Plan Document
for
City of Auburn

Effective Date of the Original Plan: July 1, 2003
Effective Date of the First Restated Plan: January 1, 2009
Effective Date of the Second Restated Plan: July 1, 2011
Effective Date of the Third Restated Plan: July 1, 2014
Effective Date of the Fourth Restated Plan: July 1, 2015

PREFACE

The **City of Auburn** HEALTH PLAN, hereinafter called 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 they incur Eligible Expenses as defined herein. The Plan is subject to all the terms, provisions and limitations re-stated herein and shall become effective as of 12:01 a.m. Standard Time on **July 1, 2015** at **Auburn, IN**.

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 Restated Plan is July 1, 2015 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 of the Employer or their Dependents shall be determined pursuant to the terms and conditions of this Plan Document.

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 and Welfare Plan. The purpose of this Plan Document is to set forth the provisions of the Plan which provide and/or affect such payment or reimbursement.

Amendment

The Plan may be amended, canceled or discontinued at any time by the Employer without the consent of or notice to any Covered Person. All Amendments shall be approved by the Employer's Board of Directors or other person or committee authorized by The Employer to make such Amendment. Additionally, all Amendments shall be communicated to the Participants as soon as practical after adoption of the Amendment. Any Amendment which decreases coverage shall be communicated to the Participants a reasonable period of time before the Amendment becomes effective.

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 right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

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 described in this Plan Document will be paid promptly upon receipt of proof that Covered Expenses have been incurred.

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 or payable 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.

Continued Group Health Plan Coverage

You may continue health care coverage for yourself, or Dependents 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 summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your Enrollment Date in your coverage.

Prohibition of Using Genetic Information

Pursuant to the Genetic Information Nondiscrimination Act of 2008, neither The Plan nor The Plan Sponsor shall:

1. adjust group premiums or contribution amounts on the basis of genetic information;

2. request or require an individual or an individual's family members to undergo genetic testing; or

3. request, require or purchase genetic information for underwriting purposes or before enrollment.

Exclusion of Temporary, Leased, or Misclassified Employees

The following classes of individuals are ineligible to participate in this Plan, regardless of any other Plan terms to the contrary, and regardless of whether the individual is a common law employee of the Employer:

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 treats as an independent contractor, during the period that the worker is so treated. A worker is treated as an independent contractor if payment for his or her services is memorialized on a form 1099, and not on a form W-2;

3. any leased employee within the meaning of §414(n) of the Internal Revenue Code, 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.

The purpose of this provision is to exclude from participation in the plan all persons who may actually be common law employees of the Employer, but who are not paid as though they were employees, regardless of the reason they are excluded from the payroll, and regardless of whether that exclusion is correct.

SECTION 2. SCHEDULE OF 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) Hospitals in the Signature Care EPO network (select counties) and Signature Care PPO Providers such as but not limited to: Professional & Ancillary services.

PPO (Tier 2) Hospitals include all other Signature Care hospitals state wide. (Excludes Signature Care EPO Hospitals)

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

Provider Network: www.ParkviewTotalHealth.com; (260) 373-9100; (800) 666-4449

Deductible (calendar year)

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:

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)

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.

PPO SPECIAL NOTES

The following listing of exceptions represents services, supplies, or treatments rendered by a non-preferred provider where covered expenses shall be payable at the preferred provider level of benefits.

1. Non-preferred anesthesiologist if the operating surgeon is a preferred provider.
2. Durable Medical Equipment, Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a non-preferred provider when the facility rendering, or physician ordering, such services is a preferred provider.
3. While confined to a preferred provider hospital, the preferred provider physician requests a consultation from a non-preferred provider.
4. When a covered dependent resides outside the service area of the Preferred Provider Organization.
5. Covered persons who do not have access to preferred providers within the Preferred Provider service area, or for emergency treatment rendered while traveling out-of-area; or for services while temporarily traveling or residing outside the Preferred Provider service area (other than for purpose of seeking medical care).

6. Treatment received from Non-Preferred Providers for emergency care will be paid the same as In-Network.

   Emergency care means care for a serious medical condition resulting from an injury or illness which arises suddenly and requires immediate care and treatment to avoid jeopardy to the life of the participant of the plan.

7. Services rendered by Non-Preferred providers will be considered as having been rendered by Preferred Providers (for benefit purposes) in the event that a Preferred Provider, of that specialty, did not exist in the network service area (unless "continuity of care" or "emergency care" principle, are applicable).

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:

	Preferred Provider (EPO-Network)	Preferred Provider (PPO In-Network)	Non-Preferred Provider (Out-of-Network) [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%

<u>Prescription Drugs – Retail</u> (34 days)
Co-Payment
$10 Generic
$30 Brand Formulary
$45 Brand Non-Formulary
$45 Specialty Medications

<u>Prescription Drugs – Mail Order</u> (90 days)
Co-Payment
$20 Generic
$60 Brand Formulary
$90 Brand Non-Formulary
$90 Specialty Medications

<u>Notes:</u>

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

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 of Coverage

Coverage provided under the Plan for Employees and their Dependents shall be in accordance with the Eligibility, Effective Date, and Termination provisions stated herein.

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, 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 below.

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.

Employees and Dependents who are Late Enrollees cannot be enrolled in this Plan unless they experience a Special Enrollment event as defined herein, or enroll at the annual Open Enrollment.

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.

Dependent Eligibility

An Employee may enroll a Dependent (subject to the Special Dependent Eligibility provision page 3.3) provided the Dependent satisfies the definition of a Dependent. An Employee will become eligible for Dependent coverage on the latest of the following:

1. The date the Employee becomes eligible for coverage;

2. The date on which the Employee first acquires a Dependent if the Employee is covered on that date;

If both the Employee and spouse are employed by the Employer, and both are eligible for Dependent coverage, 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, a newborn child will be automatically covered if the Employee is already enrolled for Dependents' coverage, providing there is no additional cost to add this Dependent; or 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 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 of marriage.

4. A Dependent shall also include a child who is placed for adoption with the Plan Participant and is to be considered having the same status and rights under the Plan as a natural child of a Covered Employee, even if the adoption has not become final according to the court having jurisdiction over such adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child.

5. A Dependent shall also include a child under a Qualified Medical Child Support Order (QMCSOs). 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 Administrator; and

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

Special Dependent Eligibility Information

The following eligibility provisions are in addition to those already listed in this document.

Spousal Eligibility

1. An eligible spouse must participate in their employer's group medical plan (available as a full time employee); and

2. An eligible spouse who does not have an employer sponsored group medical plan available to them will be considered eligible to participate under this Plan;

Dependent Children Eligibility

1. Dependent Children are eligible to participate in this Plan and/or the Spouse's group medical plan providing the Children meet the Definition of a Dependent (Section 14).

Note: It is an employee's responsibility to notify the Plan within 30 days of a change in the spouse's eligibility status. Coverage under this Plan will terminate (regardless if enrolled):

   a. The date a spouse is actively working, full time, and

   b. Has a group health plan available, and

c. Has met the Employee waiting period.

It is the Employees responsibility to provide proof of the above enrollment and/or eligibility.

Employee Effective Date

Employee coverage under the Plan shall become effective with respect to an eligible person on the date of his eligibility, provided written application for such coverage and any contribution required from such person is made on or before such date. If application is made within 30 days after the date of eligibility, the Employee coverage for the eligible person shall become effective on the original eligibility date.

An Employee's coverage under the Plan shall commence at 12:01 A.M. Standard Time, on the date such coverage is effective.

Dependent Effective Date

Each Employee who makes written request for Dependent coverage under the Plan, on a form approved by the Plan Administrator, will become covered for Dependent coverage as follows:

1. if the Employee makes such written request within 30 days of the date the Dependent is first eligible to enroll, then Dependent coverage will be effective on the date the Dependent becomes eligible for Dependent coverage;
2. if Dependent coverage under the Plan is requested and the Employee makes such written request after the end of the 30 day period specified immediately above, the Dependent cannot be enrolled in this Plan, unless experiences a Special Enrollment Event or at Open Enrollment.

Termination of Coverage

Employee and Dependent coverage for a particular benefit shall terminate immediately on the earliest of the following dates:

1. The last day of employment not extended by unused vacation; provided that coverage may be extended during leave of absence that qualifies as leave under the provision of the Family Medical Leave Act of 1993;
2. Date the Employee ceases to be in a class eligible for coverage;
3. Date the Employee fails to make any required contribution for coverage;
4. Date the Plan or a particular benefit is terminated;
5. Date the Employee dies;
6. Date the Employee becomes a full-time member of the armed forces of any country.
7. Date the Dependent fails to qualify as an eligible Dependent.
8. Date the Employee commits an act of fraud or intentional misrepresentation of a material Fact with respect to the Plan.

Reinstatement of Coverage

An employee's coverage under the Plan may be reinstated if such coverage terminated due to termination of employment with the employer and the employee returns to active employment as an eligible employee for the employer within 62 days from the date on which employment terminated. Coverage under the Plan will become effective on the date of return to active employment as an eligible employee. The employee must make written application to elect coverage under the Plan within 30 days following the date of return to active employment.

Adopted Children Coverage

A child placed with an Employee for adoption will be an eligible Dependent. Coverage for that child will begin on the later of:

1. the date coverage for the Employee's other Eligible Dependents begins;

2. 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.

Statement of HIPAA Portability Rights

Right to get Special Enrollment in Another Plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept Late Enrollees, if you request another enrollment within 30 days. (Additional Special Enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

1. Therefore, once your coverage in a group health plan ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request Special Enrollment as soon as possible.

Prohibition Against Discrimination Based On A Health Factor, Under HIPAA, a group health plan may not keep you (or your Dependents) out of the plan based on anything related to your health. Also a group health plan may not charge you (or your Dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

For More Information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa or http://www.cms.hhs.gov/hipaa.

SECTION 4. CONTINUATION OF COVERAGE (COBRA)

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under your group health insurance plan ("the Plan"). **This notice 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.**

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 the Plan's Summary Plan Description or contact the Plan Administrator.

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 notice. 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:

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

For purposes of this Section, "gross misconduct" shall be determined by the Plan Administrator, on a nondiscriminatory basis, after considering the following circumstances:

1. Was conduct illegal and/or a violation of the Employer's policies and procedures?
2. Was the conduct intentional?
3. Was the conduct disruptive or harmful to the Employer's business or the workplace?
4. Was the conduct the first disciplinary offense?
5. Was the conduct condoned or tolerated by the Employer?
6. Are there mitigating circumstances involving the conduct?

Gross misconduct includes, but is not limited to, actions which deviate from the Employer's policies and standards, regardless of whether or not the conduct constitutes a criminal offense. The fact that an Employee is offered to voluntarily resign because of any such conduct does not preclude the Plan Administrator from concluding that the Employee was terminated for "gross misconduct." To the extent the conduct involved a criminal act, the fact that the Employer does not file the applicable charges with the local prosecutor does not preclude the Plan Administrator from determining that the conduct constituted "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:

1. Your spouse dies;

2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason other than his or her gross misconduct;

4. Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

5. 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:

1. The parent-Employee dies;

2. The parent-Employee's hours of employment are reduced;

3. The parent-Employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the plan as a "Dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) "eligible individuals." Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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, in writing, the divisional Payroll, Benefits or Human Resource department within 60 days (review the entire COBRA Section in this SPD for specific rules) after the qualifying event occurs.

How is COBRA 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. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight (8) months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two 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 notice of the second qualifying event is properly given to the Plan. 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.

What is the Health Insurance Marketplace?

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

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

When can I enroll in Marketplace coverage?

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

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

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

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

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

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

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

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the applicable payroll benefits or human resource department. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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, to the address specified in the Schedule of Benefits.

CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT (USERRA)

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.

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.

COBRA/USERRA 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

In the event a qualified beneficiary's COBRA coverage terminates before the duration of COBRA coverage (either 18, 29 or 36 months after the qualifying event), 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).

SECTION 5. COVERED MEDICAL EXPENSES

Covered Expenses

In order to be considered, expenses must be incurred by a Covered Person while the Plan is in force and be the result of an Injury or an Illness, and which meets 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; and

5. 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 and Current Procedural Terminology.

Covered Expenses include the following:

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. 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.

   If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

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, pneumoencephalograms, 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, 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.

20. Voluntary sterilization.

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. Each 4 hour visit shall be considered a separate visit for purposes of any limitation under this Plan.

    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. 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. 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 prepared;

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. Pursuant to the provisions of The Patient Protection and Affordable Care Act of 2010, Participants and their covered Dependents may 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. Additionally, covered Dependents who are women shall be permitted to seek treatment for obstetrical and gynecological care without any requirement to obtain a referral.

30. 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.

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

32. 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, 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 will only be covered as follows:

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.

33. 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.

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. Off-Label Drug Use may be considered as a Covered Expense 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. The Plan can demonstrate that the Off-Label Drug Use is appropriate and generally accepted for 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 Compedia-Based Drug Bulletin, recognized it as an appropriate treatment for that form of cancer.

SECTION 5A. 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 6. MEDICAL PLAN EXCLUSIONS

Notwithstanding any provision of this Plan to the contrary, the following exclusions apply to any expense or charge otherwise payable under any provision of this Plan:

1. Charges for the part of an expense for care and treatment of an Injury or Illness that is in excess of the Usual, Customary and Reasonable Charge;

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

3. 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;

4. Charges arising out of or in the course of employment for wage or profit, whether such employment is with the Employer, with another employer, self-employment, or for which the Covered Person is entitled to benefits under any Worker's Compensation (providing the Covered Person is eligible for Workers Compensation coverage) or Occupational Disease Law, or any such similar law;

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

6. 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;

7. Charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation; 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;

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

9. 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, riding a three (3) wheel all-terrain vehicle, car racing in any professional or semi-professional sport, bungee jumping, motorcycle or ATV operating in any contest of speed;

10. Charges incurred for nutritional supplements or vitamins not medically necessary for the treatment of any Injury or Illness (except for prenatal vitamins);

11. 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;

12. Charges for any treatment for cosmetic purposes or for cosmetic surgery. Except that, the Plan will pay for Cosmetic treatment or surgery;

    a. due solely to an accidental bodily Injury

    b. due solely to reconstructive surgery

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

13. 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;

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

15. Charges for elective abortions; unless the Physician certifies in writing that the pregnancy would endanger life of mother, or expenses are to treat medical complications due to non-elective abortions, or unless 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 Physician's fees for any treatment which 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 covered benefits, for purposes:

    a. relating to judicial or administrative proceedings or orders;

    b. which are conducted for purposes of medical research;

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

d. relating in travel;

e. relating to marriage or adoption; or

f. 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 foot, or foot strain, except for open cutting operations; orthopedic shoes or other devices for support of the feet;

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 Diagnosis Statistical Manual of Mental Disorders-IV; except that any learning disability which is required by state or federal law, regulation or rule shall be excluded if any public or private school or other learning facility is required under any such law, regulation or rule to provide either diagnosis or coverage for said learning disability;

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

34. Charges incurred which resulted from: 1) the voluntary taking of drugs except those taken as prescribed by a Physician, 2) the voluntary taking of poison, 3) the voluntary inhaling of gas, or 4) 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, completion of claim forms, telephone consultations, electronic (Internet) consultations or other similar services;

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 directly or indirectly related to a Clinical Trial;

39. Charges for a dependent child maternity.

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

a. Infertility Treatment
b. Eye Glasses for Children
c. Dental Check-Up for Children
d. Basic Dental Care – Child
e. Orthodontia – Child
f. Major Dental Care – Child

41. Charges which, although within this Plan's Reasonable and Customary limitations or which are within this Plan's network reimbursement, are excluded by another employer health plan based on Referenced Based Pricing;

42. Prescription or Injectable drug charges which: 1) have been reimbursed (or will be reimbursed) through coupons, rebates, etc.; or 2) for any dependent who has primary drug coverage under another Employer sponsored group health plan; or 3) not covered under the Prescription Benefit Program such as, but not limited to: growth hormones, infertility medications or cosmetic drugs, (other exclusions may apply);

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 PROCEDURES

Claim Filing and Appeal Procedures

The following Procedures explain various rules and time limitations for filing a Claim for benefits under the **City of Auburn** Plan ("Plan") and additional rules and time limitations for filing an appeal of a Claim that is wholly or partially denied and/or for filing an external review. For purposes of interpreting these Procedures, the following terms have the following meanings as those terms appear herein:

A. Definitions

Adverse Benefit Determination means any Claim denial or partial denial.

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 1A. 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 pre-certification 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 Plan.

Claimant means any individual filing a Claim under the Plan pursuant to these Procedures. The rights of a Claimant under this Section 1A can be exercised by a Claimant's Authorized Representative.

Concurrent Care Claims means a Claim for 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 Internal Review Organization that has contracted with the Plan or the Plan's Supervisor which as organization has received applicable accreditation.

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.

Rescission means any retroactive termination of coverage other than retroactive termination involving an act of fraud or intentional misrepresentation of a material fact.

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.

B. Initial Claim Filing Requirements

1. How to file a Claim.

   All Claims must be filed with the Claims Adjudicator as designated on the insurance ID 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

   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 fifteen (15) days if the Claims Adjudicator determines that additional time is necessary due to matters outside the control of the Claims Adjudicator

   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 (5) 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); and

f. Upon request, provide all diagnostic or treatment codes given by a provider (and information involving interpretation of those codes) at no charge.

Notice of any adverse determination may be provided by the Plan via written or Electronic Notification, provided that an Electronic Notification will be sent via first class mail within seventy-two hours from the date it is originally received.

C. 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, as defined in the summary plan description. 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:

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

2. **Time Limitation for Filing Appeal.** All Claims which are wholly or partially denied may be appealed pursuant to the Procedures set forth below. All appeals must be file 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 Health Care Claims within 30 days from the date the Plan Administrator was notified of the appeal.

   c. Post-Service Health Care 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 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. After an appeal has been requested, coverage for any ongoing treatment or procedure shall remain covered by the Plan during the appeal process.

Any Claimant initiating an appeal shall, within ten (10) days after the appeal is initiated, 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 the health professional with the appropriate training and expertise. The health care professional who is consulted on appeal will not be the same Claimant who may have been consulted during the initial determination or subordinate of that Claimant. If the advice of a medical or vocation 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. **Plan Administrator's Right to Construe and Interpret Plan.** Making any Claim determinations or signing an appeal under these Procedures, the Plan document confers upon the Plan Administrator the discretion to construe and interpret the terms of the Plan and determine eligibility for benefits.

6. **Time Limitation for Filing Claimant Action.** Subject to other limitations contained in these Claim Filing and Appeal 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 date the Appeal decision of the Plan Administrator is rendered. 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.

SECTION 8. 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 insured'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;
2. Other Inpatient Facility

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 Certification/Pre-Certification, the Pre-Certification Penalty, as shown in the Schedule of Benefits, will apply. This penalty Deductible is in addition to any other Deductible or Co-payment under the Plan.

If Hospital Utilization Review is Not Used by the Covered Member, the following applies

1. 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 (3) days and the covered Person stays in the Hospital for four (4) days, the additional day's charges will not be covered by the Plan.

Certification/Pre-Certification

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.

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: The Plan Administrator provides a Large Case Management program to assist the Participant in obtaining needed medical care from the most appropriate source available.

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 and 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 primary 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

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: Any of the following providing medical or dental benefits or services:

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 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 (2) 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.

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 their 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 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 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 recover right's 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. 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 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 their 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 their 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.

Rights of Recovery

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

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 under this Plan while on such leave (provided that required contributions, if any, are made by or on behalf of that Eligible Employee).

The continuation of coverage Provision (COBRA) outlined in the Plan will apply on the earliest of:

1. the date that the Employee informs the Employer of his 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 COBRA 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 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.

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.

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 COBRA 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. 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.

<u>HIPAA Security Standards</u>

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. DEFINITIONS

Accident

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

Active Full-Time

All Employees who normally work the number of hours and are included in the employment classification set forth in the Schedule of Benefits..

Actively at Work

The active expenditure of time and energy by an Employee while an Active Full Time Employee of the Employer, regardless of the reason for the Employee's absence and regardless of whether the absence is related to the Employee's health status.

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 6.1 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 Plan Year deductible which are to be paid by the Employee.

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

Refers to a Calendar Year. Such 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 for health care benefits 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

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

Calendar Year

A period of time commencing on January 1 and ending on December 31 of the same given 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

The Claims Adjudicator (or Third Party Administrator) is Employee Plans, LLC, 1111 Chestnut Hills Parkway, Fort Wayne, Indiana 46814.

Clinical Trial

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

An acronym which stands for Consolidated Omnibus Budget Reconciliation Act. It refers to Continuation of Coverage provisions which are now mandated by this Federal law.

Cognitive Therapy

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

Co-Insurance

The percentage in the Schedule of Benefits as provided in 2.1 used to compute the amount of Covered Expenses payable by the Covered Person, when the Plan states that a percentage is payable.

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.

Contributory Coverage

Group Plan benefits for which an Employee enrolls and agrees to make any required contributions toward the cost of coverage.

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

The charge which the Covered Person is required to pay for certain health services provided under the Plan. The Covered Person is responsible for Co-payment to the medical provider at the time of service.

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 5.

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

"Custodial Care" is 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 of Covered Expenses not payable under the Plan which must be incurred during a Benefit Period before any other Eligible Expenses incurred during the Benefit Period can be considered for payment according to the applicable Benefit Percentage.

Dependent

Dependent is any one of the following persons:

1. A covered Employee's Spouse and Children from birth to the limiting age of 26 years. Coverage will end at the end of the month of the Child's 26th birthday.

   The term "Spouse" shall mean the Employee's legally recognized marital partner (of the opposite sex). The Spouse must reside in same country as the covered Employee. The Plan Administrator may require documentation proving a marital relationship.

The term "Children" shall include natural Children, Stepchildren, adopted Children or Children placed in the covered Employee's home in anticipation of adoption.

The term "Children" shall also include a child for whom the Employee has been granted legal guardianship, who lives in the Employees household, and who is Primarily Dependent Upon the covered Employee.

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a Plan Participant who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.

2. A covered Dependent Child who is incapable of self-sustaining employment by reason of physical or Intellectual Disability, Primarily Dependent Upon the covered Employee for support and maintenance. The Plan Administrator may require, at reasonable intervals during the two (2) years following the Dependent's reaching the limiting age, subsequent proof of the child's disability and dependency.

   After such two (2) year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is eligible for coverage under the Plan as an Employee.

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 husband and wife are Employees, they may be covered as either an Employee or as a Dependent. Eligible Dependent children will be covered as Dependents under either the husband or wife, 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.

Emergency Care

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 person who is engaged in Active Full-Time employment by the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer

Means City of Auburn

Enrollment Date

The first day of the Waiting Period for eligibility, or for persons enrolling through a Special Enrollment period under HIPAA, the first day of coverage.

ERISA

The Employee Retirement Income Security Act of 1974 as amended.

Essential Health Benefits

The benefits designated by the State of Alabama as "essential benefits", as that term is defined in 42 USC 1802 and listed in the Essential health Benefits Section.

Benefits including 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 § 1302 of the Patient Protection and Affordable Care Act (P.L. 111-148, enacted March 23, 2010).

Experimental Treatments, Procedures, Drugs and Devices

A drug, device, treatment or procedure which 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, devise, 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, its efficacy, 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.

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.

Family Coverage

Coverage for the Participant and his or her Dependents under the Plan.

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.

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, and the Covered Person is approved for a Hospice program by the Employer. 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 by the Employer 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, 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.

Intellectual Disability

A condition which 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. This definition does not include any intentionally self-inflicted Injury; whether sane or insane.

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.

Late Enrollee

Any individual who does not enroll in this Plan when first eligible unless they experience a Special Enrollment event.

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 Emergency

The sudden onset of severe medical symptoms that:

1. could not have been reasonably anticipated; and
2. require immediate medical treatment.

Medically Necessary

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 Part A and Part B plans described in Title XVIII of the United States Social Security Act, as amended from time to time.

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.

Non-Contributory Coverage

Group Plan benefits for which the Employee enrolls and for which he is not required to make contributions toward the cost of coverage.

Occupational Therapy

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

Off-Label Drug Use

The use of a drug for purpose other than for which it was approved by the FDA.

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.

Participant

An Employee satisfies the Eligibility requirements set forth in the Schedule of Benefits and 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 Documents

The Plan Document and the reinsurance contract contain all the provisions of the plan and govern its legal operations.

Plan Year

The 12-month period specified in the Schedule of Benefits

Primarily Dependent Upon

An individual is Primarily Dependent Upon another person if that other person provides more than half of the financial support for the individual during a Calendar Year.

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 Services

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, or clinical Social Worker who is licensed as such

under all applicable local, state and federal laws or regulations, which services and treatment care related 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 Plan Participant's child (alternate recipient) to receive benefits under the same Plan providing coverage to the Plan Participant. To be a "qualified" order, the following information must be included:

1. The name and last known address of the Plan 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

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.

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.

Special Enrollment

Any individual who within 30 days after: (i) the date an Employee acquires a new Dependent; (ii) the date an Employee loses coverage under the Employee's spouse's group health plan because of the spouse's ineligibility; (iii) the date a Covered Person's COBRA coverage under another group plan is exhausted; or (iv) the date the Employee's spouse terminates health plan coverage because the spouse's employer completely eliminates any employer subsidy for the group health plan, or (v) any other event identified in 29 USC 1181(f). Additionally, any individual who enrolls within sixty (60) days after the individual (Employee or Dependent) (i) is covered under a Medicaid or a state's Children's Health Insurance Program ("CHIP") and the CHIP coverage of the Employee or Dependent under the Medicaid or CHIP plan is terminated as a result of loss of eligibility for such coverage or (ii) becomes eligible for a premium assistance subsidy with respect to coverage under this Plan, and the Employee requests coverage under the Plan within 60 days after the date the Employee or Dependent is determined to be eligible for the premium assistance subsidy.

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.

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)

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; or

3. the "reasonable" fee which is the fee charged for unusual circumstances involving medical complications, requiring additional time, skill and experience.

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 Benefits as provided in Section 2 during which time a Participant must be a continuous, active, Full-Time, permanent Employee of the Plan Sponsor prior to becoming eligible for coverage under this Plan.

Well-Baby Care

Medical treatment, services or supplies rendered to an infant solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

SECTION 15. PLAN INFORMATION

Plan Name and Identification Number

CITY OF AUBURN HEALTH PLAN

Employer Identification Number: 35-6000943

The Plan Number assigned by the company: 501

Plan Sponsor and Plan Administrator:

City of Auburn
210 E. 9th Street
Auburn, IN 46700

Telephone: (260) 925-6450

Claims Adjudicator:

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

The Plan Administrator is liable for all benefits under the Plan.

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 Benefits.

Funding the 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 Dates: January 1, 2009; July 1, 2011; July 1, 2014; July 1, 2015

SECTION 16. 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)

SECTION 16. SIGNATURE PAGE

APPROVED AND ACCEPTED

IN WITNESS. Whereof, this document is executed at:

Auburn (City), Indiana (State) on 10/28/2015 (Date)

By: Patricia M Miller
(Name)

Clerk-Treasurer
(Title)

ON BEHALF OF:

City of Auburn
(Name of Plan)

Tamara Shipe
(Witness)

Auburn Indiana 10/28/2015