conform to changes that may be made by any subsequent guidance.

III. EFFECTIVE DATE

This Policy is effective as of 7/1/2020.

IV. DEFINITIONS

Any capitalized terms in this Policy have the following meanings:

- **Administrative Period –** The period immediately following a Measurement Period during which the Employer identifies which Employees are Full-Time Employees and conducts enrollment under the Health Plan.
  - For a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee, the initial Administrative Period is the one month period immediately following the Employee's initial Measurement Period. Thereafter, such Employee will have the same Administrative Period as an Ongoing Employee.

- For Ongoing Employees, the Administrative Period is the 90-day period immediately following the standard Measurement Period.

- **Eligible Employee –** An Eligible Employee has the same meaning as set forth in the Health Plan and shall include an Employee who is determined to be a Full-Time Employee pursuant to this Policy.

- **Employee –** A common law employee of the Employer.

- **Full-Time Employee –** An Employee who is employed an average of at least 30 Hours of Service per week with the Employer.

- **Health Plan –** A group health plan that provides minimum essential coverage, as defined in Code Section 5000A(f), which is established and maintained by the Employer, and amended from time to time.

- **Hour of Service –**

  - each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and

  - each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b-2(a)).

  Notwithstanding the preceding, an Hour of Service shall not include any hour for services:

  - performed as a bona fide volunteer;

  - performed as part of a Federal Work-Study Program or substantially similar program of a State or political subdivision thereof; or

  - to the extent the compensation for such services constitutes income from sources outside the United States.

- **Measurement Period –** The period used by the Employer to determine whether an Employee is a Full-Time Employee.

  - For a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee, the initial Measurement Period is the Employee's initial 12 months of employment with the Employer beginning with the first day of the month following date of hire. At such time that a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee has been employed for an entire standard Measurement Period, he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees.

  - For Ongoing Employees, the standard Measurement Period is the 12-month period that begins January and ends the following December.

- **Ongoing Employee** – An Employee who has been employed by the Employer for at least one complete standard Measurement Period.

- **Part-Time Employee –** A new Employee who the Employer reasonably expects to be employed on average less than 30 Hours of Service per week during the initial Measurement Period, based on the facts and circumstances at the Employee's start date.

- **Seasonal Employee –** A new Employee who is hired into a position for which the customary annual employment is six months or less. Customary annual employment means that by the nature of the position, an Employee in this position typically works for a period of six months or less, and that period begins each calendar year in approximately the same part of the year, such as summer or winter.

- **Special Unpaid Leave –** Unpaid leave under the Family and Medical Leave Act, unpaid leave subject to the Uniformed Services Employment and Reemployment Rights Act, and unpaid leave on account of jury duty.

- **Stability Period –** The period that follows, and is associated with, a Measurement Period (and related Administrative Period) during which an Employee's status as a Full-Time Employee (or not as a Full-Time Employee, as the case may be) will be generally locked in place.

  - For a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee, the initial Stability Period is the 12-month period following the Employee's initial Measurement Period and related Administrative Period. Thereafter, such Employee will have the same Stability Period as an Ongoing Employee.

  - For Ongoing Employees, the Stability Period is the 12-month period following the standard Measurement Period and related Administrative Period that begins January 1 and ends December 31.

- **Variable Hour Employees –** A new Employee for whom, based on the facts and circumstances at the Employee's start date, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 Hours of Service per week during the initial Measurement Period because the Employee's hours are variable or otherwise uncertain.

V. PROCEDURES FOR COUNTING AND CREDITING HOURS OF SERVICE

A. Hourly Employees – The Employer will calculate actual Hours of Service from records of hours worked and hours for which payment is made or due for all Employees who are paid by the Employer on an hourly basis.

B. Salaried Employees –

The Employer will calculate actual Hours of Service from records of hours worked and hours for which payment is made or due for all Employees who are paid by the Employer on a salaried basis.

VI. APPLICATION OF LOOK-BACK MEASUREMENT METHOD

A. Ongoing Employees

- An Ongoing Employee is a Full-Time Employee for a Stability Period if, during the preceding standard Measurement Period, the Ongoing Employee worked an average of at least 30 Hours of Service per week. Such Full-Time Employee will have an opportunity to elect, change, or decline Health Plan coverage for himself or herself and his or her dependents during the related Administrative Period.

- An Ongoing Employee who does not work an average of at least 30 Hours of Service per week over a standard Measurement Period is not a Full-Time Employee for the subsequent Stability Period. Notwithstanding the preceding, if an Employee described in this paragraph experiences a change in employment status during the subsequent Stability Period such that, if the Employee had begun employment in the new position,

the Employee would have reasonably been expected to be a Full-Time Employee, then, such Employee will be treated as a Full-Time Employee as of the first day of the change in employment status and shall have an opportunity to elect Health Plan coverage for himself or herself and his or her dependents.

- If an Ongoing Employee goes on a paid or unpaid leave of absence from employment, the Employee will continue to be a Full-Time Employee or not a Full-Time Employee, as applicable, for the remainder of the Stability Period in which the leave begins. Thereafter, the Employee's status as a Full-Time Employee or not a Full-Time Employee for the subsequent Stability Period will be determined based on Hours of Service during the preceding Measurement Period, taking into account any Special Unpaid Leave. The treatment of such Ongoing Employee as a new Employee or a continuing Employee upon resumption of services shall be determined under the rehire rules defined later in this Policy.

B. New Full-Time Employees

- For purposes of reporting under Code Section 6056, a new Employee is a Full-Time Employee for each calendar month only if he or she is actually employed an average of at least 30 Hours of Service per week with the Employer.

- For purposes of the Health Plan, a new Employee is subject to the following rules:

  - A new Employee who is reasonably expected at the Employee's start date to be a Full-Time Employee (and who is not a Seasonal Employee) will be a Full-Time Employee for each calendar month until such time that the new Employee has been employed for an entire standard Measurement Period, at which time he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees. Such Full-Time Employee will have an opportunity to elect, change, or decline Health Plan coverage for himself or herself and his or her dependents during an election period related to the Employee's start date.

  - If a new Employee described in this section experiences a change in employment status before the Employee has been employed for an entire standard Measurement Period, such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected not to be employed on average at least 30 Hours of Service per week, then, beginning on the first day of the next calendar month following the change in employment status, the determination of Full-Time Employee status for such Employee shall be made on a monthly basis until such time that the new Employee has been employed for an entire standard Measurement Period, at which time he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees.

  - If a new Employee described in this section goes on a paid or unpaid leave of absence from employment before the Employee has been employed for an entire standard Measurement Period, then beginning on the first day of the next calendar month following the date the leave of absence begins, the determination of Full-Time Employee status for such Employee shall be made on a monthly basis until such time that the new Employee has been employed for an entire standard Measurement Period, at which time he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees. Notwithstanding a determination that an Employee is not a Full-Time Employee with respect to a calendar month in which he or she is on a leave of

absence, Health Plan coverage shall continue to the extent required under the FMLA, USERRA, or COBRA.

C. New Variable Hour Employees, Seasonal Employees, and Part-Time Employees

- New Variable Hour Employees, Seasonal Employees, and Part-Time Employees will be tested under an initial Measurement Period to determine whether they are Full-Time Employees.

  - A new Variable Hour Employee, Seasonal Employee, or Part-Time Employee who works an average of at least 30 Hours of Service per week over his or her initial Measurement Period will be a Full-Time Employee for his or her initial Stability Period. Such Employee will have an opportunity to elect Health Plan coverage for himself or herself and his or her dependents during the related initial Administrative Period.

  - A new Variable Hour Employee, Seasonal Employee, or Part-Time Employee who does not work an average of at least 30 Hours of Service per week over his or her initial Measurement Period will not be a Full-Time Employee for his or her initial Stability Period. Notwithstanding the preceding, if a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee experiences a change in employment status during the subsequent Stability Period such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, then the Employer will treat the Employee as a Full-Time Employee on the first day of the change in employment status, and such Employee shall have an opportunity to elect Health Plan coverage for himself or herself and his or her dependents.

  - At such time that a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee has been employed for an entire standard Measurement Period, he or she will be tested under that standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees; provided, however, that a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee who is determined to be a Full-Time Employee for his or her initial Stability Period will continue to be a Full-Time Employee through the end of that initial Stability Period, even if he or she is not determined to be a Full-Time Employee during the standard Measurement Period.

- If a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee experiences a change in employment status before the end of the initial Measurement Period such that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to be a Full-Time Employee, the Employer will treat the Employee as a Full-Time Employee as of the first day of the change in employment status, and such Employee shall have an opportunity to elect Health Plan coverage for himself or herself and his or her dependents.

VII. SPECIAL RULES

A. Factors for Determining Employee Status – For purposes of determining whether an Employee is reasonably expected at his or her start date to be a Full-Time Employee (who is not a Seasonal Employee), a Part-Time Employee, or a Variable Hour Employee, the Employer will consider all of the facts and circumstances, including the following factors:

- whether the Employee is replacing an Employee who was (or was not) a Full-Time Employee or a Variable Hour Employee;

- the extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 30 Hours of Service per week during recent Measurement Periods; and

- whether the position was advertised, or otherwise communicated to the new Employee or otherwise documented (for example, through a contract or job description), as requiring Hours of Service that would average 30 (or more) Hours of Service per week, less than 30 Hours of Service per week, or may vary above and below an average of 30 Hours of Service per week.

No single factor is determinative. In determining an Employee's status, the Employer will not take into account the likelihood that the Employee may terminate employment with the Employer before the end of an initial Measurement Period.

B. **Use of Payroll Periods –** For purposes of measuring the beginning and end of a Measurement Period with respect to Employees who are paid on a weekly, bi-weekly, or semi-monthly basis, the Employer may, at its discretion, treat as a Measurement Period a period that:

- begins on the first day of the weekly, bi-weekly, or semi-monthly payroll period, as applicable, that follows the payroll period that includes the date that would otherwise be the first day of the Measurement Period, and

- ends on the last day of the weekly, bi-weekly, or semi-monthly payroll period, as applicable, that includes the date that would otherwise be the last day of the Measurement Period.

This special rule will not apply with respect to Employees who are paid on a monthly basis. The Employer is not required to measure the beginning and end of a Measurement Period by payroll periods, but to the extent this method is used, the Employer will adjust the Measurement Period consistently for all Employees who are paid on the same basis (*e.g.*, the Measurement Period will be adjusted for all Employees paid on a bi-weekly basis in the same manner).

C. **Exclusion of Special Unpaid Leave –** The Employer will determine an Employee's average Hours of Service for a Measurement Period by (i) computing the average after excluding any Special Unpaid Leave during that Measurement Period and (ii) by using that average as the average for the entire Measurement Period.

D. **Determination of Employee Status Upon Resumption of Services –** An Employee who either (i) terminates employment with the Employer and is subsequently rehired or (ii) resumes providing services to the Employer following a leave of absence in which he or she was not credited with any Hours of Service, will maintain his or her status as a Full-Time Employee or not a Full-Time Employee, as applicable, for the remainder of the Stability Period in which the termination or leave occurred, unless the Employee can be treated as a new Employee. An Employee will be treated as a new Employee upon resumption of his or her services for the Employer only if he or she is not credited with an Hour of Service:

- for a period of at least 13 consecutive weeks; or

- for a period that is longer than the period of employment preceding the break and that is at least four weeks.

This rule applies only for purposes of this Policy.

VIII. ADMINISTRATION, REVIEW AND AMENDMENT OF POLICY

The Employer will administer Measurement Periods for new and Ongoing Employees, determine an Employee's status as a Full-Time Employee (or not a Full-Time Employee, as the case may be) during Administrative Periods, and provide coverage under a Health Plan during Stability Periods to Eligible Employees determined to be Full-Time Employees, all in accordance with this Policy and the terms of the Health Plan. The Employer has full and absolute discretionary authority to interpret the terms of this Policy to determine whether its Eligible Employees are Full-Time Employees under a Health Plan. Employees who have questions regarding this Policy may contact the MGH Benefits Coordinator at 765-660-6604 for more information.

The Employer will periodically review this Policy for compliance under applicable regulations and other guidance. The Employer has the right, in its sole and absolute discretion, to revise this Policy at any time to ensure legal compliance and to further the goals of the Employer.