PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

CITY OF FINDLAY EMPLOYEE BENEFIT PLAN

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INTRODUCTION

This document is a description of CITY OF FINDLAY EMPLOYEE BENEFIT PLAN (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Para obtener asistencia en Espanol, llame al (800) 229-2210.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 229-2210.
Chinese: (800) 229-2210.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 229-2210.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other Utilization Review requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any applicable collective bargaining agreement, as well as a list of Participating Employers, may be obtained, upon request and free of charge, by contacting the Plan Administrator during normal business hours.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Utilization Review Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

MEDICAL SCHEDULE OF BENEFITS

Verification of Eligibility
(800) 229-2210

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

Note: The following services must be precertified or reimbursement from the Plan may be denied.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

<u>These services must be pre-certified</u>:

- **Hospitalizations**
- **Skilled Nursing Facility stays**
- **Human Organ Transplants**
- **Substance Abuse/Mental Disorder treatments (IP/IOP only)**

Please see the Utilization Review section in this booklet for details.

The Plan is a plan which contains Network Provider Organizations.

NWOHP - Hancock & Seneca Counties
NWOHP Choice PPO
www.ohiohealthchoice.com/nwohp
Customer Service: 800.554.0027

FRONTPATH - NW Ohio
frontpath HEALTH COALITION
419-891-5206 or 888-232-5800
www.frontpathcoalition.com

OhioHealth Choice - All other OH counties
Ohio Health Choice
Preferred Health Choice
www.ohiohealthchoice.com
Customer Service: 800.554.0027

FIRST HEALTH - Outside Ohio First Health Network www.firsthealth.com 800.226.5116

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Covered Person does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider. However, the health care professional may be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or ancillary services (e.g. anesthesiologists, radiologists, pathologists, etc.) by a Non-Network Provider at an In-Network facility.

If a Covered Person receives services at The Center for Oral & Maxillofacial Surgery, Bradley A. Gregory, DMD or John D. Erdeijac, DDS

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Deductibles/Copayments/Out-of-Pocket Maximums payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. On the first day of each Calendar Year, a new deductible amount is required.

HDHP Plan: The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by covered family members during a Calendar Year. When selecting family coverage, the entire family Deductible must be satisfied by one individual or collectively before benefits will be paid at the Coinsurance rate.

Core Plan: The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not apply toward the Plan deductible or Out-of-Pocket maximum, but do apply toward the Total Maximum Cost Share as designated by the Affordable Care Act.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

HDHP Plan: The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied, by one individual or collectively, before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.

Core Plan: The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out- of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Charges over Usual and Customary Charges for Non-Participating Providers.

(2) Charges this Plan does not cover.

(3) Dental and vision benefits, other than those dental and vision expenses paid under the major medical component of the Plan.

(4) Core Plan only: Prescription Drug Copays. (Prescription Drug Copays apply toward the Out-of-Pocket Maximum for the HDHP Plan.)

Reimbursement for these non-accumulating expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

Integration of Deductibles and Out-of-Pocket Maximums
If you use a combination of Participating Providers and Non-Participating Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid will not exceed the amount shown for Non-Participating Providers. In other words, the amount of the Deductible expense and Out-of-Pocket Maximum you pay for both Participating Providers and Non-Participating Providers will be combined and the total will not exceed the amount shown for Non-Participating Providers during a single Calendar Year.

CORE PLAN
SCHEDULE OF BENEFITS

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	UNLIMITED	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers. **NETWORK AND NON-NETWORK DEDUCTIBLE AND COINSURANCE CHARGES WILL BE INTEGRATED.**		
DEDUCTIBLE, PER CALENDAR YEAR		
Employee Only	$600	$600
Employee Plus One	$1,200	$1,200
Family	$1,800	$1,800
COPAYMENTS		
Urgent Care	$50	$50
Emergency Room	$150	$150
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR Including Deductible and Coinsurance		
Per Employee Only	$1,200	$2,100
Per Employee Plus One	$2,400	$3,600
Per Family Unit	$3,600	$6,300
CO-INSURANCE		

The Plan will pay the designated coinsurance percentage of Covered Charges until Out-of-Pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. *Under ACA, a member may spend no more than **$7,900 individual and $15,800 family** for all out-of-pocket costs including medical and prescription copayments, deductible, and coinsurance beginning January 1, 2019. This is called the **Total Maximum Cost Share** and will follow limits designated by the ACA for future Plan years.*

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.
Cost containment penalties Non-covered Services

COVERED CHARGES ***Note: Benefits are payable as shown below. However, to the extent that a service is specifically described in the Summary of Benefits and Coverage and it is not specifically addressed below, benefits will be payable at the levels shown in the Summary of Benefits and Coverage.***		
Hospital Services		
Room and Board	80% after deductible the semiprivate room rate	60% after deductible the semiprivate room rate
Intensive Care Unit	80% after deductible Hospital's ICU Charge	60% after deductible Hospital's ICU Charge
Emergency Room	100% after $150 copayment not subject to deductible	
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital or placed in a room for observation.		
Urgent Care Center	100% after $50 copayment	
Skilled Nursing Facility	80% after deductible	60% after deductible
Diagnostic Services – *See also Preventive Services*		
Endoscopic Services	80% after deductible	60% after deductible
Diagnostic Services in office (Laboratory, X-rays, Medical Tests)	80% after deductible	60% after deductible
Diagnostic Services at facility (Laboratory, X-rays, Medical Tests)	80% after deductible	60% after deductible
Diagnostic Services (CT, MRI/MRA, Nuclear Medicine, Mammography including 3D)	80% after deductible	60% after deductible

IMPORTANT NOTE REGARDING LABS: *You can search for nationally recognized and independent labs by using network information on page 1.*

CORE PLAN
SCHEDULE OF BENEFITS

	NETWORK	NON-NETWORK
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Office visits ♦	80% after deductible	60% after deductible
♦ Physician Services, when received through **TelaDoc** ® covered at 100% not subject to deductible.		
Surgery	80% after deductible	60% after deductible
Surgery in Office	80% after deductible	60% after deductible
Allergy testing	80% after deductible	60% after deductible
Allergy serum and injections	80% after deductible	60% after deductible
Inpatient Prescription Drugs	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Outpatient Private Duty Nursing	80% after deductible 100 Visits Calendar Year maximum	60% after deductible 100 Visits Calendar Year maximum
Hospice Care	80% after deductible	60% after deductible
Bereavement Couseling	80% after deductible	60% after deductible
Ambulance Service Medical Emergency	80% after deductible	
Ambulance Service Medical Non-Emergency	80% after deductible	60% after deductible
Wig After Chemotherapy	80% after deductible	60% after deductible
Speech Therapy *Additional visits may be allowed if deemed Medically Necessary.*	80% after deductible 10 Visits Calender Year maximum	60% after deductible 10 Visits Calender Year maximum
Physical Therapy *Additional visits may be allowed if deemed Medically Necessary.*	80% after deductible 10 Visits Calender Year maximum	60% after deductible 10 Visits Calender Year maximum
Occupational Therapy	80% after deductible	60% after deductible
Spinal Manipulation	80% after deductible 10 Visits Calender Year maximum	60% after dedutctible 10 Visits Calender Year maximum
Cardiac Rehabilitation	80% after deductible	60% after deductible
Pulmonary Rehabilitation	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Ostomy Supplies	80% after deductible	60% after deductible
Diabetic Education, Training, And Supplies ⩘	80% after deductible	60% after deductible
Neurobiological Disorders/ Autism Spectrum Disorder Services (Diagnosis Only)	80% after deductible	60% after deductible
Temporomandibular Joint Dysfunction (TMJ)	80% after deductible	60% after deductible
Accident Only Dental Services	80% after deductible	60% after deductible
Mental Disorders/Substance Abuse		
Inpatient	80% after deductible	60% after deductible
Partial Hospitalization	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Human Organ Transplant	80% after deductible	60% after deductible
Infertility (Diagnosis Only)	80% after deductible	60% after deductible
Pregnancy	80% after deductible	60% after deductible

⩘ ***IMPORTANT NOTE REGARDING DIABETIC SUPPLIES:*** *Diabetic Testing Supplies are covered under the plan with no member cost share. You can purchase these diabetic testing supplies through CVS/Caremark with your doctor's prescription or through a NETWORK Durable Medical Equipment (DME) Provider: Alcohol wipes, Lancets, Lancet Devices, Strips (Diagnostic), Syringes. Deductible and coinsurance apply if purchased through Non-Network provider.*

CORE PLAN
SCHEDULE OF BENEFITS

	NETWORK	NON-NETWORK
Preventive Care		
Routine Well Adult Care*	100% not subject to deductible	60% after deductible
Screening Tests	Standard Preventive tests Cholesterol, High Blood Pressure, Diabetic, routine physical examination, prostate (PSA), x-rays, laboratory tests, STI and HIV screening and counseling, tobacco cessation program, colonoscopies, bone density scans, stress tests and sigmoidoscopies.	
	https://www.healthcare.gov/what-are-my-preventive-care-benefits/	
Immunizations	Hepatitis A, Hepatitis B, HIB, HPV, MMR, HIV, DTP, Pneumococcal, Shingles and Flu Shots.	
	http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf	
Women's Preventive	Mammography, Thermography (3D), gynecological exam, PAP, HPV screening, pregnancy related screenings, breast feeding support and supplies, Contraceptive coverage (prescriptions subject to prescription plan copayment if applicable.)	
	https://www.healthcare.gov/what-are-my-preventive-care-benefits/women	
Routine Well Child Care*	100% not subject to deductible	60% after deductible
Screening Tests	Standard Preventive tests, routine physical examination, x- rays, laboratory tests, vision tests, newborn hearing screening, developmental screening.	
	https://www.healthcare.gov/what-are-my-preventive-care-benefits/children	
Immunizations	DTaP, HIB, Hepatitis A, Hepatitis B, HPV, RV, IPV, MCV, PCV, Pneumococcal, Flu Shots.	
	http://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf http://www.cdc.gov/vaccines/who/teens/downloads/parent-version-schedule-7-18yrs.pdf	

*Other preventive care and services required by applicable law if provided by a Network Provider.
*Preventive Care and Screening Services and Immunizations for children, adolescents and adults that:
-- have a rating of A or B in the current United States Preventive Services Task Force recommendations, or
-- are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or
-- are provided for in comprehensive guidelines supported by the Health Resources and Services Admin., with respect to the individual
--are included in the Women's Preventive Services outline by the Dept. of Health and Human Services

Please consult the recommendations and guidelines for age, frequency and other guidelines.
You may also call 800-229-2210 to obtain a no-cost paper copy from Enterprise Group Planning, Inc.

Frequency limits for preventive mammogram:
Ages 35-40 and over Limited to one (1) per two year calendar year,
Ages 40 and over Limited to one (1) per calendar year;

Frequency limits for pap smear (Cytologic Screenings): One (1) per calendar year

Frequency limits for Colon/Rectal exam, Colonoscopy, and Prostate Screening:
Ages 50 and over Limited to one (1) per calendar year

Frequency limits for Routine Vision exam: One (1) per every calendar year through age 19.
See Vision Benefits section for Adult exams.

Frequency limits for Routine Hearing exam: One (1) per every calendar year

CORE PLAN
PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
NOTE: The Covered Person will be reimbursed 75% of the cost of the drug purchased less the applicable Copay if Prescription Drugs are obtained from a Non-Participating Provider.	
Retail Pharmacy: 30-day supply	
Over-the-Counter Drug	$0 Copay, then 100%
Generic Drug	$10 Copay, then 100%
Formulary Drug	$20 Copay, then 100%
Non-Formulary Drug	$40 Copay, then 100%
Specialty Drug (limited to 30 day supply)	$120 Copay, then 100%
Preventive Drug	$0 Copay, then 100%
Diabetic Supplies (lancets and test strips)	$0 Copay, then 100%
Mail Order Pharmacy: 90-day supply	
Over-the-Counter Drug	$0 Copay, then 100%
Generic Drug	$20 Copay, then 100%
Formulary Drug	$40 Copay, then 100%
Non-Formulary Drug	$80 Copay, then 100%
Preventive Drug	$0 Copay, then 100%
Diabetic Supplies (lancets and test strips)	$0 Copay, then 100%

NOTE: All Prescription Drugs are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)

Mandatory Maintenance Program
This Plan allows for 2 refills of a maintenance drug at a retail pharmacy. All refills for maintenance drugs after 2 refills for name brand (non-generic) at a retail pharmacy will be required to be filled in a 90 day supply through the mail order, or a local CVS or Target pharmacy.

Preventive Drug means a list of Prescription Drugs, FDA approved contraceptive devices and FDA approved over- the-counter medications (including over-the-counter emergency contraceptives) when prescribed by a Physician, which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. The term “Preventive Drug” does not include abortifacient drugs or over-the-counter contraceptives (other than FDA approved over-the counter emergency contraceptives) regardless of whether or not such items are prescribed by a Physician. Please contact the Prescription Drug Card Program Administrator for a complete listing of the Preventive Drugs covered under this Plan and any restrictions on the available drugs. You may also view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

NOTE: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age.

HDHP PLAN
SCHEDULE OF BENEFITS

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	UNLIMITED	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers. **NETWORK AND NON-NETWORK DEDUCTIBLE AND COINSURANCE CHARGES WILL BE INTEGRATED.**		
DEDUCTIBLE, PER CALENDAR YEAR** ***Maximum family deductible.(Aggregate) Family deductible must be met before benefits are provided on a family contract.*		
Employee Only	$1,500	$1,500
Employee Plus One	$3,000	$3,000
Family	$3,000	$3,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR Including Deductible and Coinsurance		
Per Employee Only	$2,500	$2,500
Per Employee Plus One	$6,000	$6,000
Per Family Unit	$6,000	$6,000
CO-INSURANCE		

The Plan will pay the designated coinsurance percentage of Covered Charges until Out-of-Pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. *Under ACA, a member may spend no more than **$7,900 individual and $15,800 family** for all out-of-pocket costs including medical and prescription copayments, deductible, and coinsurance beginning January 1, 2019. This is called the **Total Maximum Cost Share** and will follow limits designated by the ACA for future Plan years.*

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.
Cost containment penalties Non-covered Services

COVERED CHARGES ***Note: Benefits are payable as shown below. However, to the extent that a service is specifically described in the Summary of Benefits and Coverage and it is not specifically addressed below, benefits will be payable at the levels shown in the Summary of Benefits and Coverage.***		
Hospital Services		
Room and Board	80% after deductible the semiprivate room rate	60% after deductible the semiprivate room rate
Intensive Care Unit	80% after deductible Hospital's ICU Charge	60% after deductible Hospital's ICU Charge
Emergency Room	80% after deductible	
Urgent Care Center	80% after deductible	
Skilled Nursing Facility	80% after deductible	60% after deductible
Diagnostic Services – *See also Preventive Services*		
Endoscopic Services	80% after deductible	60% after deductible
Diagnostic Services in office (Laboratory, X-rays, Medical Tests)	80% after deductible	60% after deductible
Diagnostic Services at facility (Laboratory, X-rays, Medical Tests)	80% after deductible	60% after deductible
Diagnostic Services (CT, MRI/MRA, Nuclear Medicine, Mammograms including 3D)	80% after deductible	60% after deductible

IMPORTANT NOTE REGARDING LABS: *You can search for nationally recognized and independent labs by using network information on page 1.*

HDHP PLAN
SCHEDULE OF BENEFITS

	NETWORK	NON-NETWORK
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Office visits ♦	80% after deductible	60% after deductible
♦ Physician Services, when received through **TelaDoc** ® covered at $40 copay which can be applied toward deductible.		
Surgery	80% after deductible	60% after deductible
Surgery in Office	80% after deductible	60% after deductible
Allergy testing	80% after deductible	60% after deductible
Allergy serum and injections	80% after deductible	60% after deductible
Inpatient Prescription Drugs	80% after deductible	60% after deductible
Outpatient Prescription Drugs	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Outpatient Private Duty Nursing	80% after deductible 100 Visits Calendar Year maximum	60% after deductible 100 Visits Calendar Year maximum
Hospice Care	80% after deductible	60% after deductible
Bereavement Couseling	80% after deductible	60% after deductible
Ambulance Service Medical Emergency	80% after deductible	
Ambulance Service Medical Non-Emergency	80% after deductible	60% after deductible
Wig After Chemotherapy	80% after deductible	60% after deductible
Speech Therapy *Additional visits may be allowed if deemed Medically Necessary.*	80% after deductible 10 Visits Calender Year maximum	60% after deductible 10 Visits Calender Year maximum
Physical Therapy *Additional visits may be allowed if deemed Medically Necessary.*	80% after deductible 10 Visits Calender Year maximum	60% after deductible 10 Visits Calender Year maximum
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Pulmonary Rehabilitation	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Ostomy Supplies	80% after deductible	60% after deductible
Diabetic Education, Training, And Supplies ⮙	80% after deductible	60% after deductible
Neurobiological Disorders/ Autism Spectrum Disorder Services (Diagnosis Only)	80% after deductible	60% after deductible
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Accident Only Dental Services	80% after deductible	60% after deductible
Mental Disorders/Substance Abuse		
Inpatient	80% after deductible	60% after deductible
Partial Hospitalization	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Human Organ Transplant	80% after deductible	60% after deductible
Infertility (Diagnosis Only)	80% after deductible	60% after deductible
Pregnancy	80% after deductible	60% after deductible

⮙ ***IMPORTANT NOTE REGARDING DIABETIC SUPPLIES:*** *Diabetic Testing Supplies are covered under the plan with no member cost share. You can purchase these diabetic testing supplies through CVS/Caremark with your doctor's prescription or through a NETWORK Durable Medical Equipment (DME) Provider: Alcohol wipes, Lancets, Lancet Devices, Strips (Diagnostic), Syringes. Deductible and coinsurance apply if purchased through Non-Network provider.*

HDHP PLAN
SCHEDULE OF BENEFITS

	NETWORK	NON-NETWORK
Preventive Care		
Routine Well Adult Care*	100% not subject to deductible	60% after deductible
Screening Tests	Standard Preventive tests Cholesterol, High Blood Pressure, Diabetic, routine physical examination, prostate (PSA), x-rays, laboratory tests, STI and HIV screening and counseling, tobacco cessation program, colonoscopies, bone density scans, stress tests and sigmoidoscopies.	
	https://www.healthcare.gov/what-are-my-preventive-care-benefits/	
Immunizations	Hepatitis A, Hepatitis B, HIB, HPV, MMR, HIV, DTP, Pneumococcal, Shingles and Flu Shots.	
	http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf	
Women's Preventive	Mammography, Thermography (3D), gynecological exam, PAP, HPV screening, pregnancy related screenings, breast feeding support and supplies, Contraceptive coverage (prescriptions subject to prescription plan copayment if applicable.)	
	https://www.healthcare.gov/what-are-my-preventive-care-benefits/women	
Routine Well Child Care*	100% not subject to deductible	60% after deductible
Screening Tests	Standard Preventive tests, routine physical examination, x- rays, laboratory tests, vision tests, newborn hearing screening, developmental screening.	
	https://www.healthcare.gov/what-are-my-preventive-care-benefits/children	
Immunizations	DTaP, HIB, Hepatitis A, Hepatitis B, HPV, RV, IPV, MCV, PCV, Pneumococcal, Flu Shots.	
	http://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf http://www.cdc.gov/vaccines/who/teens/downloads/parent-version-schedule-7-18yrs.pdf	

*Other preventive care and services required by applicable law if provided by a Network Provider.
*Preventive Care and Screening Services and Immunizations for children, adolescents and adults that:
-- have a rating of A or B in the current United States Preventive Services Task Force recommendations, or
-- are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or
-- are provided for in comprehensive guidelines supported by the Health Resources and Services Admin., with respect to the individual
--are included in the Women's Preventive Services outline by the Dept. of Health and Human Services

Please consult the recommendations and guidelines for age, frequency and other guidelines.
You may also call 800-229-2210 to obtain a no-cost paper copy from Enterprise Group Planning, Inc.

Frequency limits for preventive mammogram: Ages 35-40 and over Limited to one (1) per two year calendar year, Ages 40 and over Limited to one (1) per calendar year
Frequency limits for pap smear (Cytologic Screenings): One (1) per calendar year
Frequency limits for Colon/Rectal exam, Colonoscopy, and Prostate Screening: Ages 50 and over Limited to one (1) per calendar year
Frequency limits for Routine Vision exam: One (1) per every calendar year through age 19. See Vision Benefits section for Adult exams.
Frequency limits for Routine Hearing exam: One (1) per every calendar year

HDHP PLAN
PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
NOTE: The Covered Person will be reimbursed 75% of the cost of the drug purchased less the applicable Deductible and Coinsurance if Prescription Drugs are obtained from a Non-Participating Provider.	
Calendar Year Deductible: **(**combined with major medical Deductible)	Single $1,500 Family $3,000
Calendar Year Out-of-Pocket Maximum: (combined with major medical Out-of-Pocket)	Single $6,350 Family $12,700
Retail Pharmacy: 30-day supply	
Over-the-Counter Drug	$0 Copay after Deductible
Generic Drug	$10 Copay after Deductible
Formulary Drug	$20 Copay after Deductible
Non-Formulary Drug	$40 Copay after Deductible
Specialty Drug (limited to 30 day supply)	$120 Copay after Deductible
Preventive Drug	100% (Deductible and Copay waived)
Diabetic Supplies (lancets and test strips)	$0 Copay after Deductible
Mail Order Pharmacy: 90-day supply (Optional)	
Over-the-Counter Drug	$0 Copay after Deductible
Generic Drug	$20 Copay after Deductible
Formulary Drug	$40 Copay after Deductible
Non-Formulary Drug	$80 Copay after Deductible
Preventive Drug	100% (Deductible and Copay waived)
Diabetic Supplies (lancets and test strips)	$0 Copay after Deductible

NOTE: All Prescription Drugs are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)

Voluntary Maintenance Program
This Plan allows for drugs to be filled in a 90 day supply through the mail order, or a local CVS or Target pharmacy.

Preventive Drug means a list of Prescription Drugs, FDA approved contraceptive devices and FDA approved over- the-counter medications (including over-the-counter emergency contraceptives) when prescribed by a Physician, which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. The term “Preventive Drug” does not include abortifacient drugs or over-the-counter contraceptives (other than FDA approved over-the counter emergency contraceptives) regardless of whether or not such items are prescribed by a Physician. Please contact the Prescription Drug Card Program Administrator for a complete listing of the Preventive Drugs covered under this Plan and any restrictions on the available drugs. You may also view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

NOTE: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age.

DENTAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT (Subject to Usual and Customary Charges)
PRE-DETERMINATION LIMIT	$200
CALENDAR YEAR DEDUCTIBLE Single Family	 $25 $50
CLASS A, B AND C EXPENSES COMBINED CALENDAR YEAR MAXIMUM BENEFIT	$1,000 per Covered Person
CLASS D ORTHODONTIC LIFETIME MAXIMUM BENEFIT (Coverage is provided only for Covered Persons under age 19)	$1,000 per Covered Person
DENTAL BENEFITS	
Class A-Preventive Services	100% (Deductible waived)
Class B-Basic Services	80% after Deductible
Class C-Major Services	50% after Deductible
Class D-Orthodontic Services	60% after Deductible
THIS PLAN DOES NOT HAVE A DENTAL NETWORK REQUIREMENT.	

NOTE: The dental benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. You have a separate right to enroll in the dental benefits under the Plan. If you choose to enroll in such dental benefit, you will be charged an employee contribution amount that is separate from what you are charged for any other benefit offered under the Plan. The amount of any employee contribution will be communicated to you prior to the annual open enrollment period.

VISION SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
Eye exam, one exam per Calendar Year	100% up to $75 maximum
Lenses, per pair, per Calendar Year	
Single vision	100% up to $75 maximum
Bifocal	100% up to $100 maximum
Trifocal	100% up to $125 maximum
Lenticular	100% up to $150 maximum
Contact Lenses, one pair per Calendar Year (Medically Necessary)	100% up to $150 maximum
Contact Lenses, one pair per Calendar Year (Cosmetic)	100% up to $75 maximum
Frames, one pair every two Calendar Years	100% up to $130 maximum
THIS PLAN DOES NOT HAVE A VISION NETWORK REQUIREMENT.	

If the Covered Person is eligible to purchase new frames, but elects not to purchase new frames, then he or she may use the frame allowance shown above to be applied toward the cost of the lenses purchased, including contact lenses. The Covered Person must send a written statement to the Third Party Administrator to request that the frame allowance be applied toward the cost of the lenses purchased.

NOTE: The vision benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. You have a separate right to enroll in the vision benefits under the Plan. If you choose to enroll in such vision benefit, you will be charged an employee contribution amount that is separate from what you are charged for any other benefit offered under the Plan. The amount of any Employee contribution will be communicated to you by the Plan Administrator prior to the annual open enrollment period.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees.

A full-time union or non-union Employee of the Employer who regularly works 30 or more hours per week will be eligible to enroll for coverage under this Plan once he/she completes a waiting period of 30 days from the date he or she completes at least one hour of service with the Employer. Participation in the Plan will begin as of the first day of the month coinciding with or next following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Plan Administrator.

You are not eligible to participate in the Plan if you are a part-time, temporary, leased or seasonal employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency).

Union employees hired 1/1/2013 or after and non-union employees hired 11/1/2013 or after may only enroll in the HDHP. Employees that do not meet either of these requirements may elect either the Core or HDHP plans at open enrollment or at the time of a qualifying event.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered employee, if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's child will also include children, adopted children and children placed for adoption with the Employee's spouse. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the month of the child's birthday.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

(3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include children for whom the Employee or Spouse is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years. Coverage will end at the end of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

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 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 covered 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 deductibles and all amounts applied to maximums.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

When you and your Spouse are both Covered Employees

When both you and your Spouse are covered Employees, each of you must choose coverage as either an Employee or as a Dependent. You may not be covered under this Plan as both an Employee and a Dependent.

When both you and your Spouse are covered Employees, only one may cover Dependent children.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll each Dependent for coverage also

Enrollment Requirements for Newborn Children.
A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollment.

Timely Enrollment
Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 30 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you decline enrollment for you and/or your Dependents, you must provide a written statement to the Plan Administrator indicating that the reason you are declining enrollment is due to other health coverage. If you lose such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you and/or your Dependents a right to enroll in the Plan mid-year due to such loss of coverage. However, if you failed to submit such written statement when initially eligible, you will lose your right to this special mid-year enrollment opportunity.

If you fail to complete and submit the appropriate election and enrollment forms within the 30-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

Late Enrollment
If you did not enroll during your original 30-day eligibility period you may do so by making written application to the Plan Administrator during the annual open enrollment period (refer to annual open enrollment period section above). In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

Special Enrollment Event
A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

(1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following provided, however, you submitted a written statement to the Plan Administrator when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:

(a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

(b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or

(c) Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date you acquire such Dependent.

(a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such child's date of birth and will continue for the first 30 days after birth. If you wish to continue coverage beyond this 30-day period, you must complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after the child's birth. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan beyond the first 30 days after the child's birth.

(b) Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after your date of marriage. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.

(c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.

Status Change Event

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event. If a Status Change Event occurs you may make a new election under the Plan provided your new election is consistent with the Status Change Event. A Status Change Event includes the following:

(1) A change in your legal marital status, including divorce, legal separation or annulment;

(2) The death of your Spouse or Dependent Child;

(3) Termination or commencement of employment by you, your Spouse or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;

(4) A reduction or increase in your hours of employment or those of your Spouse or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;

(5) A change due to your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;

(6) A change in the place of residence or work of you, your Spouse or your Dependent Child;

(7) Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or your Dependent Child;

(8) Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;

(9) A change due to you, your Spouse or your Dependent Child gaining coverage under another employer's plan;

(10) A significant increase in the cost of your coverage under the Plan during the Plan Year. If the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose one of the following options: (a) maintain existing coverage and agree to pay the increased cost; (b) revoke your existing election and elect similar coverage under another Plan option (if any); or (c) drop coverage under the Plan, but only if there is no similar option available under the Plan;

(11) Addition or significant improvement of a Plan option. If the Plan adds a new option or significantly improves an existing option, you may revoke your existing election and elect coverage under the new option. Any eligible Employee, regardless of whether or not he/she elected coverage under the Plan previously, may elect coverage under any new option or significantly improved option for himself or herself and any eligible Dependents;

(12) Significant Curtailment of Coverage without Loss. If your coverage under the Plan is significantly curtailed without a loss of coverage (for example, a significant increase in the Out-of-Pocket maximum you are required to pay), you may revoke your existing election under the Plan and elect coverage under a similar Plan option, if any. If no similar option is available, then you must maintain your existing election until the end of the current Plan Year;

(13) Significant Curtailment of Coverage with Loss. If your coverage under the Plan is significantly curtailed with a loss of coverage (for example, elimination of a benefit option under the Plan), then you may either revoke your existing election under the Plan and elect coverage under a similar Plan option (if any) or drop your existing coverage provided there is no similar Plan option available; and

(14) Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including another plan maintained by the Employer or a plan maintained by the employer of your Spouse or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the Status Change Event. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.

Rehire Provision: Layoff
After you become covered under the Plan, if you are laid off and you are re-called by the Employer within the time frame outlined in the union contract or the civil service classification rules, your coverage will take effect on the first day of the month following the date you complete at least one hour of service with the Employer. The waiting period will be waived.

If you coverage resumes within the same Calendar Year, the Plan will consider coverage continuously in force for purposes of applying Deductible, Out-of-Pocket Maximum, and plan maximums.

If you were not covered under the Plan on the date of your layoff or you are rehired by the Employer outside of the time frame outlined in the union contractor the civil service classification rules, you will be treated as a new Employee and will be required to satisfy the waiting period.

Rehire Provision: Retire
An Employee who retires from a position and is then rehired to another position or the same position may remain on the health plan without having to satisfy the waiting period as long as he/she does not have a break in service.

If your coverage resumes within the same Calendar Year, the Plan will consider coverage continuously in force for purposes of applying Deductible, Out-of-Pocket Maximum, and plan maximums.

If you were not covered under the Plan on the date of your retirement or you are not rehired by the Employer with no break in service, you will be treated as a new Employee and will be required to satisfy the waiting period.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

Termination of Employee Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(3) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below;

(4) The end of the month in which you cease to be eligible for coverage under the Plan;

(5) The end of the month in which you terminate employment or cease to be included in an eligible class of Employees;

(6) The date of your death;

(7) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and

(8) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

Termination of Dependent Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) The date the Plan discontinues coverage for Dependents;

(3) The end of the month following the date your Dependent becomes enrolled as an Employee under the Plan;

(4) The date coverage terminates for the Employee;

(5) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(6) The date the Dependent Spouse reports to active military service;

(7) The end of the month in which a Dependent ceases to be a Dependent as defined by the Plan;

(8) The end of the month in which the Employee dies;

(9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; and

(10) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage
Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Continuation of Plan Coverage due to Layoff or Approved Leave of Absence
Medical, dental and vision coverage will be continued by your Employer for you and your Dependents in the event of layoff or an approved leave of absence. Coverage will continue as follows:

(1) In the event of a layoff, up to the end of the month following the date of layoff.

(2) In the event of an Employer-approved personal or medical leave of absence, your coverage will continue up to the end of the month following 90 days from the date the Employee begins such leave.

If your leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)
The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by your Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

Continuation of Coverage under State Family and Medical Leave Laws
To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Continuation of Coverage under USERRA
You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to the Plan Administrator within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. Your Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of militaryleave.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

OPEN ENROLLMENT

The annual open enrollment period will be a 30 day period designated by the employer. During open enrollment covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

CO-PAY:
The Co-Pay is an amount which must be paid by the covered individual per occurrence for the indicated benefits. The Co-Pay does not count towards satisfaction of the Out-of-Pocket Maximum.

Physician office visit Co-Pay includes office visit exam and related lab work, x-rays, surgery and injection/immunization services rendered by the same physician on the same date of service.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the confinement starts within 3 days of a Hospital confinement of at least 5 days; and

(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

(a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, x-ray and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery.

(b) **TelaDoc.** The Plan provides coverage for telephone consults or e-mail consults provided by a Physician for non-emergent care. Common examples of when to use TelaDoc for non-emergent medical care, include but are not limited to the following: care after office hours; care while on vacation; to refill a short term (non-DEA controlled) prescription; second opinions; and research and advice on a particular health condition. To utilize this service, please visit www.MyDrConsult.com. If you do not have internet service available, please call 1-800-362-2667 to utilize this service. If a prescription is requested, you will be required to complete an electronic medical record prior to receiving a consult. This electronic medical record is confidential and will be maintained by the TelaDoc program. For any questions with respect to the TelaDoc benefit, please contact the Plan Administrator. Coverage under this benefit does not include telephone or e-mail consults from your regular Physician; it only includes coverage for telephone or e-mail consults to the extent the Physician who is consulted participates in the TelaDoc program. The TelaDoc benefit is not available in the State of Oklahoma.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(c) Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge 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 procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 25% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

Charges for Private Duty Nursing Care are subject to the limits as described in the Schedule of Benefits.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient's death.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Allergy Services:** Allergy testing, serum and injections. Desensitization treatments are also covered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(b) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

Professional ground or air ambulance charges for convenience are not covered. Air ambulance is considered only when terrain, distance or condition warrants.

Eligible expenses will be payable as listed in the schedule of benefits.

(c) **Ambulatory Surgery Center:** Services and supplies provided by an Ambulatory Surgery Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(d) Administration of **anesthesia**, done in connection with a Covered Service, by a Physician or certified registered nurse anesthetist who is not the surgeon, the Assistant Surgeon or a hospital employee. This benefit includes care before and after the administration.

(e) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(f) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(g) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Charges made by a Chiropractor for treatment that is determined to be for maintenance, palliation, or excessive will not be considered eligible.

(h) Services and supplies related to **Circumcision**. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

(i) Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an Approved Clinical Trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to

pay in the absence of this coverage.

(j) Initial **contact lenses** or glasses required following cataract surgery.

(k) **Diabetic Self-Management** services will be covered subject deductible and coinsurance as listed in the Schedule of Benefits when prescribed by treating physician

(l) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(m) Treatment of a kidney disorder by **hemodialysis or peritoneal dialysis** as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit.

(n) Care, supplies and services for the diagnosis of **infertility**.

(o) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(p) **Massotherapy.** Expenses related to medically necessary massotherapy.

(q) **Maternity**. Expenses Incurred by all Covered Persons for:

(i) Pregnancy.

(ii) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(iii) Services provided by a Birthing Center.

(iv) One amniocentesis test per Pregnancy.

(v) Up to one ultrasound per Pregnancy (more than one, only when it is determined to be Medically Necessary).

(vi) Elective induced abortions.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If a newborn remains hospitalized beyond the time frames specified above, the confinement should be precertified or a penalty may be applied.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(r) Treatment of **Mental Disorders and Substance Abuse**. Regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate annual limit, financial requirement, out-of-network exclusion or non-quantitative treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

(i) All treatment is subject to the benefit payment limits shown in the Medical Schedule of Benefits.

(ii) Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

This includes the diagnosis of autism and the testing for ADD and ADHD.

(s) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

i. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

ii. Emergency repair due to Injury to sound natural teeth.

iii. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

iv. Excision of benign bony growths of the jaw and hard palate.

v. External incision and drainage of cellulitis.

vi. Incision of sensory sinuses, salivary glands or ducts.

vii. Removal of impacted teeth in a physician's office.

viii. No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc. or is necessary due to accidental Injury to sound natural teeth.

(t) **Nutritional Supplements.** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(u) **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy

(v) **Organ transplant** procedures**.**

(i) This Plan covers the Medically Necessary expenses for any type of medically recognized human organ or tissue transplant from a donor to a transplant recipient requiring surgical removal of the donated part, subject to the criteria and limitations outlined below in this Section. Included in this benefit are any evaluation tests required to determine the suitability of both potential and actual donors, and the costs of procurement.

A second opinion must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending physician's findings regarding the medical necessity of such procedure. The physician rendering the second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, approved by the Plan Administrator, and must not be affiliated in any way with the physician who will be performing the actual procedure.

(ii.) When both the transplant recipient and donor or potential donor are covered under this Plan, Transplant Benefits, provided they are Pre-Certified, will be provided for the recipient and the donor.

(iii) When the transplant recipient is covered under this Plan but the donor or potential donor is not, benefits will be provided for each to the extent that benefits to the donor or potential donor are not provided under any other medical-surgical coverage.

(iv) The following are the two (2) categories of transplants and how they will be treated with respect to this provision:

Category No. 1
The services and supplies associated with these procedures will be subject to an individual maximum Transplant Benefit as indicated in the Medical Schedule of Benefits payable on behalf of a Covered Person under this Plan. This maximum applies to all charges incurred as a result of the transplants. The procedures subject to this maximum are:

(a) Human organ or tissue transplants

(b) Bone marrow transplants, including any related high-dosage chemotherapy to treat cancerous conditions

(c) Cornea transplants

(d) Kidney transplants

Category No. 2
All other procedures not specifically mentioned in Category No. 1 are excluded and no benefits shall be paid for any charges associated with them.

(v) Exclusions and limitations:

(a) Human organ transplant services for which the cost is covered or funded by governmental, foundation or charitable grants are not covered. This includes services performed on potential or actual living donors, recipients, and cadavers. If any organ or tissue is sold rather than donated to the recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to the evaluation and procurement are covered up to this Plan's maximum benefit limitations.

(b) Human organ transplants that are considered EXPERIMENTAL / INVESTIGATIONAL and/or not accepted as a standard medical procedure are not Eligible Charges (as described in herein).

(c) To be considered an Eligible Charge under this Plan, the transplant procedure must meet the criteria established by Medicare for payment of benefits under Medicare. This criteria applies regardless of whether or not

the individual is covered by Medicare.

(d) Expenses that are in excess of the Usual and Reasonable charges are not Eligible Charges.

(w) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(x) **Physical Therapy** will be covered provided that the **therapy** services are:

(i.) for the rehabilitation of an acquired disability and are not primarily for maintenance; and

(ii.) likely to cause improvement in the Covered Person's Condition within 60 days of initial treatment and are concluded within 90 days of initial treatment.

(y) **Prescription** Drugs (as defined).

(z) **Podiatry.** Treatment for the following foot conditions:
(i) bunions, when an open cutting operation is performed
(ii) non-routine treatment of corns or calluses;
(iii) toenails when at least part of the nail root is removed; and
(iv) any Medically Necessary Surgical Procedure required for a foot condition, if done in connection with an underlying medical condition such as diabetes or hardening of the arteries.

In addition, orthopedic shoes when an integral part of a leg brace will also be covered, as well as orthotics prescribed for full-time wear and constructed through the means of a special mold or cast applied to the foot or feet are covered by the Plan.

(aa) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Medical Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  -Breastfeeding support, supplies, and counseling.
  -Gestational diabetes screening.

Standard Preventive Care includes women's contraceptives sterilization procedures, and counseling.

Standard Preventive Care includes some contraceptives and counseling but does not include abortifacients.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  -Diphtheria,
  -Pertussis,
  -Tetanus,
  -Polio,
  -Measles,
  -Mumps,
  -Rubella,
  -Hemophilus influenza b (Hib),
  -Hepatitis B,
  -Varicella.
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

(bb) Artificial limbs, eyes or other **Prosthetic Devices** when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered.

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(cc) **Pulmonary Therapy:** Pulmonary therapy under the recommendation of a Physician for which measurable improvement is expected within a reasonable period of time. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(dd) **Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(i) For the correction of a Congenital Anomaly for a Dependent Child.

(ii) Any other Medically Necessary Surgery related to an Illness or Injury.

(iii) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

a. reconstruction of the breast on which a mastectomy has been performed,

b. surgery and reconstruction of the other breast to produce a symmetrical appearance, and

c. coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(ee) **Speech therapy** by a licensed speech therapist that is expected to restore speech to an individual who has lost an existing speech function as the result of a disease or injury. Speech therapy for developmental delay or to change voice sound will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(ff) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license.

(gg) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(hh) Surgical and non-surgical treatment of **Temporomandibular Joint Dysfunction (TMJ).**

The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves and other tissues related to the temporomandibular joint. Treatment shall include, but is not limited to: orthodontics; physical therapy; and any appliance that is attached to or rests on the teeth.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(ii) **Tobacco Cessation Programs** shall be covered with no cost sharing as a Standard Preventive Care benefit if provided by In Network Providers.

(jj) Routine **vision** examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office once per two Plan Years. Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses under the medical benefit. See Vision section for details.

(kk) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal well-baby care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for routine well-baby nursery care for the first 1 days after birth while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child, provided the newborn child is enrolled on a timely basis.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges for routine well-baby care made by a Physician for the first pediatric visit to the newborn child after birth while Hospital confined.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child, provided the newborn child is enrolled on a timely basis.

(ll) Charges associated with the initial purchase of a **wig after chemotherapy**.

(mm) Diagnostic **X-rays**.

PRE-CERTIFICATION AND UTILIZATION & REVIEW

UTILIZATION REVIEW SERVICES PHONE NUMBER

AMERICAN HEALTH: 1-800-641-5566 Option 2

Please refer to the Employee ID card for the Utilization Review Services phone number.

The provider, patient or family member must call this number to receive certification of certain Utilization Review Services. This call must be made at least 5 days in advance of services being rendered or within 48 hours after a Medical Emergency.

Any costs incurred because of reduced or denied reimbursement due to failure to follow Utilization Review procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

<u>These services must be pre-certified</u>:
Hospitalizations
Substance Abuse/Mental Disorder treatments (IP/IOP)
Skilled Nursing Facility stays
Hospice Care

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency inpatient basis or receives the other medical services listed above, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 5 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment may be denied.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable as listed in the Medical Schedule of Benefits even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Charges for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis, will be paid at the rate as listed in the Medical Schedule of Benefits.

CASE MANAGEMENT

Case Management

A case manager consults with the patient, the family and the attending Physician 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:

- personal support to the patient;
- contacting the family to offer assistance and support;
- collaborative planning with physician, patient, family to establish patient-centered goals;
- facilitation of positive communication among all parties;
- assurance of quality and appropriateness of care;
- prevention of fragmentation or duplication of care (assure that specialist providers are appropriately communicating);
- coordination of care from diagnosis through rehabilitation;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options;
- assisting in obtaining any necessary equipment and services, including home care;
- identification of beneficial community resources.

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

Alternate Benefit Program

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

The Alternate Benefit program may be implemented when this benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Alternate Benefit program by providing guidance and information on available resources and the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the Alternate Treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

(1) **Acupuncture:** Expenses for acupuncture or oriental pain control will not be considered eligible, except if Medically Necessary and under the supervision of a Physician.

(2) **Adoption:** Expenses related to adoption will not be considered eligible.

(3) **Armed forces of a government.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any Covered Person in the armed forces of a government.

(4) **Autism**. Expenses for the treatment of Autism will not be covered.

(5) **Biofeedback:** Expenses related to biofeedback will not be considered eligible.

(6) **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(7) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

(8) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

(9) **Cognitive and Kinetic Therapy:** Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning and memory. Kinetic therapy is defined as therapy related to motion or movement (e.g., the study of motion, acceleration or rate of change). This exclusion will not apply to expenses related to a neurological brain impairment resulting from an acute major Illness or the diagnosis, testing and treatment of ADD or ADHD.

(10) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible. This exclusion does not apply to complications from abortions as specified under Eligible Medical Expenses.

(11) **Contraceptives:** Expenses for contraceptive procedures and devices, including but not limited to, oral contraceptives and the placement or removal of a contraceptive device will not be considered eligible, except as specified under the Prescription Drug Card Program and except as otherwise covered as a preventive service as specified under the Eligible Medical Expenses section of the Plan.

(12) **Confinement.** Services and supplies furnished during confinement in a hospital or institution owned or operated by the United States Government or any agency thereof, unless there is a legal obligation to pay charges without regard to the existence of any insurance. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury

(13) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible.

(14) **Cosmetic surgery.** Cosmetic surgery; or reconstructive surgery; or plastic surgery; or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except; reconstructive surgery is covered when such services are incidental to or follow a medically necessary surgery due to trauma, infection or other acquired disease of the Covered Person. The Plan will cover the reconstructive surgery for a covered minor child which is needed as a result of congenital disease or anomaly which impairs normal function. This does not include teeth or the structure that supports the teeth. In no case will the Plan pay for treatment required as a result of complications from treatment not covered under the Plan.

(15) **Counseling:** Expenses for religious, marital, family, or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

(16) **Court Ordered.** Services or supplies for court ordered testing or care unless Medically Necessary.

(17) **Custodial Care:** Expenses for Custodial Care, sanitarium care and rest care or charges made by a Hospital for a confinement primarily for physiotherapy or hydrotherapy will not be considered eligible.

(18) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses.

(19) **Developmental Delays:** Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD and to expenses covered as a preventive service under the Eligible Medical Expense section of the Plan.

(20) **Educational or vocational testing.** Services for educational or vocational testing or training when not related to medical diagnosis.

(21) **Environment:** Expenses for any confinement in an institution primarily to change one's environment will not be considered eligible.

(22) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(23) **Exercise Programs:** Expenses for exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(24) **Expenses.** Expenses for preparing medical reports, itemized bills or claim forms, mailing and/or shipping and handling expenses and expenses for broken appointments or telephone calls.

(25) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an Approved Clinical Trial. Charges will be covered only to the extent specifically set forth in the "Covered Charges" section.

(26) **Eye care**. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan. Refer to Vision Benefits for eligible services.

(27) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable or flat feet, care or removal of corns, care of bunions, care or removal of calluses, care of toe nails and the treatment of subluxation of the foot will not be considered eligible, except as specified under Eligible Medical Expenses section of the Plan.

(28) **Foot care.** Expenses for routine foot care, treatment of weak, unstable or flat feet, care or removal of corns, care of bunions, care or removal of calluses, care of toe nails and the treatment of subluxation of the foot will not be considered eligible, except as specified under Eligible Medical Expenses section of the Plan.

(29) **Foot Orthotics:** Expenses for foot only orthotics, orthopedic shoes (except as specified under the Eligible Medical Expenses section of the Plan), arch supports or for the exam, prescription or fitting thereof will not be considered eligible, except if deemed Medically Necessary and rendered by a licensed Podiatrist.

(30) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(31) **Genetic Testing/Counseling:** Expenses for genetic testing or genetic counseling will not be considered eligible, except amniocentesis testing and except as otherwise covered as a preventive service as specified under the Eligible Medical Expenses or Preventive Care section of the Plan.

(32) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state- sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(33) **Growth hormone therapy.** Growth hormone therapy unless specifically approved on a continuous basis through Pre-certification and Case Management to verify medical necessity.

(34) **Hair Loss:** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits

(35) **Hearing Exams/Aids:** Expenses for routine hearing examinations, hearing aids (including the fitting thereof) and supplies will not be considered eligible, except for the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure or as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(36) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(37) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.

(38) **Iatrogenic disorder**. Any charges arising out of or in any way connected with an iatrogenic disorder (any adverse condition induced by effects of treatment by a physician) including, but not limited to, all charges incurred in connection with the care and treatment giving rise to said disorder and the care and treatment required to treat said disorder.

(39) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(40) **Infertility:** Expenses for confinement, treatment, testing or services related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible. Nothing in this section is intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).

(41) **Injectables.** Expenses for injectables will not be considered eligible, except for allergies or not available through the Prescription Drug Card Program.

(42) **Learning disabilities or developmental disorders**. Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD and to expenses covered as a preventive service under the Eligible Medical Expense section of the Plan

(43) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(44) **Massage Therapy:** Expenses for massage therapy will not be considered eligible, except as specified under the Eligible Medical Expenses section of the Plan.

(45) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(46) **Missed Appointments:** Expenses for completion of claim forms or reports, sales tax, missed appointments or telephone consultations will not be considered eligible. This exclusion does not apply to telephone consultations provided as part of the TelaDoc program as described in the Eligible Medical Expenses section of the Plan.

(47) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.

(48) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(49) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(50) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(51) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(52) **Nutritional Counseling:** Expenses related to nutritional counseling will not be considered eligible, except as otherwise covered as a preventive service or as specified under the Eligible Medical Expenses section of the Plan.

(53) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(54) **Obesity.** Screening and counseling for obesity will be covered to the extent required under Standard Preventive Care. Other care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded. Medically Necessary surgical and non-surgical charges for Morbid Obesity are not covered.

(55) **Occupational.** Care and treatment of an Injury or Sickness that is occupational that is, arises from work for wage or profit including self-employment.

(56) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

(57) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided

to a Covered Person for a non-service related Illness or Injury.

(58) **Orthopedic Therapy:** Expenses related to orthopedic therapy or training will not be considered eligible, unless related to a covered Illness or Injury.

(59) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment, drugs or supplies will not be considered eligible.

(60) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(61) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(62) **Plan Maximums:** Expenses for charges in excess of Plan maximums will not be considered eligible.

(63) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(64) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD.

(65) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

(66) **Relative giving services**. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(67) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(68) **Riot/Revolt:** Expenses resulting from a Covered Person’s participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(69) **Routine Care:** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(70) **Self-Inflicted Injury:** Expenses for Injury or Illness arising out of attempted suicide or an intentional self- inflicted Injury will not be considered eligible. This exclusion will not apply if self-inflicted Injuries result from a medical condition (physical or mental) or act of domestic violence and the benefits for such Injuries are normally covered under the Plan. Self-inflicted Injuries sustained while intoxicated are excluded, unless the self-inflicted Injuries are a result of alcoholism.

(71) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(72) **Sex Transformation:** Expenses in connection with sex transformation will not be considered eligible.

(73) **Sexual Dysfunction/Impotence:** Expenses for services, supplies or drugs related to sexual dysfunction/ impotence will not be considered eligible, unless related to organic disease or due to side effects and/or complications from prescription drugs when taken according to Physician directions. Expenses for sex therapy will not be considered eligible.

(74) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

(75) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(76) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than Employee and Spouse will not be considered eligible, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses. This exclusion does not apply to preventive services as described under the Eligible Medical Expenses section of the Plan.

(77) **Third Party.** Any charges arising out of or relating to injuries and/or medical conditions caused by a Third Party(s) for which Recovery has previously been obtained, but only to the extent of such Recovery.

(78) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

(79) **Unbundling.** Any portion of any charge which is as a result of Unbundling.

(80) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(81) **Vision Care:** Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service under the Eligible Medical Expense section of the Plan.

(82) **War:** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(83) **Worker's Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

PRESCRIPTION DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician, diabetic supplies; smoking deterrents and oral contraceptives, contraceptive shots and contraceptive patches (regardless of intended use). Please note Prescription Drugs are subject to the cost-sharing provisions described in the Prescription Drug Schedule of Benefits unless the Prescription Drug qualifies as a Preventive Drug (as described below).

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply.

Maintenance drugs of more than a 30-day supply may be purchased through the mail order program, or a local CVS or Target pharmacy.

When using the mail order program, or a local CVS or Target pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for injectables that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Manager identified in the General Plan Information section of this Plan and listed on the back of your Employee identification card.

CORE PLAN: Mandatory Maintenance Program
This Plan allows for 2 refills of a maintenance drug at a retail pharmacy. All refills for maintenance drugs after 2 refills for name brand (non-generic) at a retail pharmacy will be required to be filled through the mail order program, or a local CVS or Target pharmacy.

HDHP PLAN: Voluntary Maintenance Program
This Plan allows for drugs to be filled in a 90 day supply through the mail order, or a local CVS or Target pharmacy.

Step Therapy

What is Step Therapy?

Step Therapy is a program especially for people who take Prescription Drugs regularly for ongoing conditions like arthritis and high blood pressure.

In Step Therapy, drugs are grouped in categories based on cost:

- Front-line drugs - the first step - are generic drugs proven to be safe, effective and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.
- Back-up drugs - Step 2 and Step 3 drugs - are brand-name drugs. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs typically cost more than front-line drugs.

How does Step Therapy work?

The next time the Physician writes a prescription, ask the Physician if a Generic Drug listed by the Plan as a front- line drug is appropriate. It makes good sense to ask for these drugs first because, for most everyone, they work as well as Brand Name drugs - and they almost always cost less.

If the Covered Person already tried a front-line drug, or his or her Physician decides one of these drugs isn't appropriate, then the Covered Person's Physician can prescribe a back-up drug. The Covered Person should ask his or her Physician if one of the lower-cost Brand Name Drugs (Step 2 drugs) listed by the Plan is appropriate. Remember, the Covered Person can always get a higher-cost Brand Name Drug at a higher co-payment if the front- line or Step 2 back-up drugs are not appropriate.

If on January 1, 2014, the Covered Person is currently using a medication that requires step therapy he or she may continue using that medication. If the Covered Person is trying to fill a medication for the first time in 6 months he or she will be required to use the first-line therapy before the step therapy medication can be filled. Please contact the Prescription Drug Card Program Manager for more information on the step therapy program.

Failure to use the step therapy program will result in the Covered Person being responsible for the entire cost of the drug.

Brand Name Drug: Means a trade name medication.

Formulary Drug: A list of Brand Name drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. The Prescription Drug Card Program Manager will have a list of Formulary Drugs available.

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

Non-Formulary Drug: Any Brand Name drugs that do not appear on the list of Formulary Drugs.

Prescription Drug: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Drug means a list of Prescription Drugs, FDA approved contraceptive devices and FDA approved over- the-counter medications (including over-the-counter emergency contraceptives) when prescribed by a Physician, which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. The term "Preventive Drug" does not include abortifacient drugs or over-the-counter contraceptives (other than FDA approved over-the counter emergency contraceptives) regardless of whether or not such items are prescribed by a Physician. Please contact the Prescription Drug Card Program Administrator for a complete listing of the Preventive Drugs covered under this Plan and any restrictions on the available drugs. You may also view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

NOTE: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age.

Please contact the Prescription Drug Card Program Administrator for a complete listing of the Preventive Drugs covered under this Plan and any applicable restrictions. To the extent the above does not cover any Preventive Drug or contraceptive device required to be covered by the U.S. Department of Health Human Services (HHS) or under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such Preventive Drug or contraceptive device to the extent required by the HHS and/or such guidelines.

DENTAL EXPENSES

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they meet all of the following conditions:

(1) Constitute Dentally Necessary treatment.

(2) Are Incurred while covered under this Plan.

(3) Are Usual and Customary Charges.

The Plan will pay for such eligible expenses as shown in the Dental Schedule of Benefits.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

Deductible
A Deductible is the total amount of eligible expenses as shown in the Dental Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Dental Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

Pre-Determination of Benefits
When the total cost of eligible dental expenses is expected to exceed the Pre-Determination Limit as shown in the Schedule of Dental Benefits, the Dentist's treatment plan should be sent to the Third Party Administrator before the first date of treatment. Based on the treatment plan, the Third Party Administrator will estimate the amount of the benefit available if treatment is performed and inform the Dentist of the determination. The treatment plan should:

(1) Show the Dentist's proposed course of treatment;

(2) Show the total charge for the treatment;

(3) Include x-rays, study models and any other data requested by the Third Party Administrator;

(4) Show how long the treatment will take; and

(5) Show the classification of malocclusion (if the treatment plan is for Orthodontic Treatment).

Pre-determination is not necessary when eligible dental expenses are Incurred for emergency dental care or accidental dental Injuries.

Pre-treatment review is not a guarantee of the benefits that will be payable. It tells the Covered Person and the Dentist, in advance, what is payable for the eligible dental services named in the treatment plan. But payment is conditioned on:

(1) The work being done as proposed and while the Covered Person is covered under this Plan; and

(2) The Deductible and payment limit provisions listed in the Dental Schedule of Benefits and all of the other terms of this Plan.

Alternative Treatment
The Plan has an "alternative treatment" clause that limits the Plan's payment to the most cost effective treatment of a dental condition that provides a professionally acceptable result as determined by national standards of dental practice. If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment that provides professionally satisfactory results at the most cost-effective level.

Eligible Dental Expenses

Class A-Preventive Services:

(1) Routine oral examinations are limited to twice per Calendar Year.

(2) Prophylaxis (cleaning, scaling and polishing) is limited to twice per Calendar Year.

(3) X-rays as follows:

(a) Bitewing x-rays are limited to two sets per Calendar Year.

(b) Diagnostic x-rays, including: full mouth x-rays, periapical x-rays and panorex x-rays are limited one every 36 months.

(4) Topical application of fluoride for a Covered Person under age 19.

(5) Space maintainers for a Covered Person under age 19.

(6) Emergency palliative treatment.

Class B-Basic Services:

(1) Problem focused or specialty exams.

(2) Repair of prosthetics (dentures, crowns, bridges, partials).

(3) Fillings made of silver amalgam, silicate or plastic.

(4) Simple extractions.

(5) Periodontal scaling and root planing.

(6) Endodontics, including pulpotomy, pulp capping and root canal treatment.

(7) Apicoectomy (surgical removal of the apex of the tooth root).

(8) Alveolectomy (surgery performed on the alveolar bone, including flap entry and closure).

(9) Vestibuloplasty.

(10) Removal of gum tissue around the necks of the teeth and the recontouring of the gum tissue.

(11) Procedures to prevent and treat diseases of the pulp and gums.

(12) General anesthesia for a covered oral or dental Surgery.

(13) Surgical extraction of erupted teeth.

Class C-Major Services: Eligible Major expenses will be paid on the date of completion.

(1) Inlays up to once every 5 years per tooth.

(2) Onlays up to once every 5 years per tooth.

(3) Crowns that are not part of a bridge, including stainless steel crowns; crowns are limited to once every 5 years per tooth.

(4) Dentures, full and partial, subject to the following: limited to once every 5 years. Relining and rebasing are covered if done no less than 6 months after initial placement but not more than once in any 12 month period. One replacement of a temporary denture is allowed if a permanent denture is installed within 12 months of the installment of the temporary denture. If an appliance can be made serviceable, a replacement appliance is not covered. Personalized restorations and specialized techniques in constructing dentures or bridges will not be considered eligible.

(5) Bridges, fixed and removable; limited to once every 5 years per unit.

Class D-Orthodontic Services
Orthodontic Treatment is available for Covered Persons under age 19 only when one or more of the following conditions are present:

(1) The existence of an extreme bucco-lingual version of the teeth, either unilateral or bilateral. (The teeth are pushed out toward the cheek or in toward the tongue on one or both sides.)

(2) A protrusion of the upper teeth of more than 4 millimeters.

(3) A protrusive or retrusive relation of the maxillary or mandibular arch of at least one cusp. (The upper and lower teeth buck back.)

(4) An arch length difference of more than 4 millimeters in either the maxillary or mandibular arch.

(5) A bimaxillary protrusion of 4 millimeters or more.

(6) A cross-bite.

Charges are eligible only to the extent that they are made in connection with an orthodontic procedure, including:

(1) Cephalometric x-rays.

(2) Diagnostic casts for orthodontic purposes.

(3) Surgical exposure of an impacted tooth for orthodontic purposes.

(4) Orthodontic appliances for tooth guidance.

(5) Fixed or removable appliances to correct Harmful Habits.

The first payment for banding after the appliances are in place will be limited to not more than 25% of the Covered Person’s Lifetime maximum for Orthodontic services.

If you were receiving Orthodontic treatment (active or retention treatment) prior to your effective date for dental benefits, then only services Incurred after your effective date will be covered based on a pro-ration of the expected months of treatment.

Eligible expenses include those for preliminary study and treatment plan. Also covered under this benefit are extractions for the purposes of Orthodontic Treatment. The first month of active treatment includes all active and retention appliances. Payments will be made in equal installments for the duration of covered treatment, until no longer covered or until the maximum benefit has been paid, whichever occurs first.

DENTAL EXCLUSIONS AND LIMITATIONS

In addition to the General Exclusions and Limitations section of this Plan, no payment will be eligible under any portion of this Plan for Dental Expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

(1) **Administrative:** Expenses for services for failure to keep a scheduled appointment with the Dentist or the preparation of dental reports or itemized bills will not be considered eligible.

(2) **Alternative Treatment:** If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment which provides professionally satisfactory results at the most cost-effective level.

(3) **American Dental Association:** Expenses that do not meet the standards of dental practices accepted by the American Dental Association will not be considered eligible.

(4) **Congenital or Developmental Malformation:** Expenses for congenital or developmental malformation or other services primarily to improve appearance will not be considered eligible.

(5) **Cosmetic:** Expenses for services or supplies partially or wholly Cosmetic in nature will not be considered eligible, unless such service is necessary as a result of an accidental Injury. Cosmetic dental procedures include: facings on crowns or pontics posterior to the second bicuspid or characterizations and personalization of prosthetic devices.

(6) **Department Maintained by an Employer:** Expenses for services received from a Dentist or dental department maintained by an employer, labor union, etc., where the individual is eligible under any group insurance plan will not be considered eligible.

(7) **Duplicate Devices:** Expenses for duplicate prosthetic devices or appliances; expenses for a lost or stolen dental appliance; will not be considered eligible.

(8) **Harmful Habit Appliances:** Expenses for Harmful Habit appliances will not be considered eligible, except as specified in Eligible Dental Expenses.

(9) **Hospital Expenses:** Expenses for Hospital expenses will not be considered eligible.

(10) **Implants:** Expenses for implants, including any appliances and/or crowns and the surgical insertion or removal of implants will not be considered eligible.

(11) **Installation or Replacement:** Expenses for installation, replacement or alteration of or addition to, dentures and fixed bridgework will not be considered eligible, except as shown in Eligible Dental Expenses.

(12) **Not Performed By a Dentist:** Expenses for treatment by other than a Dentist or Physician will not be considered eligible, except charges for treatment performed under the supervision and direction of a Dentist or Physician by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations.

(13) **Not Prescribed by a Dentist:** Expenses for services not prescribed as necessary by a Physician or Dentist will not be considered eligible.

(14) **Occlusion:** Expenses for restorations or procedures to splint, change vertical dimension or restore occlusion will not be considered eligible, except as shown in Eligible Dental Expenses.

(15) **Oral Hygiene:** Expenses for oral hygiene, dietary or plaque control programs or other educational programs will not be considered eligible.

(16) **Orthognathic Surgery:** Expenses for Surgery to correct malposition in the bones of the jaw will not be considered eligible.

(17) **Personalization:** Expenses for personalization of dentures will not be considered eligible.

(18) **Plan Design:** Expenses excluded or limited by the Plan design as stated in this document will not be considered eligible.

(19) **Replacement:** Expenses for replacement of lost or stolen appliances will not be considered eligible.

(20) **Sealants:** Expenses for sealants will not be considered eligible.

(21) **Services By More Than One Dentist:** Expenses for services rendered by more than one Dentist will not be considered eligible. If you change Dentists during a course of treatment or if more than one Dentist treats you for a procedure, additional benefits are not provided.

(22) **Space Maintainer:** Expenses for the repair of a damaged space maintainer or replacement of a lost or stolen space maintainer will not be considered eligible.

(23) **Take Home Items:** Expenses for take home items will not be considered eligible.

(24) **Temporary:** Expenses for temporary dental service will be considered an integral part of the final dental service rather than a separate service.

(25) **Temporomandibular Joint Dysfunction (TMJ):** Expenses for appliances or restorations in connection with Temporomandibular Joint Dysfunction (TMJ) or myofunctional therapy will not be considered eligible.

Integration with Medical Benefits
In the event benefits are available for the same expenses under both the medical and dental provisions of this Plan, such charges will first be considered for payment as a medical expense. The charges will be considered under the dental expenses only if the amount normally paid under the dental expenses exceeds the amount paid under the medical expenses and only up to the excess amount.

VISION BENEFITS

Vision Care Benefits performed by a licensed Optician, Optometrist or Ophthalmologist and provided to a Covered Person will be covered as shown in the Schedule of Vision Benefits.

Eligible Expenses
The following Vision Care Benefits will be payable as shown in the Schedule of Vision Benefits:

(1) Vision examinations;

(2) Lenses and their fittings, excluding customization such as rolled edges and non-glare coatings;

(3) Contact lenses and their fittings; and

(4) Frames.

Exclusions and Limitations
In addition to the General Exclusions and Limitations section of this Plan, Vision expenses are not provided for:

(1) Orthoptics or vision training and any associated supplemental testing will not be considered eligible.

(2) Lenses and frames furnished under this Plan which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

(3) Medical or surgical treatment of the eyes will not be considered eligible.

(4) Charges for lenses ordered without a prescription will not be considered eligible.

(5) Charges for non-prescription sunglasses will not be considered eligible.

(6) Charges for prescription sunglasses will not be considered eligible.

(7) Charges for safety glass and safety goggles will not be considered eligible.

(8) Any eye examination or any corrective eyewear required by an employer as a condition of employment will not be considered eligible.

(9) Diagnostic services, drugs or medications not part of a vision examination will not be considered eligible.

(10) Tints other than Number One or Two will not be considered eligible.

(11) Tints with photosensitive or antireflective properties will not be considered eligible.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under CITY OF FINDLAY EMPLOYEE BENEFIT PLAN (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage under the Plan is administered by the COBRA Administrator. The COBRA Administrator is ENTERPRISE GROUP PLANNNING INC 5910 HARPER ROAD CLEVELAND OH 44139 (800) 229-2210.Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

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

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends, if the Employee does not return to work in an Eligible Class.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This 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. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication - and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment -related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should 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.

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

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

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 or someone on your behalf must notify the COBRA Administrator at 5910 HARPER ROAD CLEVELAND OH 44139 (800) 229-2210 within 60 days after the Qualifying

Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person listed at the address shown above.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the COBRA Administrator receives *timely 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 for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to **COBRA Administrator at 5910 HARPER ROAD CLEVELAND OH 44139 (800) 229-2210**in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to **COBRA Administrator at 5910 HARPER ROAD CLEVELAND OH 44139 (800) 229-2210**in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS
If you have questions about your COBRA continuation coverage, you should contact **COBRA Administrator at 5910 HARPER ROAD CLEVELAND OH 44139 (800) 229-2210** in accordance with the procedures above.

For more information about your rights under 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR 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.

CLAIM PROCEDURES

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Your provider of service will submit your claims following the instructions on your Identification Card.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

Enterprise Group Planning, Inc.
5910 Harper Road
CLEVELAND, Ohio 44139
(800) 229-2210

WHEN CLAIMS SHOULD BE FILED

All claims must be filed with the Third Party Administrator within 12 months following the date services were incurred. Claims filed after this time period will be denied. Benefits are based on the Plan's provisions at the time the charges were incurred.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Utilization Review section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	30 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

This notice is the Final Adverse Benefit Determination.

EXTERNAL REVIEW PROCESS

External Review of Denied Claims
NOTE: This provision does not apply to dental and vision benefits.

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network 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.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit 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.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Medicaid Coverage
You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid
In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non- discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over and rules concerning working disabled individuals (as discussed below).

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical charges. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer, including but not limited to the Covered Person's insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses. This provision expressly abrogates the "make whole" and "common fund" doctrines and similar defenses to the Plan's claims. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person or his designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

DEFINED TERMS

In this section you will find the defined terms for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those defined terms will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These defined terms are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Approved Clinical Trial means a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

Effective January 1, 2014, the Patient Protection and Affordable Care Act requires that if a "Qualified Individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("Routine Patient Costs").

A "Qualified Individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine Patient Costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's network area unless out-of network benefits are otherwise provided under the Plan.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have 1 or 2 Assistant Surgeons. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Birthing Center means any 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. This 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 Name means a trade name medication.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent or in- law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance has the same meaning as set forth in the section of this Plan entitled “Medical Benefits”.

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions are not included: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Concurrent Review means the Medical Management Program Administrator will review all Inpatient admissions for a patient’s length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay has the same meaning as set forth in the section of this Plan entitled “Medical Benefits”.

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Expense means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

(2) For prescription drug expenses, any prescription drugs or medicines eligible for coverage under the Prescription Drug Card Program.

(3) For dental expenses, an item or service listed in the Plan as an eligible dental expense for which the Plan provides coverage.

(4) For vision expenses, an item or service listed in the Plan as an eligible vision expense for which the Plan provides coverage.

Covered Person means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dentally Necessary means services or supplies, which are determined by the Plan Administrator to be:

(1) Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, Injury or Illness;

(2) Provided for the diagnosis or direct care and treatment of the dental condition, Injury or Illness;

(3) Within standards of good dental practice within the organized dental community;

(4) Not primarily for the convenience of the Covered Person, the Covered Person's Dentist or another provider; and

(5) The most appropriate supply or level of service which can safely be provided.

Dependent is a Covered Person, other than the Employee**,** who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

(1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

Employee is defined in the "Eligibility for Participation" section of the Plan.

Employer means the City of Findlay, or any successor thereto.

Endodontic Treatment means procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

Enrollment Date means the earlier of first day of coverage or, if there is a waiting period, the first day of the eligibility waiting period.

Essential Health Benefit has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

(2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

Reliable Evidence shall mean 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, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(1) The named drug is not specifically excluded under the General Limitations of the Plan; and

(2) The named drug has been approved by the FDA; and

(3) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

(4) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

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

Genetic Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

Harmful Habit means the acquired habit of thumb sucking, tongue thrusting or bruxism, which causes damage to the teeth and/or periodontal support.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

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

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing inpatient diagnostic and therapeutic services at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission, the American Osteopathic Association, or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises which are provided by or under the supervision of a staff of Physicians; and it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s). The Plan Administrator may accept accreditation of a Hospital by an organization other than those specifically listed, provided that the designation of an alternative accreditation body is consistently applied across institutions.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

Illness means a non-occupational bodily disorder, disease, physical sickness, Pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

Incurred means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Infertility means incapable of producing offspring.

Injury means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special lifesaving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

Leave of Absence means a Leave of Absence of an Employee that has been approved by the Employer, as provided for in the Employer’s rules, policies, procedures and practices.

Legal Guardian is defined in the "Eligibility for Participation" section of the Plan.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Participating Employer means any employer that has, with the consent of the Plan Sponsor, adopted this Plan pursuant to a participation agreement by and between the Plan Sponsor and the employer for the exclusive benefit of its Employees and their eligible Dependents.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the CITY OF FINDLAY EMPLOYEE BENEFIT PLAN.

Plan Administrator means the Plan Sponsor. The Plan Sponsor may delegate fiduciary and other responsibilities to the Plan Administrator.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Sponsor means City of Findlay or any successor thereto.

Plan Year means the period from January 1 - December 31 each year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, “Caution: federal law prohibits dispensing without prescription,” (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Care shall mean certain Preventive Care services.
This Plan intends to comply with the Patient Protection and Affordable Care Act’s (PPACA) requirement to offer for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.html or at https://www.healthcare.gov/prevention.
For more information, you may contact the Plan Administrator / Employer

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary

purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Recovery is any payment, consideration, value, or return from any source whatsoever. Recoveries include, without limitation, payments received through uninsured motorist coverage, underinsured motorist coverage, no-fault motorist, all other insurance coverages, governmental programs and all other sources. By way of example, a recovery may be made by settlement, compromise, gift, award, or judgment.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) nursing services are available 24 hours a day; and (8) the confinement is not for Custodial Care or maintenance care.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by 2 or more patients.

Sickness is:

For a covered Employee and covered Spouse or Dependent: Illness, disease or Pregnancy.

Skilled Nursing Facility is a facility that meets all of the following requirements:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Special Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse is defined in the "Eligibility for Participation" section of the Plan.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as

may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Substance Abuse shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a Drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:
   a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance related absences, suspensions or expulsions from school; neglect of Children or household);
   b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
   c. Craving or a strong desire or urge to use a substance; or
   d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

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Surgery or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Third Party Administrator means Enterprise Group Planning, Inc., 5910 Harper Road, CLEVELAND, OH 44139.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Unbundling is the practice of coding the individual components of a procedure when only a single code is needed or generally utilized to describe the service.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance

at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. For Network Provider charges, the Usual and Reasonable Charge will be the contracted rate.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

PLAN ADMINISTRATION

Authority to Make Decisions
The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to

determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of CITY OF FINDLAY's workforce are designated as authorized to receive Protected Health Information from CITY OF FINDLAY EMPLOYEE BENEFIT PLAN ("the Plan") in order to perform their duties with respect to the Plan: STAFF OF CITY AUDITORS OFFICE.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

MISCELLANEOUS INFORMATION

Assignment of Benefits
No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in the Plan's QMCSO procedures.

Clerical Error
Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

Conformity with Applicable Laws
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Employer's general assets. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document
The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependent*s*.

Minimum Essential Coverage
Refer to the Employer's Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides "minimum essential coverage" within the meaning of Code Section 5000A9f) and any accompanying regulations or guidance and whether it provides "minimum value" within the meaning of Code section 38B(2)(c)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).

Misstatement of Essential Data
If the Company or its designee determines that any misstatements or omissions of information have been made on the enrollment application, claim form, or other such documentation submitted by an Employee and/or Dependent, coverage under this Plan may be rescinded and/or terminated. If coverage is rescinded, no payments will be made for any claims submitted, whether or not the treatment was related to the condition for which information was omitted or misstated. Contributions already paid for the time period for which coverage has been rescinded will be refunded less all payments made by the Plan and all expenses incurred by the Plan in connection with said coverage.

No Contract of Employment
This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of, the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Nonassignability and Spendthrift Clause
No benefits, rights, claims, or causes of action arising from or relating to the Plan shall be assignable or otherwise transferable, nor subject to any claim of any creditor of any individual covered under the Plan or to legal process by any creditor of any individual covered under the Plan, unless the Company provides written consent thereto. The Plan's act and/or practice of issuing benefits directly to a health care provider shall not constitute acceptance or waiver, either express or implied, of any attempted assignment to that provider.

No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or

condition for the future or as to any act other than the one specifically waived.

Right to Receive and Release of Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Severability
If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Worker's Compensation
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

(1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(2) Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to

the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

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

(2) Ensure that any agents , 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 or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

(9) 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, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

(a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

(1) The Plan documents have been amended to incorporate the above provisions; and

(2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop- loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program);
(3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA's standards for security (the "security standards"), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

(3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.

(4) Report to the Plan any Security Incident of which it becomes aware.

(5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

GENERAL PLAN INFORMATION

NAME OF PLAN:	CITY OF FINDLAY EMPLOYEE BENEFIT PLAN
PLAN SPONSOR:	CITY OF FINDLAY 318 DORNEY PLAZA, 313 MUNICIPAL BUILDING FINDLAY, OHIO 45840 (419) 424-7101
PLAN ADMINISTRATOR:	CITY OF FINDLAY 318 DORNEY PLAZA, 313 MUNICIPAL BUILDING FINDLAY, OHIO 45840 (419) 424-7101
PLAN SPONSOR EIN:	34-6400448
PLAN EFFECTIVE DATE:	JANUARY 1, 2017
PLAN AMENDMENT DATE:	JANUARY 1, 2020
PLAN YEAR:	JANUARY 1 - DECEMBER 31
PLAN NUMBER:	501
PLAN TYPE:	WELFARE BENEFIT PLAN PROVIDING MEDICAL, DENTAL, VISION AND PRESCRIPTION DRUG BENEFITS. THIS PLAN IS MAINTAINED PURSUANT TO ONE OR MORE COLLECTIVE BARGAINING AGREEMENTS. FOR A COPY OF SUCH AGREEMENT, PLEASE CONTACT THE PLAN ADMINISTRATOR.
PLAN FUNDING:	ALL BENEFITS ARE PAID FROM THE ACCRUED EMPLOYEE/EMPLOYER INSURANCE FUND.
CONTRIBUTIONS:	THE COST OF COVERAGE UNDER THE PLAN IS FUNDED IN PART BY EMPLOYER CONTRIBUTIONS AND IN PART BY EMPLOYEE CONTRIBUTIONS.
THIRD PARTY ADMINISTRATOR:	ENTERPRISE GROUP PLANNING, INC. 5910 HARPER RD CLEVELAND, OHIO 44139 (800) 229-2210
COBRA ADMINISTRATOR:	ENTERPRISE GROUP PLANNING, INC. 5910 HARPER RD CLEVELAND, OHIO 44139

BROKERAGE FIRM:	FIRST INSURANCE GROUP 643 MIAMI STREET SUITE 5 TIFFIN, OH 44883 (888) 442-8287
MEDICAL MANAGEMENT PROGRAM ADMINISTRATOR:	AMERICAN HEALTH HOLDINGS CAMPUS ROAD 510 NEW ALBANY, OH 43054 (800) 242-1199
PRESCRIPTION DRUG CARD PROGRAM ADMINISTRATOR:	CVS/CAREMARK P.O. BOX 52010 PHOENIX, AZ 85072-2010 (866) 475-7589
AGENT FOR SERVICE OF LEGAL PROCESS:	CITY OF FINDLAY 318 DORNEY PLAZA, 313 MUNICIPAL BUILDING FINDLAY, OHIO 45840 (419) 424-7101

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.

BY THIS AGREEMENT, CITY OF FINDLAY EMPLOYEE BENEFIT PLAN is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for CITY OF FINDLAY on or as of the day and year first below written.

By _____
CITY OF FINDLAY

Title _____

Date _____

Witness _____

Title _____

Date _____