Plan Document and Summary Plan Description for the City of Columbus Employee Benefit Plan

- Medical Benefits
- Prescription Drug Benefits

INTRODUCTION

City of Columbus (the "Employer" or "Plan Sponsor") is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet describes your medical and prescription drug benefits and serves as the Summary Plan Description (SPD) and Plan document for the City of Columbus Employee Benefit Plan ("the Plan"). It sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits.

Because the sponsor of the Plan is a governmental agency, the Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This SPD and Plan replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

Patient Protection and Affordable Care Act. *The City of Columbus Employee Benefit Plan believes this plan is* ***not*** *a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). For more information, contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.*

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SECTION I: DEFINITIONS

Accident: an unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Active Employee (Actively at Work): a Participant is considered "actively at work" if he or she:

- is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- was present at work on the last scheduled working day before:
    - a scheduled vacation;
    - an absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
    - a scheduled day off within the participant's working schedule; or
    - an absence excused by the Plan Sponsor.

Acute Rehabilitation: designed to provide intensive rehab therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management and rehabilitation needs require and can be reasonably expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitative care. Criteria are 24 hours of nursing and medical oversight and multidisciplinary rehab therapy providers.

Ambulatory Surgical Center: 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.

Appeal: a resort to a higher authority or greater power, as for sanction or a decision.

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: January 1st through December 31st of the same year.

Certified Nurse-Midwife: A registered nurse (R.N.) certified by the American College of Nurse-Midwives.

Chiropractic Care: services provided by a Chiropractor (D.C.) or licensed physician (M.D. or D.O.) including office visits, diagnostic x-rays, manipulations, supplies, heat treatment, cold treatment and massages.

Claims Administrator: refers to the individual business or entity, if any, appointed and retained by the Plan Administrator to supervise the administration, consideration, investigation, and settlement of claims, maintain records, and offer such ministerial and supportive functions as may be set forth in a written administrative agreement. If no Claims Administrator is appointed or retained (as a result of the termination or expiration of the administrative agreement or any other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by an entity in writing, the term will mean the Plan Administrator. Both the ultimate responsibility for the administration of this Plan and the final authority to interpret the Plan should remain with the Plan Administrator.

Coinsurance: the percentage of the cost of covered expenses a Participant must pay after meeting any applicable deductible.

Complete Claim: a previously incomplete claim for which a Participant has submitted the missing or additional information required for the Plan to make a determination.

Concurrent Care Claim: a claim for a benefit that involves an ongoing course of treatment.

Confinement: an inpatient admission to a healthcare facility.

The Consolidated Omnibus Budget Reconciliation Act ("COBRA"): this Federal law, as amended, allows a continuation of health care coverage in certain circumstances.

Copayment
The fixed dollar amount of covered expenses a participant must pay before Plan pays.

Cosmetic Dentistry: dentally unnecessary procedures.

Covered Expense: an expense that will be reimbursed according to the terms of the Plan.

Covered Family is the covered Employee or Retiree or Dependent who is covered under the Plan.

Custodial Care: services and/or care not intended primarily to treat a specific injury or illness (*including mental health and substance abuse*) which services/care include, but are not limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that usually can be self-administered; and

  services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible: the dollar amount (for individual or family) a Participant is responsible to pay each year before the Plan begins to pay benefits.

Diagnostic: a test or procedure performed for specified symptoms to detect or to monitor a disease or illness and ordered by a physician or professional provider.

Doctor or Physician: a doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The term also includes a chiropractor (D.C.), dentist (D.M.D. or D.D.S.), or a podiatrist (D.P.M.). In all cases, the person must be legally qualified and licensed to perform a service at the time and place of the service.

Durable Medical Equipment ("DME"): equipment which

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- generally is not useful to a person in the absence of an illness or injury; and
- is appropriate for use in the home.

Eligible Provider: any practitioner or facility offering covered services and acting within the scope of the appropriate license; examples include a licensed doctor, specialist, osteopath, podiatrist, chiropractor, hospital, or laboratory.

Emergency Services: a medical screening examination (as required under §1867 of the Social Security Act (EMTALA) within the capability of the Hospital Emergency Department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Medical Emergency is defined 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 individual, the health of the individual unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part.

Employee: a person who works for the Plan Sponsor in an employer-employee relationship.

Emergency Dental Care: An urgent, unplanned diagnostic visit and/or alleviation of acute or unexpected Dental condition.

Employer: City of Columbus

Enrollment Date: the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental or Investigational Services: Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the FDA to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial actually is subject to FDA oversight; or
- not demonstrated through authoritative medical or scientific literature published in the U.S. to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Family and Medical Leave Act ("FMLA"): a Federal law, as amended, that provides for an unpaid leave of absence of up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Plan Sponsor for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Plan Sponsor has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Plan Sponsor. You should contact the Plan Sponsor with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

FDA: the United States Food and Drug Administration.

Formulary: a list of prescription drugs that represent safe, effective therapeutic medications covered by the Plan including:

- Generic;
- Preferred Brand Name; and
- Non-Preferred Brand Name

Foster Child: means a child for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency. A

covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic Drug Alternative: a generic drug that is not the exact equivalent of the brand-name drug, but can be used to treat that medical condition. For example, there are generic options to treat high cholesterol.

Generic Drug Equivalent: a generic drug that has the exact same active ingredients as the brand-name drug. When a drug patent expires, other companies may produce a generic version of the brand-name drug. A generic medication **(***also approved by the FDA***)** is basically a copy of the brand-name drug and is marketed under its chemical name. A generic may have a different color or shape than the brand name, but it must have the same active ingredients, strength, and dosage form (i.e., pill, liquid, or injection), and provide the same effectiveness and safety.

GINA: The Genetic Information Nondiscrimination Act of 2008, as amended.

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

HITECH: The Health Information Technology for Economic and Clinical Health Act, as amended.

Home Health Care Agency: is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Hospice: a licensed (if required by the state in which it is located) provider set up to give terminally ill patients a coordinated program of inpatient, outpatient, and home care. The Plan must approve the hospice and treatment plan supervised by a physician.

Hospital: a legally licensed facility that:

- is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association Healthcare Facilities Accreditation Program or is approved by Medicare; or
- provides a broad range of 24-hour-a-day medical and surgical services by or under the direction of a staff of doctors and is engaged primarily in providing either:
    - general inpatient medical care and treatment through medical, diagnostic, and major surgical facilities on its premises or under its control; or
    - specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises and under its control.

The term hospital does not include a facility that primarily is a place for rest, a place for the aged, or a nursing home.

Illness (or Disease): a pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Injury: Bodily harm that is the sole and direct result of an accident.

In-Network Provider: an eligible provider that is contracted by the Plan to provide health care benefits under the Plan.

Intensive Care Unit: is defined as 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."

Leased Employee: as defined in Internal Revenue Code §414(n), as amended.

Legal Guardian; a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medical Care Facility: means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Condition: an injury or illness.

Medically or Dentally Necessary: to be medically or dentally necessary, all care must be:

- in accordance with standards of good medical or dental practice;
- consistent in type, frequency, and duration of treatment with scientifically based guidelines, as accepted by the Plan;
- required for reasons other than the convenience of the health care provider or the comfort or convenience of the patient;
- provided in a cost-efficient manner and type of setting appropriate for the delivery of that service/supply;
- consistent with the diagnosis of the medical or dental condition;
- not Experimental or Investigational, as determined by the Plan; and
- demonstrated through authoritative medical literature to be safe and effective for treating or diagnosing the medical or dental condition or illness for which its use is proposed.

The fact that an eligible provider performs or prescribes a procedure or treatment or that it may be the only treatment for a particular medical condition does not mean that it is medically necessary as defined here.

The Plan reserves the right to conduct a utilization review to determine whether services are medically or dentally necessary for the proper treatment of the Participant and may also require the participant to be independently examined while a claim is pending.

Medicare: 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: means a bodily disorder or disease in which a person's BMI (Body Mass Index) is 40 or greater, or 35 or greater with co-morbid conditions including hypertension, cardiovascular disease, diabetes, pulmonary hypertension of obesity (Pickwickian Syndrome), or obtrusive sleep apnea.

Network: a group of doctors, hospitals, and other providers contracted by the Plan to provide health care services for the Plan's members at agreed-upon rates.

Network Pharmacy: a pharmacy contracted by the Plan to provide prescription drug benefits under the Plan.

NMHPA: The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Nurse Practitioner: a registered nurse with special training for providing primary health care, including many tasks customarily performed by a physician.

Out-of-Pocket Maximum: the maximum amount a participant pays for covered medical expenses (*including expenses for covered dependents*) in a calendar year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the calendar year.

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 Ambulatory Surgical Center, or the patient's home.

Participant: an eligible employee or eligible dependent who elects to participate in the Plan by completing the necessary enrollment forms.

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.

Plan Year: is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Post-Service Health Claim: a claim for a benefit under the Plan that is a request for payment under the Plan for covered medical services already received by the Participant. Such a claim cannot be a pre-service health claim.

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

Pregnancy: is childbirth and conditions associated with Pregnancy, including complications.

Pre-Service Health Claim: a claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition to receive the benefit. Such a claim cannot be a post-service health claim.

Primary Care Physician: a Family Practice Physician, a Pediatrician, an OB/GYN, or a General Internist. All other physicians are considered specialists.

Proper Claim: a claim for which a participant has submitted all required information to the Plan to make a determination.

Prudent Layperson: an individual who is without medical training but possesses an average knowledge of health and medicine from practical experience and, thus, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): any court order that:

- provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law; or
- enforces a law relating to medical child support described in §1908 of the Social Security Act, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Referral: the process of directing or redirecting (as a medical case or patient) to an appropriate specialist or agency for definitive treatment.

Retired Employee: is a former Active Employee of the Employer who has retired while employed by the Employer under formal written plan of the Employer and elects to contribute to the Plan contribution required from the Retired Employee.

Skilled Nursing Facility: a facility that qualifies under Medicare and is approved by the Plan.

Sub-Acute Facilities: are licensed and accredited to provide professional services to a person needing extended intensive care services. Services would include, but not limited to, continuous care for multiple dysfunctions involving multiple body systems, constant monitoring with 10-12 hours of critical care, complete medical record for each patient, complex care of ventilator/dialysis/extensive wound care, Utilization review, 24-hr in-house monitoring of respiratory therapy, registered dietician, licensed pharmacist (24-hr coverage) and specialized wound care team.

Substance Abuse: is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint Dysfunction (TMJ): Pain, swelling, clicking, grinding, popping, dislocation, locking, malposition, bite discrepancies or other pathological conditions which create a loss or decrease of function in or around one or both of the jaw joints.

Totally Disabled: A person who is determined as disabled for Social Security purposes.

Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"): a Federal law covering the rights of participants who have a qualified uniformed services leave.

Urgent Pre-Service Health Claim: a claim for medical treatment which, if the regular time periods observed for claims were adhered to:

- 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 a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed.

Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent pre-service health claim. Otherwise, whether a claim is an urgent pre-service health claim or not will be determined by an individual acting on behalf of the Plan, and applying the judgment of a prudent layperson.

Usual and Customary: if you use out-of-network providers, covered medical expenses are subject to certain limits under the Plan, and you are responsible for paying any charges above this limit. The maximum benefit payable is based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. Determination of the prevailing charge is based on the:

- complexity of the service and level of specialty of the provider;
- range of services provided; and
- the geographic area where the provider is located and other geographic areas with similar medical cost experience.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

WHCRA: The Women's Health and Cancer Rights Act of 1998, as amended.

SECTION II: PLAN OVERVIEW

Your Eligibility

You are eligible for benefits if you are:

- An Active Employee who is:
    - normally scheduled to work a minimum of 30 hours per week;
    - on the regular payroll of the Plan Sponsor; and
    - in a class of employees eligible for coverage; or
- A Retired Employee, as defined below, of the Employer.

The following individuals are not eligible for benefits: seasonal employees, leased employees, employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, independent contractors, any person who is on active duty in any military service of any country for longer than two (2) weeks, unless coverage may be extended pursuant to USERRA, and other individuals who are not on the Plan Sponsor payroll, as determined by the Plan Sponsor, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse who is a resident of the same country in which the Employee resides. The term “spouse” shall include any individuals who are lawfully married. The Plan Administrator may require documentation proving a legal marital relationship;
- a dependent of a Retiree, who continues to meet all other eligibility requirements, and who is eligible to continue coverage under the Plan as defined below;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status; and
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

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

“Principally supported by you” means that the child is dependent on you for more than one-half of his or her support, as defined by §152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- a child for whom the Covered Employee and/or Spouse have been named Legal Guardian;
- your legally adopted child (*including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support*);
- a step child as long as you are married to the child's natural parent; or
- an eligible child for whom you are required to provide coverage under the terms of a QMCSO or a NMSN.

An eligible dependent does *not* include:

- a person enrolled as an employee under the Plan;
- any person who is in active military services;
- a foster child;
- a legally separated Spouse;
- a former Spouse;
- a domestic partner; and
- a domestic partner's child(ren)

In addition, an eligible dependent who lives outside the U.S. cannot be covered as your dependent, unless the dependent has established his or her primary residence with you.

It is your responsibility to notify the Plan Sponsor if your dependent becomes ineligible for coverage.

Working Spouse Rule

The purpose of the Working Spouse Rule is to share the costs of the medical expenses with other plans or insurance carriers when the Spouse of an Employee is eligible for medical coverage where the spouse is employed. (*Medicare does not count as an employer-sponsored plan for the purpose of this rule).*

- If a Spouse of an eligible Employee is employed with a company which offers group medical insurance coverage and that Spouse is eligible for that plan, that Spouse will not be eligible for this Plan.

- If the Spouse is employed with a company that does not offer group medical coverage or is ineligible to be enrolled, the Spouse may be enrolled in this Plan at the current applicable rate. (A statement from the Spouse's employer that verifies they have no coverage available with that employer will be required).

Proof of Dependent Eligibility

The Plan Sponsor reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

Eligible Retirees

A retired Employee will be eligible to continue coverage upon retirement from employment with City of Columbus if the following has been met:

Retired Public Safety Employees

A Public Safety Employee who, on or after June 30, 1989, retires or receives disability benefits (*under Ind. Code § 36-8-6, 7, 7.5, 8, and 10*) may elect coverage for himself, his or her spouse, and Dependents if the following criteria are met:

- he or she is not eligible for Medicare on the date that he or she retires or becomes eligible for disability payments pursuant to the statutory provisions referenced above;
- files a written request to the City of Columbus within ninety (90) days after the employee's retirement date or the date he or she begins receiving disability payments; and
- employee agrees to make timely payment for premiums in an amount determined by the Employer (which cannot exceed the total amount paid by the Employer and an active Employee for equivalent coverage).

The surviving spouse and Dependents of a Public Safety Employee who dies while in active service or after retirement may continue coverage for himself or herself and his or her Dependents. In order to continue coverage, the spouse or Dependent must file a written request for coverage on a form satisfactory to the Employer within ninety (90) days after the employee's death. He or she must also make timely payment of an amount determined by the Employer but not more than the total amount paid by the Employer and an active Employee for equivalent coverage.

Retired Employees (non-Public Safety Employees)

A retired Employee (other than Public Safety Employees) who retires on or after June 30, 1986 may elect coverage for himself, his or her spouse, and Dependents if the following criteria are met:

- completed twenty (20) years of creditable employment with a public employer, ten (10) years of which must have been completed immediately prior to his or her retirement date;
- completed fifteen (15) years of participation in the Employer's retirement plan on or before his or her retirement date;
- reached age 55;

- not eligible for Medicare on his or her retirement date;
- filed a written request to City of Columbus within ninety (90) days after the employee's retirement date or the date he begins receiving disability payments; and
- employee agrees to make timely payment of an amount determined by the Employer but not more than the total amount paid by the Employer and an active Employee for equivalent coverage.

Coverage is available to all retired Employees who meet the defined criteria listed above and to all eligible Dependents of the retired Employee. All eligible retirees will be required to elect coverage in writing each year to continue their coverage. The Retired Employee is required to pay the amount as set by the Plan Administrator.

When Coverage Begins

Look-back Measurement Method for Determining Full-time Employee Status

City of Columbus uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- All employees

The look-back measurement method involves three different periods:

- Measurement period
- Stability period
- Administrative period

The measurement period is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the standard measurement period and any administrative period.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the "initial measurement period." Your hours of service during the initial measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, City of Columbus will determine your status as a full-time employee who is eligible for the Plan's health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

The stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of City of Columbus. There are exceptions to this general rule for employees who experience certain changes in employment status.

An administrative period is a short period between the measurement period and the stability period when City of Columbus performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by City of Columbus or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation.

City of Columbus intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

For You

Your health care coverage begins the first day of employment after you meet all eligibility requirements.

For Your Dependents

If you enroll your eligible dependents within 31 days of your initial eligibility, their coverage begins at the same time as yours.

If both parents are Employees with City of Columbus, their children will be covered as a Dependent of one of the parents, but not both. Coverage for newly eligible Dependents will begin on the date they become a Dependent as long as you enroll them within 31 days of the date on which they became eligible.

If you are covered under this Plan, and change status from Employee to Dependent, or Dependent to Employee, and both of you have been covered continuously under this Plan before, during and after the change in status, credit will be given for Deductible, Copay and/ or Coinsurance amounts.

If two Employees (Spouses) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period, as long as coverage has been continuous. Credit will be given for Deductible, Copay and/ or Coinsurance amounts.

If you acquire a new Dependent, such as a through marriage, dependent birth or an adoption or placement for adoption, coverage will take effect on the date of the marriage, birth, the date of the adoption, or placement for adoption, as long as you enroll the dependent within 31 days of the date on which they became eligible.

A newborn child born while you are enrolled for medical coverage will automatically be covered on your Plan from birth for a period of thirty-one (31) days. Coverage will continue for the newborn as long as you enroll them within thirty-one (31) days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll the newborn until the next annual enrollment period. Charges for nursery and physician care for the newborn will be applied toward the plan of the covered newborn. A separate deductible and coinsurance will apply to charges incurred by the newborn child.

Your Cost for Coverage

Both the Plan Sponsor and you share in the cost of your health care benefits. Each year, the Plan Sponsor will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the coverage categories available to you.

You pay your portion of this cost through pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in medical and prescription drug coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Plan Sponsor to deduct any required premiums from your pay.

The elections you make will remain in effect until the next January 1, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverages designated by the Plan Administrator, if applicable, as shown in your enrollment materials.

You will automatically receive identification (ID) cards when your enrollment is processed.

Late Entrant

Your enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 31 days after you first become eligible; or
- You again elect coverage after cancelling.

Unless the Special Enrollment Rights apply, if you are a late entrant, you will be required to wait until the next open enrollment period.

Open Enrollment

Every 4th Quarter (time to be announced), during the open enrollment period, you will be given the opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage, if applicable, you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on January 1 and stay in effect through December 31, unless you have a qualifying change in status.

Every 4th Quarter (time to be announced) during the open enrollment period, 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.

During the designated open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective on January 1 of each year and remain in effect unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce or adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

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

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

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of Internal Revenue Code (“IRC”) §125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Plan Sponsor nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days of the following:

- The date you have a qualifying change in status;
- The date you meet the Special Enrollment Rights criteria described.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- marital status changes (e.g., marriage, legal separation, annulment, or divorce);
- changes in the number of dependents (e.g., increase through birth or adoption, or decrease through death);
- changes in residence that affect eligibility (i.e., moving out coverage area for a managed care option);
- changes in employment status of employee or dependent that affects eligibility for Plan (e.g., change from full-time to part-time, commencement or return from unpaid leave, or termination);
- changes in hours of service that affect eligibility under the Plan;
- cessation of coverage in order to purchase coverage through the Marketplace established under the PPACA;
- a dependent ceases to qualify as such under the Plan (i.e., becomes ineligible or regains eligibility); and
- any of the HIPAA special enrollment events (please see section titled “Special Enrollment Rights”).

In certain limited circumstances, an employee may make changes to his or her coverage if the following Change in Status events require him or her to do so:

- Judgment, decree or order (i.e., qualified medical child support order);
- Entitlement to Medicare or Medicaid, or a loss of such entitlement (please note that this does not include state CHIP, Veteran’s Affairs, or TRICARE benefits);
- Significant mid-year Plan changes (e.g., significant changes in the cost of coverage or significant curtailment of coverage); and
- Certain required circumstances under Family and Medical Leave Act of 1993 (“FMLA”) when applicable to your employer (*please see below section titled “Continuation during Family and Medical Leave”*)

If you believe that you have experienced a Change in Status, you should report that change and fill out any necessary forms as soon as possible, but no later than 31 days, after the event occurs.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

Your coverage under this Plan ends on the last day of the calendar month in which you cease to be in one of the Eligible Classes. This includes death or termination of Active Employment, or the date your Eligible Class is eliminated, unless benefits are extended through COBRA;

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the day your dependent is no longer eligible for coverage. However, for a dependent child who reaches the limiting age, coverage will end on the last day of the calendar month of their birthday.

Coverage will also end for you and your covered dependents as of the date the Plan Sponsor terminates this Plan or, if earlier, the date you request termination of coverage for you and your covered dependents.

If your coverage under the Plan ends for reasons other than the Plan Sponsor's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under COBRA.

Reinstatement of Coverage

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements in order to be covered under the Plan unless the following scenarios apply to your situation.

A rehired employee would retain previous eligibility and not be treated as a new employee if:

- an employee has more than 13 consecutive weeks of experience in his/her previous period of employment, an employee has a break of service of less than 13 weeks; or
- an employee has less than 13 consecutive weeks of experience in a previous period of employment, an employee has a break of service that does not exceed 4 weeks or a break of service that does not exceed his/her previous period of employment.

For a Retired Public Safety Employee, your coverage ends on the earliest of the following:

- the date the person (Retired Public Safety Employee, surviving spouse, or Dependent) becomes eligible for Medicare (i.e., turns 65, etc.);
- the date the Employer terminates health coverage for active Public Safety Employees; or
- the first day of the month for which a person fails to make timely payment of premiums;

AND in addition, in the case of a surviving spouse:

- the date of the spouse's remarriage;
- the date health benefits become available through surviving spouse's own employment; or
- the date health insurance become available through a new employer;

AND in addition, in the case of a Dependent:

- the date the Dependent fails to meet the definition of a Dependent; or
- the date health insurance become available through a new employer.

For a Retired Employees (non- Public Safety Employees), your coverage ends on the earliest of the following:

- the date the person (Retired Employee, surviving spouse, or Dependent) becomes eligible for Medicare (i.e., turns 65, etc.);
- the date the Employer terminates health coverage for active Employees; or
- the first day of the month for which a person fails to make timely payment of premiums;

AND in addition, in the case of a surviving spouse:

- the date of the spouse's remarriage; or
- two (2) years after the death of the Employee

AND in addition, in the case of a Dependent, the date the Dependent fails to meet the definition of a Dependent.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan.

Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent. You will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activities that are in excess of the premiums paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, health care coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you continue to be paid while you are absent from work, any premium payments will continue to be deducted from your pay on a pre-tax basis. If you are not receiving your pay during an absence, you will need to make arrangements for payment of any required premiums. You should discuss with your supervisor what options are available for paying your share of costs while you are absent from work.

If You Are Disabled or FMLA Approved Leave

If you become disabled or take an approved FMLA Leave of Absence, your coverage will terminate at the end of the 13th week after benefits begin unless additional leave is approved as provided above and required by applicable laws and regulations (i.e., the Americans with Disabilities Act (“ADA”).

If You Are Temporarily Laid Off

If you are laid off for a temporary period of time, your coverage will end on the day in which you cease to be in one of the Eligible Classes.

Leave of Absence

If you take a leave of absence, your coverage will end on the last day of the calendar month in which you cease to be in one the Eligible Classes, unless benefits are extended through COBRA.

While continued, coverage will be the same as it was on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for you.

Continuation during Family and Medical Leave

This Plan shall at all times comply with the FMLA as promulgated in regulations issued by the Department of Labor to the extent it does not otherwise conflict with other relevant laws and regulations (i.e., ADA).

To the extent the FMLA applies to the Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. An Employee with questions concerning any rights and/or obligations should contact his Employer.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both USERRA and COBRA, which run concurrently, starting on the date your military service begins.

If You Are Permanently Laid Off

If you are permanently laid off (separated from service), your coverage under this Plan ends on the last day of the calendar month in which you cease to be an Active Employee.

SECTION III: YOUR MEDICAL BENEFITS

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

All benefits described in this SPD 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 Customary; 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 Plan contains a Participating Provider Organization (PPO) which is a group contracted providers that provide services at negotiated rates. Please refer to your identification card for information about your PPO network(s).

PPO name:	Inspire Network
Address:	PO Box 1787 Columbus, IN 47202
Telephone:	(800) 443-2980
Website:	www.siho.org

PPO name:	SIHO Network
Address:	PO Box 1787 Columbus, IN 47202
Telephone:	(800) 443-2980
Website:	www.siho.org

Out-of-Area PPO name:	PHCS Healthy Directions
Address:	1100 Winter St. Waltham, MA 02451
Telephone:	1-888-779-7427
Website:	www.multiplan.com

Therefore, when a Plan Participant uses a Network Provider, that Plan Participant will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Plan Participant's choice as to which Provider to use.

In some cases, Plan Participants (Employees and Dependents) receive health care services or supplies from non-network facilities and providers. In order to assist the Plan Sponsor in reducing the cost of health care in these circumstances, the Plan may access additional network vendors through contractual arrangements established by the Claims Administrator and its affiliated entities. In the event a particular facility or provider is not contracted with any other specific network listed in this SPD as of the applicable date of the particular health care service or supply, the Plan Sponsor reserves the right to establish another network for the purpose of potentially reducing the cost of services and/or preventing the provider from balance billing the

Plan Participants. In the below circumstances, the In-Network payment will be made for certain Non-Network services; otherwise, the payment will apply to the Out-of-Network benefit level.

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

- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the PPO service area, services will apply to the Tier 1 Inspire benefit level.
- If a Plan Participant has an Emergency Medical Condition requiring immediate care benefits will apply to the Tier 1 Inspire benefit level.
- If a Plan Participant receives Physician or anesthesia services from a Non-Network Radiologist, ER Physician, Pathologist or Anesthesiologist at an In-Network facility, the benefit will apply to the same Tier benefit level as the facility where services were rendered.
- If a Plan Participant receives Physician services from a Radiologist, ER Physician, Pathologist or Anesthesiologist that is in the Tier 2 or Tier 3 Network but services are provided at a higher Tier Network facility, the benefit will apply to the same Tier benefit level as the facility where services were rendered.
- If a Plan Participant has lab work taken by a network Physician, but the Physician sends it to a Non-Network facility for evaluation, services will apply to the same Tier benefit level as the ordering Physician.
- If a Plan Participant utilizes a PHCS Healthy Directions Provider while traveling or living outside the PPO service area, services will apply to the Tier 1, Inspire benefit level.
- If a Plan Participant resides outside the PPO service area, such as a full time student, and receives services at a Non-Network provider, services will apply to the Tier 1, Inspire benefit level.

The Plan does not require you to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist.

A network of providers gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care in- or out-of-network. Refer to the Summary of Medical Benefits for more information.

To select a Primary Care Physician or “PCP,” or to obtain a listing of current providers (at no cost to you) or confirm whether a provider participates in the network, contact the Claims Administrator for the network by visiting www.siho.org.

If you use in-network providers, the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or Claims Administrator may require you to do so.

If you use out-of-network providers, the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible), up to the Usual and Customary limit or maximum plan allowance. You are responsible for charges in excess of this limit and this excess amount may not apply to your deductible or any out-of-pocket maximum. You may also pay a higher deductible and out-of-pocket maximum (if applicable) out-of-network, and you may be required to file claim forms. See the Summary of Medical Benefits for additional information.

Your Deductible

A deductible is money you must pay for certain covered expenses before the Plan pays benefits. It is calculated on a calendar year basis. Each January 1st a new deductible amount will be required. Consult the Summary of Medical Benefits chart for more information.

PPO Deductible Accumulation: Embedded

The Plan uses an embedded deductible which means when any one individual reaches the individual deductible limit, the Plan coverage takes effect for that member only. If there are multiple Participants covered under the Plan, the remaining family deductible amount may be met by a combination of Participants at which time the Plan coverage takes effect for the family.

HDHP Deductible Accumulation: Non-Embedded

A deductible is any amount of money that is paid once a Calendar Year per Covered Person or Family. Each January 1st, a new deductible amount is required. For single coverage, the Covered Person must meet the individual deductible before the benefit plan coverage takes effect. For family coverage the deductible is "**non-embedded**" meaning the entire family deductible must be met before the benefit plan coverage takes effect. The family deductible may be met by any one or a combination of family members.

High Deducible Health Plan with Health Savings Account

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives you greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

Your Copayment

Some services may require a copayment – a fixed dollar amount you must pay before the Plan pays for that service. This amount applies regardless of whether the deductible has been satisfied. Any copayments will be shown in the Summary of Medical Benefits Chart or the Summary of Prescription Drug section.

PPO Plan Special Copayment for Non-Emergency Use of Emergency Room

A Special Copayment, as shown in the Summary of Medical Benefits, will apply to all services rendered at the emergency room when the services are deemed to be non-emergency in nature. The definition of Emergency Care in the Definitions section of this document will be used to determine whether the diagnosis submitted on the claim should be deemed as an emergency or a non-emergency.

The Special Copayment is in addition to any normal deductibles and coinsurance the covered person is responsible for under this Plan.

Coinsurance Stop Loss Amount

Coinsurance is the shared costs for Covered Expenses between the Plan Participant and the Plan. The amounts shown in the Summary of Medical Benefits are the percentages that the Plan will pay for Covered Expenses after the Deductible has been met, unless otherwise noted. The Plan Participant is responsible for the remaining percentage amount. The Coinsurance Stop-Loss Amount is the total amount a Plan Participant or Covered Family must pay (after the Deductible) before the Plan begins paying 100% for Covered benefits for the remainder of the Calendar Year.

Out-of-Pocket Limit

Covered Charges are payable at the percentages shown each Calendar Year until the out of pocket limit shown in the Summary of Medical Benefits is reached. Then, Covered Charges incurred by a Plan Participant will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year. The out-of-pocket limit combines the copayment, deductible and coinsurance stop-loss amounts.

When a Covered Family reaches the out of pocket limit, Covered Charges for that Covered Family will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year. Charges that are excluded from the out-of-pocket limits are as follows:

- Premiums;
- Balance Billed Charges;
- Precertification Penalties; and
- Healthcare this Plan does not cover.

Summary of Medical Benefits

PPO Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
MAXIMUM ANNUAL BENEFIT AMOUNT	Unlimited		
DEDUCTIBLE, PER CALENDAR YEAR			
Per Individual	$750	$750	$750
Per Covered Family	$1,500	$1,500	$1,500
NOTE: *Amounts used to satisfy the Tier 1 Deductible accumulates toward the satisfaction of the Tier 2 Deductible and vice versa. Tier 3 does not cross apply with any other Network.*			
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Individual	$4,750	$4,750	$750
Per Covered Family	$9,500	$9,500	$1,500
NOTE: *Amounts used to satisfy the Tier 1 Maximum Out-of-Pocket accumulates toward the satisfaction of the Tier 2 Maximum Out-of-Pocket and vice versa. Tier 3 does not cross apply with any other Network.*			
NOTE: *The Plan will pay the designated 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. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: premiums, balance-billed charges, precertification penalties, and services this Plan does not cover.*			
COVERED CHARGES			
Hospital Services			
Generally			
Room and Board*	80% after deductible	70% after deductible	60% after deductible
Intensive Care Unit*	80% after deductible	70% after deductible	60% after deductible
Pre-Admission Testing	80% after deductible	70% after deductible	60% after deductible
***Precertification required**			
Skilled Nursing Facility*	80% after deductible	70% after deductible	60% after deductible
Sub-Acute Inpatient Facility*	80% after deductible	70% after deductible	60% after deductible
Acute Rehabilitation Hospital*	80% after deductible	70% after deductible	60% after deductible
****Precertification required***. Calendar Year Maximum: 60 Days for Skilled Nursing			
Ambulance Service*	80% after deductible		
NOTE: ****Emergent Ambulance charges will apply to the Tier 1 benefit level. This includes non-emergent transportation from one facility to another facility.*			
Non-Emergent Ambulance	80% after deductible	70% after deductible	60% after deductible

Summary of Medical Benefits (*continued*)

PPO Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
Emergency Room Services			
Facility Charges	80% after deductible		
Physician Charges	80% after deductible		
NOTE: *Any charges incurred at Non-Network provider due to True emergency will apply as In-Network benefits.*			
Non-Emergency Facility Charges	$150 copayment; then 80% after deductible	$150 copayment; then 70% after deductible	$150 copayment; then 60% after deductible
Non-Emergency Physician Charges	80% after deductible	70% after deductible	60% after deductible
Physician Services			
Primary Care			
Office visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Specialist Care			
Office Visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Urgent Care			
Office visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Inpatient/Outpatient Physician Services	80% after deductible	70% after deductible	60% after deductible
Lab Tests			
Performed at Prompt Med; CRH lab at Sandcrest; any provider sending specimen to CRH	100% no deductible	100% no deductible	N/A
All Other Physicians/Facilities *(including labs performed directly at CRH)*	80% after deductible	70% after deductible	60% after deductible
Outpatient Services			
Outpatient Surgery	80% after deductible	70% after deductible	60% after deductible
Diagnostic X-Rays	80% after deductible	70% after deductible	60% after deductible
CT Scan/MRI	80% after deductible	70% after deductible	60% after deductible
Chemotherapy/Radiation*	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
****Precertification required for Chemotherapy and Radiation***			
Specialty Medication*	80% after deductible	70% after deductible	60% after deductible
****Precertification required. Covered under the Medical Benefit.***			

Summary of Medical Benefits (*continued*)

PPO Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
Preventive Health Benefits (PHB)*			
Wellness Benefit*	100% no deductible	100% no deductible	100% no deductible
*For more complete information, please consult the ***SIHO Comprehensive PHB guidelines*** available on SIHO's website (*www.siho.org*).			
Preventive Dental Services*	100% no deductible	100% no deductible	100% no deductible
* Preventive Dental exams, X-rays (bite-wings), & cleanings limit to 2 per year; Fluoride for children under age 15, limit to 2 per year - covered under the Preventive Care Benefit.			
Mental Health/Substance Abuse			
Inpatient*	80% after deductible	70% after deductible	60% after deductible
Residential Treatment (RES)*	80% after deductible	70% after deductible	60% after deductible
Outpatient Office Services	80% after deductible	70% after deductible	60% after deductible
Intensive Outpatient (IOP)*	80% after deductible	70% after deductible	60% after deductible
Partial Hospitalization (PHP)*	80% after deductible	70% after deductible	60% after deductible
****Precertfication required for Inpatient, Residential Treatment, Intensive Outpatient (IOP), and Partial Hospitalization (PHP).***			
Therapy Services			
Occupational Therapy	80% after deductible	70% after deductible	60% after deductible
Physical Therapy	80% after deductible	70% after deductible	60% after deductible
Speech Therapy*	80% after deductible	70% after deductible	60% after deductible
ABA Therapy*	80% after deductible	70% after deductible	60% after deductible
****Precertfication required for Speech Therapy and ABA Therapy.***			
Other Services			
Chiropractic/Spinal Manipulation*	80% after deductible	70% after deductible	60% after deductible
*Calendar Year Maximum: 30 Visits. X-rays do **not** apply to the Calendar Year Maximum.			
Dialysis*	80% after deductible	70% after deductible	60% after deductible
****Precertification required***			
Second Surgical Opinion	80% after deductible	70% after deductible	60% after deductible
*Durable Medical Equipment (DME) & Prosthetics	80% after deductible	70% after deductible	60% after deductible
****Precertification required for purchases over $750 and all rentals***			
Orthotics	80% after deductible	70% after deductible	60% after deductible
Home Health Care*	100% no deductible	100% no deductible	100% no deductible
****Precertification required*** - Calendar Year Maximum: 100 Visits			
Hospice Care* *(includes bereavement counseling)*	80% after deductible	70% after deductible	60% after deductible
****Precertification required*** - Calendar Year Maximum: 3 months outpatient; 6 months inpatient			
Maternity/Pregnancy	80% after deductible	70% after deductible	60% after deductible
****Dependent Daughter Maternity Covered***			
Morbid Obesity Treatment*	80% after deductible	70% after deductible	60% after deductible
*Calendar Year Maximum: $1,000			
TMJ/Jaw Joint	80% after deductible	70% after deductible	60% after deductible
Foot Care	80% after deductible	70% after deductible	60% after deductible
Clinical Trials	80% after deductible	70% after deductible	60% after deductible

Summary of Medical Benefits (*continued*)

PPO Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
Organ/Tissue Transplant*	80% after deductible	70% after deductible	60% after deductible
Precertification required			
Wigs*	80% after deductible	70% after deductible	60% after deductible
*Initial purchase of a wig after chemotherapy			

Summary of Medical Benefits (*continued*)

HDHP Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
MAXIMUM ANNUAL BENEFIT AMOUNT	Unlimited		
DEDUCTIBLE, PER CALENDAR YEAR			
Per Individual	$1,500	$1,500	$1,500
Per Covered Family	$3,000	$3,000	$3,000
NOTE: *Amounts used to satisfy the Tier 1 Deductible accumulates toward the satisfaction of the Tier 2 Deductible and vice versa. Tier 3 does not cross apply with any other Network. The deductible is **"non-embedded"** meaning for family coverage, the entire family deductible must be met before any money is paid by the Plan.*			
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Individual	$4,750*	$4,750*	$4,750*
Per Covered Family	$9,500*	$9,500*	$9,500*
NOTE: *Amounts used to satisfy the Tier 1 Maximum Out-of-Pocket accumulates toward the satisfaction of the Tier 2 Maximum Out-of-Pocket and vice versa. Tier 3 does not cross apply with any other Network.*			
**Even though the deductible is non-embedded for family coverage, an individual will only need to meet the individual out-of-pocket maximum before the Plan pays at 100% for that individual.*			
NOTE: *The Plan will pay the designated 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. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: premiums, balance-billed charges, precertification penalties, and services this Plan does not cover.*			
COVERED CHARGES			
Hospital Services			
Generally			
Room and Board*	80% after deductible	70% after deductible	60% after deductible
Intensive Care Unit*	80% after deductible	70% after deductible	60% after deductible
Pre-Admission Testing	80% after deductible	70% after deductible	60% after deductible
***Precertification required**			
Skilled Nursing Facility*	80% after deductible	70% after deductible	60% after deductible
Sub-Acute Inpatient Facility*	80% after deductible	70% after deductible	60% after deductible
Acute Rehabilitation Hospital*	80% after deductible	70% after deductible	60% after deductible
****Precertification required***. Calendar Year Maximum: 60 Days for Skilled Nursing			
Ambulance Service*	80% after deductible		
NOTE: ***Emergent Ambulance charges will apply to the Tier 1 benefit level. This includes non-emergent transportation from one facility to another facility.**			
Non-Emergent Ambulance	80% after deductible	70% after deductible	60% after deductible

Summary of Medical Benefits (*continued*)

HDHP Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
Emergency Room Services			
Facility Charges	80% after deductible		
Physician Charges	80% after deductible		
NOTE: *Any charges incurred at Non-Network provider due to True emergency will apply as In-Network benefits.*			
Non-Emergency Facility Charges	80% after deductible	70% after deductible	60% after deductible
Non-Emergency Physician Charges	80% after deductible	70% after deductible	60% after deductible
Physician Services			
Primary Care			
Office visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Specialist Care			
Office Visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Urgent Care			
Office visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Inpatient/Outpatient Physician Services	80% after deductible	70% after deductible	60% after deductible
Lab Tests			
Performed at Prompt Med; CRH lab at Sandcrest; any provider sending specimen to CRH	80% after deductible	70% after deductible	60% after deductible
All Other Physicians/Facilities *(including labs performed directly at CRH)*	80% after deductible	70% after deductible	60% after deductible
Outpatient Services			
Outpatient Surgery	80% after deductible	70% after deductible	60% after deductible
Diagnostic X-Rays	80% after deductible	70% after deductible	60% after deductible
CT Scan/MRI	80% after deductible	70% after deductible	60% after deductible
Chemotherapy/Radiation*	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
****Precertification required for Chemotherapy and Radiation***			
Specialty Medication*	80% after deductible	70% after deductible	60% after deductible
Precertification required. Covered under the Medical Benefit.			

Summary of Medical Benefits (*continued*)

HDHP Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
Preventive Health Benefits (PHB)*			
Wellness Benefit*	100% no deductible	100% no deductible	100% no deductible
*For more complete information, please consult the ***SIHO Comprehensive PHB guidelines*** available on SIHO's website (*www.siho.org*).			
Mental Health/Substance Abuse			
Inpatient*	80% after deductible	70% after deductible	60% after deductible
Residential Treatment (RES)*	80% after deductible	70% after deductible	60% after deductible
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Partial Hospitalization (PHP)*	80% after deductible	70% after deductible	60% after deductible
****Precertfication required for Inpatient, Residential Treatment, Intensive Outpatient (IOP), and Partial Hospitalization (PHP).***			
Therapy Services			
Occupational Therapy	80% after deductible	70% after deductible	60% after deductible
Physical Therapy	80% after deductible	70% after deductible	60% after deductible
Speech Therapy*	80% after deductible	70% after deductible	60% after deductible
ABA Therapy*	80% after deductible	70% after deductible	60% after deductible
****Precertfication required for Speech Therapy and ABA Therapy.***			
Other Services			
Chiropractic/Spinal Manipulation*	80% after deductible	70% after deductible	60% after deductible
*Calendar Year Maximum: 30 Visits. X-rays do **not** apply to the Calendar Year Maximum.			
Dialysis*	80% after deductible	70% after deductible	60% after deductible
****Precertification required***			
Second Surgical Opinion	80% after deductible	70% after deductible	60% after deductible
*Durable Medical Equipment (DME) & Prosthetics	80% after deductible	70% after deductible	60% after deductible
****Precertification required for purchases over $750 and all rentals***			
Orthotics	80% after deductible	70% after deductible	60% after deductible
Home Health Care*	80% after deductible	70% after deductible	60% after deductible
****Precertification required*** - Calendar Year Maximum: 100 Visits			
Hospice Care* *(includes bereavement counseling)*	80% after deductible	70% after deductible	60% after deductible
****Precertification required*** - Calendar Year Maximum: 3 months outpatient; 6 months inpatient			
Maternity/Pregnancy	80% after deductible	70% after deductible	60% after deductible
****Dependent Daughter Maternity Covered***			
Morbid Obesity Treatment*	80% after deductible	70% after deductible	60% after deductible
*Calendar Year Maximum: $1,000			
TMJ/Jaw Joint	80% after deductible	70% after deductible	60% after deductible
Foot Care	80% after deductible	70% after deductible	60% after deductible
Clinical Trials	80% after deductible	70% after deductible	60% after deductible

Summary of Medical Benefits (*continued*)

HDHP Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
Organ/Tissue Transplant*	80% after deductible	70% after deductible	60% after deductible
Precertification required			
Wigs*	80% after deductible	70% after deductible	60% after deductible
*Initial purchase of a wig after chemotherapy			

Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered illness, accidental injury, pregnancy or other covered health care condition. Services received from an out-of-network provider are subject to the Usual and Customary limit.

The following are common conditions and services for which expenses are typically paid:

- **Abortions:** including elective abortions are covered if the pregnancy is a result of rape or incest or if continuing the pregnancy is life-threatening to the mother. Complications from an abortion will be a covered expense even if the abortion is not covered.
- **Acute care (inpatient) and rehab hospitals**: At an acute rehabilitation facility located in a freestanding hospital, or a rehabilitation unit in an acute care hospital. To qualify as an acute rehabilitation facility, the following must be available: medical care, physical therapy, occupational therapy, speech-language therapy, vocational rehabilitation, therapeutic recreation, psychological services, 24-hour nursing care and other services as needed. Patient must be capable of performing at least 3 hours of therapy a day, at least 5 days a week.
- **Allergy testing and treatment**: includes allergy testing, serum and injections.
- **Ambulance**: includes medically necessary professional ambulance services. 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 Claims Administrator finds a longer trip was medically necessary. Includes charges for local ground or air transportation by a professional ambulance service.
- **Ambulatory Surgical Center**: includes services and supplies provided by an Ambulatory Surgical Center in connection with a covered outpatient surgery. A Center is a licensed facility used mainly for performing outpatient surgery and does not provide for overnight stays.
- **Anesthesia**: includes anesthetics and the services of a licensed physician or certified registered nurse anesthetist (C.R.N.A.)
- **Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder**: includes diagnosis and treatment.
- **Autism and Asperger's Syndrome (*also known as Pervasive Developmental Disorders*)**: includes diagnosis and treatment, including ABA Therapy services.
- **Blood**: includes blood and blood derivatives (if not replaced by or on behalf of the patient), including blood processing and administration services.
- **Cardiac Patient Exercise Program**: covered services for an individually prescribed exercise program for cardiac patients to improve cardiovascular function and physical work capacity. These services are only covered for those who have a history of bypass surgery, stable angina pectoris or acute myocardial infarction within the past twelve months. Services must be prescribed and authorized by the attending physician.

- **Cardiac Rehabilitation Phase I and II**: as deemed Medically Necessary provided services are rendered under the supervision of a Physician, in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery, initiated within 12 weeks after other treatment for the medical condition ends, and is performed in a Medical Care Facility. ***Phase III is not covered*.**
- **Chemotherapy**: includes medically necessary and appropriate drugs and services of a physician or medical provider;
- **Chiropractic Care/Spinal Manipulations**: services by a licensed M.D., D.O or D.C. Chiropractic Care is intended to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interfaces from or related to distortion, misalignment or subluxation of the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractic Care. X-Rays are not subject to the Calendar year visit maximum.
- **Circumcision**
- **Clinical Trials**:
    - Routine patient care costs that are covered:
        - those that would be covered for a patient not enrolled in a clinical trial
        - services required for the provision of the investigational item or service
        - services needed for reasonable and necessary care arising from the provision of the investigational item or service.
    - Routine patient care costs that are not covered:
        - investigational item, device, or service, itself;
        - 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; or
        - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
    - In order to be considered a Covered Service the following criteria must be met:
        - a physician must determine and document that the member is appropriate for a clinical trial; and
        - the member must meet the eligibility criteria of the trial.
    - The trial must be:
        - conducted for the prevention, detection or treatment of cancer or other life threatening disease or condition; **and is**
        - Federally-funded;
        - sponsored by FDA; or
        - a drug trial exempt from Investigational New Drug (IND) requirements.
    - A trial is considered federally funded if it is approved and funded by one or more of these agencies:
        - National Institutes of Health

        - Centers for Disease Control
        - Agency for Healthcare Research Quality
        - Centers for Medicare and Medicaid Services
        - Department of Defense
        - Veterans Administration; or the
        - Department of Energy.
    - If the Covered Person is eligible to participate in a clinical trial that is offered by both a network provider and a non-network provider, only the trial offered by the network provider (and otherwise meeting the criteria of this section) will be considered a Covered Benefit.

- **Contraceptives**: all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all people with reproductive capacity are covered under the Preventive Health Benefit as required by the Affordable Care Act.
- **Diabetic Education**: including management training.
- **Diabetic Supplies**: not purchased through the pharmacy will be covered under major medical.
- **Diagnostic Lab and X-Ray, Outpatient**: includes laboratory, X-ray, EKGs, and other non-surgical services performed to diagnose medical disorders by physicians throughout the United States; also includes advanced scanning and imaging work (e.g., CT scans, MRIs) and other similar advanced tests.
- **Dialysis**: treatment for acute renal failure or chronic irreversible renal insufficiency for removing waste materials from the body. Dialysis includes hemodialysis and peritoneal dialysis.
- **Durable Medical or Surgical Equipment**: rental of 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.
- **Emergency Room Visits** – includes medical treatment for an emergency. An emergency is an accident or the sudden and unexpected onset of an acute condition, illness, or severe symptoms that require immediate medical care. Examples include fractures, lacerations, motor vehicle accidents, hemorrhage, shock, poisoning, or other conditions associated with deterioration of vital life functions.

  Colds, sore throats, flu, and infections are examples of non-emergencies, although they may require urgent treatment.

  The Plan determines which conditions and symptoms are medical emergencies using the “prudent layperson” definition of emergency. A prudent layperson is someone who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person. For example, if someone goes to the emergency room with chest pains and the situation turns out to be indigestion, a prudent layperson would agree that seeking emergency care was appropriate.

- **Eyeglasses/Contact Lenses**: coverage for the initial pair of eyeglasses, contact lenses or intra-ocular lenses following cataract surgery only.
- **Foot care**: Charges for any foot care including Orthotics will be covered. Covered foot care expenses include, but are not limited to, services in connection with weak, strained or flat feet, any instability or imbalance of the foot, metatarsalgia, and plantar fasciitis. The following foot care expenses will also be covered:
  - open cutting operation/surgery
  - care of corns, bunions, calluses or toenails when medically necessary because of diabetes or circulatory problems
  - care of heel spurs (not including Orthotics)
- **Hemodialysis and Peritoneal Dialysis Services**: includes the services of a person to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or other approved covered provider.
- **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 Illness 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. Services include but are not limited to, physical, speech, occupational or respiratory therapy by a licensed qualified therapist; nutrition counseling provided by or under the supervision of a registered dietician; or medical supplies, laboratory services, drugs, and medications prescribed by a Physician.

  Home Health Care must meet the following qualifications: 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. 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.
- **Hospice Care Services and Supplies**: charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Plan Participant'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.

  Bereavement counseling services by a licensed social worker or licensed pastoral counselor for the patient's immediate family (covered Spouse and/or Dependent Children) is covered. Bereavement services must be furnished within six months after the patient's death.
- **Hospital Services**: includes hospital, ambulatory surgical center or birthing center charges for the following:
  - *Room and board* - For a semiprivate room, charges are covered at the most common rate; for a private room in a hospital with semiprivate rooms, charges are covered only up to the hospital's most common semiprivate room rate. However, if it is medically necessary to stay in a private room, the full charge will be a covered

medical expense. For a private room in a private-room-only hospital, the full cost of the private room will be considered a covered medical expense.

- services required for medical or surgical care, whether as an outpatient or inpatient, and other related services;
- services of nursing staff and other hospital staff providing care;
- emergency room services; and
- medically necessary services.

An inpatient hospital stay for the diagnosis of an illness or injury will be covered only if the stay is mandatory or is required for the safety of the patient or the success of a medical treatment or test. Also includes services that can be done on an outpatient basis, or services performed inpatient when a concurrent medical hazard exists that prevents the patient from being treated on an outpatient basis.

- **Human Organ and Tissue Transplants**
  - *Pre-certification Requirement for Transplant Evaluation*: expenses incurred in connection with the evaluation of a Plan Participant for any human organ or tissue transplant will be covered, but only after Referral and Precertification through the Claims Administrator has occurred. The Plan Participant or his Physician should contact the Claims Administrator for Precertification of an evaluation prior to the Referral to a transplant Physician. The Claims Administrator will assign a Case Manager to work with the Plan Participant closely through the transplant process.
  - *Pre-certification Requirement for Transplant Procedure*: After the evaluation by a Plan-designated transplant Physician has occurred, the Plan Participant or the transplant Physician should contact the Case Manager. Medical information about the Plan Participant's condition and the proposed transplant protocol will be requested for review. The Case Manager will coordinate the review of the medical information for Medical Necessity and coverage determination. The Case Manager will communicate the determination to the Plan Participant and transplant Physician.
  - *Definitions*
    - Covered Transplant Procedures: any of the following adult or pediatric human organ and tissue transplant procedures determined to be Medically Necessary:
      - Heart;
      - Liver;
      - Bone marrow (related or unrelated);
      - Lung;
      - Kidney;
      - Pancreas;
      - Cornea;
      - Multivisceral/intestine;
      - Simultaneous pancreas/kidney; and

- Simultaneous heart/lung.

- Transplant Services: any services directly related to a Covered Transplant Procedure including, but not limited to, Inpatient and Outpatient Hospital services, Physician services for diagnosis, treatment, and Surgery for a Covered Transplant Procedure, diagnostic services, and procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, as well as surgical, storage and transportation costs incurred and directly related to the successful acquisition of an organ or tissue used in an eligible and covered organ transplant. Transplant Services also include, but are not limited to, Durable Medical Equipment rental outside of the Hospital, prescription drugs including immunosuppressives, surgical supplies and dressings, and home health care.
- Organ and/or Tissue Procurement: the payments for procurement expenses for a donor organ or tissue are covered when the Covered Transplant Procedure is performed by a specialty care Network Provider.

- *Specific Exclusions for Organ/Tissue Transplants*: there are no benefits for:
  - services and supplies of any Provider located outside of the United States of America, except for procurement services (subject to the amounts shown in the Maximums section), which will be limited to those nations which share the same protocols, standards, and registry with the U.S.A.;
  - services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied or received unless otherwise covered as a clinical trial;
  - implant of an artificial or mechanical heart or part thereof – this does not include replacement of a heart valve;
  - services for non-human organ transplants;
  - all other exclusions, limitations, or conditions set forth in this Plan, unless otherwise provided in this Human Organs and Tissue Transplants section;
  - services or supplies, including rehabilitation services, which are provide in a non-continuous chronology related to an actual transplantations performed within the effective eligibility of the Plan Participant under this Plan;
  - charges for organ transplant surgery, other than those provided in this Human Organs and Tissue Transplants section;
  - travel expenses, meals and lodging; and
  - transplants that are not medically recognized or that are experimental.
- **Medical Supplies**: includes supplies such as casts, splints, dressings, catheters, colostomy bags, oxygen and syringes and needles for the treatment of allergies or diabetes.
- **Medicines**: includes medicines dispensed and administered during an inpatient stay. See Prescription Drug Benefits for outpatient prescription drug coverage information.
- **Mental Disorders and Substance Abuse**: includes care, supplies and treatment of Mental Health and Substance Abuse.

- Coverage for mental health treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008.
- Coverage for Substance abuse includes inpatient, partial hospitalization, and outpatient treatment of substance abuse, as well as intensive outpatient programs if approved by the Plan. For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.
  - Employee Assistance Program (EAP) - Employees and Dependents with mental/nervous or substance abuse problems may receive guidance for treatment alternatives through the Employee Assistance Program (EAP). This is a confidential counseling program created to help Employees identify those types of problems in their lives.

    The Employee will contact the Employee Assistance Provider to assess the problem and refer them to an appropriate provider for help. This Plan will cover charges of facilities and professionals who can provide the medically necessary care.

    Often treatment can be provided through an outpatient program. This allows the patient to remain in their job and family environment during treatment. A "step program" gives the most effective care in the least restrictive environment.

    Care provided by the EAP director at Columbus Regional Hospital will be payable at 100% for up to five (5) visits. Additional sessions with the EAP director and/or care approved by but not rendered by the EAP director will be payable at 80%.

    Step Program – This program includes: Outpatient Counseling; Intensive Outpatient Treatment; and Inpatient Care. If Outpatient Counseling is successfully completed, then the Intensive Outpatient Treatment and Inpatient care will not be necessary. Only if a critical need exists would a patient begin treatment above the Outpatient Counseling step. The "Step Program" is designed and administered by professionals within the mental health and substance abuse industry. Your Employer works with the providers to get you and your dependents the treatment which gives the best results and fewest restrictions.

    Your EAP Provider is Columbus Regional Hospital, Employee Assistance Program, 2526 E. 17th Street, Columbus, Indiana, (812) 376-5450.

- **Military Medical Facility**: includes expenses for a U.S. military retiree and his/her covered dependents while confined in a military medical facility.
- **Morbid Obesity**: includes all treatment for Morbid Obesity including medication, surgical treatment, and complications requiring Medically Necessary intervention up to the annual maximum listed in the Summary of Medical Benefits.
- **Newborn Care**: includes services and supplies for a covered newborn who is sick or injured, including infant formula when needed for the treatment of inborn errors of

metabolism while the infant is hospital-confined. Also includes hospital nursery services and routine newborn care provided during the birth confinement or on an outpatient basis for non-hospital births. A newborn child born while you are enrolled for medical coverage will automatically be covered on your Plan from birth for a period of thirty-one (31) days. Coverage will continue for the newborn as long as you enroll them within thirty-one (31) days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll the newborn until the next annual enrollment period. Charges for nursery and physician care for the newborn will be applied toward the plan of the covered newborn. A separate deductible and coinsurance will apply to charges incurred by the newborn child. Charges for a dependent child's newborn will not be covered.

- **Oncology Services**: medically necessary cancer screenings not otherwise covered under Preventive Health Benefit.
- **Oral Surgery/Dental Care**: includes oral surgery and dental care for the following procedures:
  - removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof or floor of the mouth;
  - surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth ;
  - excision of benign bony growths of the jaw or hard palate;
  - incision of sensory sinuses or salivary glands ducts;
  - external incision and drainage of cellulitis;
  - removal of impacted teeth;
  - reduction of dislocations and excision of temporomandibular joints (TMJ);
  - emergency repair due to Injury to sound natural teeth;
  - congenital defects and birth abnormality including frenulum, frenum, cleft palate or cleft lip; and

  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.
- **Orthotics**: includes orthopedic braces, casts, splints, trusses and other orthotics prescribed by a physician that are required for support of an injured or deformed part of the body as a result of a congenital condition or an accidental injury or illness.
- **Physician Care**: professional services of a Physician for surgical or medical services.
- **Preadmission Testing**: will be payable for diagnostic lab test and x-ray exams when:
  - performed on an outpatient basis within seven days before a Hospital confinement;
  - related to the condition which causes the confinement; or
  - performed in place of tests while Hospital confined

Covered Charges for this testing will be payable even if test shows the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

- **Pregnancy**: care and treatment of pregnancy are covered, including charges provided by a licensed mid-wife. Covered expenses include one routine ultrasound. Any ultrasound beyond the first test will be covered only if medically necessary. Pregnancy of a Dependent Daughter is also covered, however the newborn of the dependent will not be covered.

  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 for a vaginal delivery (or 96 hours following a cesarean section).
- **Private Duty Nursing**: provided inpatient only when care is medically necessary and the hospital's intensive care unit is filled or the hospital has no intensive care unit. Outpatient Private Duty Nursing is not covered.
- **Prosthetics**: includes the initial purchase of artificial limbs, eyes or other prosthetic appliances required to replace natural limbs, eyes or other body parts which have been lost due to an accidental injury, illness or surgery. Coverage includes repairs to return prosthetic devices to serviceable condition, or replacement if prosthetic cannot be repaired. Repairs or replacement for misuse or abuse of prosthetic is not covered.

  To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.
- **Radiation Therapy**: includes radium and radioactive isotope therapy.
- **Reconstructive Surgery**: includes reconstructive surgery after a mastectomy, including reconstructive surgery of the breast on which the mastectomy was performed as well as reconstructive surgery of the other breast to produce a symmetrical appearance is also covered in accordance with the Women's Health and Cancer Rights Act of 1998. Coverage includes prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

  Coverage also includes charges for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit.
- **Routine Preventive Health Benefits ("PHB")**: covered charges are payable for routine PHBs, such as well-baby care, regular periodic health evaluations for adults and children, periodic health screenings, and routine immunizations appropriate for the Participant as required by the ACA and other applicable laws and regulations. These benefits are further described in the Summary of Medical Benefits and with more

specificity in the Preventive Health Benefit Guidelines, which SIHO makes available to all Participants on our website at www.siho.org.

- **Second Opinion**: 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 opinion program fulfills the dual purpose of protecting the health of the Plan's Plan Participants and protecting the financial integrity of the Plan.

  Benefits will be provided for a second 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.

  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.

- **Skilled Nursing Facility Care**: room and board and nursing care furnished by a Skilled Nursing Facility (*including an intensive rehabilitation facility and sub-acute hospital facility*) will be payable if and when:
  - the patient is confined as a bed patient in the facility;
  - attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
  - 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.

  A Skilled Nursing Facility is a facility that meets all the below qualifications:
  - It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. 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.
  - Its services are provided for compensation and under the full-time supervision of a Physician.
  - It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
  - It maintains a complete medical record on each patient.
  - It has an effective utilization review plan.
  - It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
  - It is approved and licensed by Medicare.

- **Sleep Disorders**: services, supplies, testing and medications related to diagnosis and treatment, if deemed medically necessary.
- **Smoking Cessation**: includes programs, counseling and medications are covered under the Preventive Health Benefit as required by the Affordable Care Act.
- **Sterilization**: includes voluntary sterilization procedures. Excludes reverse sterilization procedures.
- **Sub-Acute Facilities**: at a sub-acute rehabilitation facility or unit, or in a skilled nursing unit, the following services must be available: medical care, physical therapy, occupational therapy, speech-language therapy, therapeutic recreation, psychological services, and 24-hour nursing care and other services as needed.
- **Surgery**: includes surgeries performed in a doctor's office, outpatient facility, or hospital. Covered charges will be subject to the following provisions:

  If two (2) or more surgical procedures are performed during the same operative session, the maximum benefit is as follows:

  - if all procedures are performed through the same incision or in the same natural body orifice; the amount for the procedure with the highest Maximum Eligible Charge;
  - if the procedures are performed in remote operative fields and through separate incisions; the amount for the procedure with the highest Maximum Eligible Charge plus 50% of the Maximum Eligible Charge for each other procedure;
  - if bilateral procedures are performed in separate operative fields, they are treated as one (1) procedure; the Plan will pay 1-1/2 times the Maximum Eligible Charge for the unilateral procedure; and
  - if an assistant surgeon is required, the reimbursement for the assistant surgeon's Covered Charge will not exceed 20% of either the surgeon's contracted rate for Network Physicians, or the Usual and Customary allowance for a non-network physician.
- **Surgical Dressings**: splints, casts and other devices used in reduction of fractures and dislocations.
- **Temporomandibular Joint Dysfunction (TMJ):** surgical and nonsurgical treatment of TMJ, myofascial pain dysfunction syndrome and/or orthognathic treatment. Coverage excludes orthodontia services by a Physician or Dentist.
- **Therapy, Short-Term**: includes the following rehabilitation therapy services provided on an outpatient basis:

  - *Physical Therapy*: includes services by a licensed therapist or physician for improvement of bodily function and provided in accordance with physician's order as to type, frequency and duration.
  - *Occupational Therapy*: includes services and supplies when provided by a certified occupational therapist under the direction of a physician that are needed to improve and maintain a patient's ability to function.

- *Speech Therapy*: includes services of a licensed speech therapist when prescribed by a physician following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy), injury, or illness (other than a learning or mental disorder).

Maintenance care is not covered under any category above. Occupational therapy does not include coverage for recreational or social interaction.

- **Veterans Administration Hospital**: services for treatment of a non-service connected disability in a Veterans Administration hospital.
- **Wigs**: charges associated with the initial purchase of a wig after chemotherapy.

For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

Expenses Not Covered

The following expenses, among others, are not covered under the Plan:

Alternative Treatments

- acupuncture or acupressure treatments, whether or not performed by a licensed Physician;
- biofeedback;
- homeopathy;
- massage therapy and or myofascial release, whether or not performed by a massage therapist unless part of a physical treatment plan;
- any other complementary or alternative medicine treatments and supplies which are not specified as covered under this Plan.

Behavioral Exclusions

- services to treat injuries sustained or an illness contracted while the Participant or covered Dependent committed, conspired, or attempted to commit a felony or misdemeanor, or was engaged in an illegal occupation, conduct, or activity; this exclusions does not apply to an injury or illness contracted as the result of domestic violence or a medical (both physical and mental) condition;

- programs or confinements resulting from an arrest or citation for substance abuse and their related use if court ordered;

- services or expenses to treat an intentionally self-inflicted injury while sane or insane; this exclusion does not apply if the injury resulted from an act of domestic violence or a medical (both physical and mental) condition;

- services, supplies, care, or treatment for an injury or illness that results from engaging in a hazardous hobby or activity – a hobby or activity is hazardous if it is characterized by a constant threat of danger or risk of bodily harm; Hazardous hobbies or activities include skydiving, auto racing, and hang gliding;

- services, supplies, care, or treatment resulting from a Participant's or covered Dependent's illegal use of alcohol – the arresting officer's determination of inebriation will be sufficient for this exclusion; expenses will be covered for injured Participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan; this exclusion does not apply if the injury resulted from an act of domestic violence or a medical (both physical and mental) condition; and

- services, supplies, care, or treatment resulting from a Participant's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a physician; expenses will be covered for injured Participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan; this exclusion does not

apply if the injury resulted from an act of domestic violence or a medical (both physical and mental) condition.

Counseling (*unless otherwise listed as covered*)

- services of dieticians and/or nutritionists and nutrition programs unless otherwise listed as covered;
- educational or vocational testing, except as specified for diabetic training;
- legal and pastoral counseling;
- marital and pre-marital counseling; and
- financial counseling.

Custodial Care and Comfort/Convenience Items and Services

- custodial care (as defined above in the Definition section);
- care at halfway houses and group homes; and
- personal convenience items or equipment including but not limited to: radio/television rentals, air conditioners, humidifiers, air purification or heating units, exercise equipment, elastic bandages or stockings, non-hospital adjustable beds, orthopedic mattresses, blood pressure instruments, scales, and first aid supplies and other non-prescription drugs or medicines.

Dental/Oral

- the care and treatment of the teeth, gums or alveolar process, dentures, orthodontic appliances and treatment, or supplies used in such care and treatment, except as shown as covered expenses.

Hearing Aids and Exams

- Hearing aids and the fitting thereof; or hearing services and supplies not rendered in connection with medical or surgical treatment for injury or illness (voluntary ear implants for hearing loss will be covered).

Home Services/Nursing

- home management and compensatory training, meal preparation, safety procedures, and adaptive equipment instructions used to support activities of daily living;
- respite care;
- custodial care; and
- outpatient private duty nursing services

Hospital Services

- any hospital stay that is not for the diagnosis or treatment of an illness or injury; and
- non-emergency hospital admission on a Friday or Saturday unless surgery is performed within 24 hours of admission.

Medical Supplies/Appliances

- replacement braces unless there is sufficient change in the patient's condition to make the original device no longer functional.

Never Events

- not medically necessary "never events" as defined by the Centers for Medicare and Medicaid Services ("CMS"); errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients; conditions that indicate a serious problem in the safety and credibility of a health care facility or professional.

Non-compliance

- all charges in connection with treatments or medication where the patient either is in non-compliance with or is discharged from a hospital or skilled nursing facility against medical advice.

Obesity

- treatment for weight loss, including but not limited to: diet, health programs; health club dues; reversals, or weight reduction clinics. Morbid Obesity treatment will be covered up to the limits shown in the Summary of Medical Benefits.

Physical Appearance

- care, services or treatment of cosmetic procedures including but not limited to rhinoplasty, breast reductions or enlargements, and face lifts, except as listed in the eligible expenses. Medically necessary Breast Reductions are a covered benefit.

- Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by the Plan.

- 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 summary of medical benefits.

Reproduction/Sexual

- abortion unless the pregnancy is a result of rape or incest or if continuing the pregnancy is life-threatening to the mother. Complications from a covered and non-covered abortion will be covered;

- sterilization reversals;

- care, or treatment of sexual dysfunction or impotence, including expenses for supplies or services for the restoration or enhancement of sexual activity unless the impotence is caused by an underlying medical condition. A letter of Medical Necessity is required; and

- charges for services and supplies for testing and treatment of infertility, including, but not limited to, artificial insemination, gamete intra fallopian transfer (GIFT), and in vitro fertilization, except as specifically provided.

Services Provided by another Plan

- services and supplies covered by laws or regulations of any government agency, unless specifically covered under the Plan; and

- services for any condition, illness, or injury, or any complication thereof arising out of or in the course of employment, when the Participant or covered Dependent is furnished care or services covered hereunder, or could/might have been furnished such care or services if pursued or sought, according to the provisions of any Worker's Compensation or occupational disease law or insurance policy, or any other law or regulation of the United States (or any state, territory, or subdivision thereof), or according to any recognized legal remedy available to the Participant or covered Dependent.

Travel-Related Expenses

- travel and accommodation expenses unless otherwise provided under the Plan for a particular service; and

- expenses for care or treatment outside of the United States, if travel was for the sole purpose of obtaining medical services.

Vision Services

- routine eye exams, eyeglasses, contact lenses, or related services, except the initial eyeglasses or contact lenses after a cataract operation; this exclusion does not apply to aphakic patients and soft lenses or sclera shells for use as corneal bandages except as may be covered under wellness benefits; and

- expenses for radial keratotomy, keratectomy, or any other surgery to correct nearsightedness, farsightedness, or refractive errors.

Miscellaneous

- services rendered by an unlicensed provider;

- 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;

- services or supplies for an illness, defect, disease, or injury due to war or a warlike action in time of peace;

- experimental or investigational services or supplies (as defined above in the Definitions);

- services or supplies that are not medically necessary for diagnosing or treating your condition, as determined by the Plan;

- any charges in excess of the maximum amount payable under the Plan for a particular service or supply;

- services or supplies for which the patient does not have to pay, or for which no charges would be made if this coverage did not exist;

- charges that a school system is required by law to provide;
- charges for failure to keep a scheduled visit, telephone consultations between patient and doctor, or completion of claim forms;
- services not recommended and approved by a physician or treatment, services, or supplies when the participant is not under the regular care of a physician that is appropriate for the injury or illness;
- professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service;
- services performed by a person who ordinarily resides in the participant's home or who is related to the Participant and/or his covered Dependents as a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists at law; and
- services, supplies, medications, or treatment required as a result of complications from a treatment not covered under the Plan are not covered, except for non-covered abortions.

Pre-certification

Pre-certification of certain medical procedures is a condition to the Plan covering certain types of medical services, treatment, pharmaceuticals, and equipment. The following services must be pre-certified:

- All Inpatient Admissions (including, but not limited to long-term acute, sub-acute, and rehabilitation admissions);
- Skilled Nursing Facility Admissions and Stays;
- Inpatient for Mental Health/Substance Abuse;
- Residential Treatment (RES) for Mental Health/Substance Abuse;
- Intensive Outpatient Program (IOP) for Mental Health/Substance Abuse;
- Partial Hospitalization Program (PHP) for Mental Health/Substance Abuse;
- Oncology Services (including Chemotherapy and Radiation);
- Transplant Evaluations and Procedures;
- Specialty Medications;
- Home Health Care;
- Hospice Care;
- Durable Medical Equipment (DME) (*any purchase over $750 and all rentals*);
- Prosthetics (*any purchase over $750 and all rentals);*
- Applied Behavior Analysis (ABA Therapy);
- Implantation of Cardiac Defibrillators;
- Dialysis; and
- Speech Therapy.

Note: The attending Physician does not have to obtain pre-certification 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.

Procedure

Clinical information for elective medical care facility admissions must be submitted to SIHO Medical Management at least **forty eight (48) hours or the next business day** prior to admission. Emergency admissions are to be reported to SIHO Medical Management within **forty eight (48) hours or the first business day** following admission or on the next business day after admission.

Precertification is the responsibility of the Plan Participant. The utilization review program is set in motion by a telephone call from the Plan Participant and/or the service Provider. Contact SIHO Medical Management at the telephone number on your ID card **at least 48 hours or the next business day** before services are scheduled to be rendered with the following information:

- name of the patient and relationship to the covered Employee;
- name, Member ID number and address of the covered Employee;
- name of the Employer;
- name and telephone number of the attending Physician;

- name of the Medical Care Facility, proposed date of admission, and proposed length of stay;
- diagnosis and/or type of surgery; and
- proposed rendering of listed medical services

In the event certification of medical necessity is denied by SIHO Medical Management, the Plan Participant may appeal the decision.

Penalty for Noncompliance with Precertification

If the Plan Participant does not follow precertification procedures and receive prior authorization from the Plan for the services, treatment, pharmaceuticals, and equipment as listed above or anywhere else in this Agreement, each failure will result in a 10% reduction up to $500 per claim.

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.

Case Management

In cases where the Plan Participant's condition is expected to be or is of a serious nature, case management services are available. The use of case management is a voluntary program to the Plan Participant; however these services will generally provide a greater benefit to the Plan Participant by participating in the program.

The case manager will review the medical care provided to Plan Participants and may recommend alternative, cost-efficient programs of treatment. Such programs will be implemented only with the consent of the Plan Participant, his physician, and SIHO Medical Management, and may, in appropriate cases, provide for payment of benefits that would not otherwise be covered by the Plan, if payment of such benefits is expected to accelerate recovery or reduce overall expenses. 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;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

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

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

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.

SECTION IV: YOUR PRESCRIPTION DRUG BENEFITS

How the Plan Works

Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of an illness or injury. Covered drugs must be:

- prescribed by a licensed physician, dentist, or any other medical professional licensed to prescribe medication under the circumstances and dispensed by a registered pharmacist; and
- approved by the FDA for general use in treating the illness or injury for which they are prescribed.

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network.

You may purchase covered prescription drugs at any participating network retail pharmacy or mail order pharmacy.

Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. Your medical ID card will include PBM information. Present your ID card to the network pharmacy when you purchase covered prescription drugs. There are no claim forms to complete.

If You Use an Out-of-Network Retail Pharmacy

Prescriptions purchased from an Out-of-Network Pharmacy will not be covered.

Direct Member Reimbursement

CVS/Caremark Participating Pharmacy

If you purchase a drug from a participating pharmacy when your ID card is not used, you may have to pay full cost of the medication.

In order for reimbursement to occur, you must complete a prescription drug claim form, which can be obtained by calling SIHO Member Service at 1-800-443-2980 or on our website at www.siho.org. Attach all the required items listed on the prescription claim form, and submit to the address that is listed on the form that corresponds with the RXBIN # that is on the back of your ID card. You will be reimbursed the amount you paid to the pharmacy subject to the terms set forth in the plan document.

Coverage Categories

There are three tiers in the prescription drug Plan; the “Summary of Pharmacy Benefits” shows your Coverage amounts.

Prescription Formulary Drug Tiers

Tier 1: Generic Drug: Using generic drugs when available, instead of costlier brand-name drugs, can save you money. Pharmacies will dispense generic equivalent drugs, which are therapeutically equivalent to their brand-name drug in safety and effectiveness, when taken as prescribed unless your physician orders a specific brand name drug. Please see the "Prescription Drug Benefit" chart for coverage amounts.

Tier 2: Preferred or Formulary Brand Name Drugs: This category includes brand-name drugs for which there are no or limited generic drug alternatives. Most brand-name drugs used to treat asthma or diabetes are included in this category. If a generic drug is available, it will automatically be dispensed unless your physician orders a brand name drug or you request it.

Tier 3: Non-Preferred or Non-Formulary Brand Name Drugs: This category includes brand-name drugs for which no generic equivalent drugs and/or appropriate generic drug alternatives are available. Please see the "Prescription Drug Benefit" chart for coverage amounts.

Prescription Copayments – PPO Plan

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. Copayments accrue toward the medical out-of-pocket maximum. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

If a Covered Person requests a brand name prescription when a generic equivalent is available, the Covered Person is required to pay the difference between the cost of the brand and generic drug in addition to the brand copayment.

Prescription Deductible/Coinsurance – HDHP Plan

The deductible and coinsurance is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The deductible and coinsurance accrue toward the medical out-of-pocket maximum. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

If a Covered Person requests a brand name prescription when a generic equivalent is available, the Covered Person is required to pay the difference between the cost of the brand and generic drug in addition to the brand deductible and coinsurance.

Prior Authorization and Limits

Certain prescriptions may require prior authorization by the Claims Administrator. This process allows the Plan to verify that the drug is a part of a specific treatment plan and is medically necessary. Your physician will need to contact the Claims Administrator with written documentation of the reason for prescribing the medication and the length of time it should be covered. If you discover that a prescription requires prior authorization while you are at a retail pharmacy, you or the pharmacist will need to contact your doctor, who must then contact the Claims Administrator.

If your prescription is authorized, you will be able to fill your prescription at any participating pharmacy or through the mail service program. If authorization is not received, you will be required to pay the full cost of the prescription.

Certain drugs may also be limited by drug-specific quantity limitations per month, benefit period, or lifetime as specified by the Plan and based on medical necessity. Other drugs may be covered under your medical benefits and will be subject to your deductible and coinsurance. If your prescription is affected by these limits, you or your pharmacist should contact the Claims Administrator.

Specialty Medications

Certain drugs are considered "specialty medications" and may only be purchased through a network pharmacy, except as required in an emergency:

- Blood Modifiers
- Hemophilia
- Interferon
- IGIV
- Oral Oncologics

For information on ordering specialty medications, dispensing limitations, and your required cost for these drugs, contact the prescription drug benefit claims manager.

Covered Prescription Drugs and Supplies

The following prescription drugs and supplies, among others, are covered under the Plan:

- Hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order;
- Insulin, disposable insulin pens, insulin cartridges, and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits);
- Prescription prenatal vitamins;
- Specialty medication;
- Compound prescriptions containing at least one prescription ingredient in a therapeutic quantity;
- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) medication.

- Contraceptives: all FDA-approved contraceptive methods for all women with reproductive capacity are covered as required by the Affordable Care Act.
- Smoking-cessation programs, counseling and medication are covered under the Preventive Health Benefit as required by the Affordable Care Act.
- Drugs used for the purpose of treating HIV/AIDS, unless considered experimental or investigational.

Expenses Not Covered

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Summary of Medical Benefits, a charge for the following is not covered:

Administration: any charge for the administration of a covered Prescription Drug.

Consumed on premises: any drug or medicine that is consumed or administered at the place where it is dispensed.

Devices: devices of any type, even though such devices may require a prescription, with the exception of the Nuva Ring. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

Drugs used for cosmetic purposes: charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

Experimental: experimental drugs and medicines, even though a charge is made to the Plan Participant.

FDA: any drug not approved by the FDA.

Growth hormones: charges for drugs to enhance physical growth or athletic performance or appearance.

Immunization: immunization agents or biological sera.

Impotence: a charge for impotence medication, unless the impotence is a result of an underlying medical condition. A letter of Medical Necessity is required.

Infertility: a charge for infertility medication.

Injectable supplies: a charge for hypodermic syringes and/or needles (other than for insulin).

Inpatient medication: a drug or medicine that is to be taken by the Plan Participant, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

Investigational: a drug or medicine labeled: "Caution - limited by federal law to investigational use".

Medical exclusions: a charge excluded under Medical Plan Exclusions.

No charge: a charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

No prescription: a drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

Off-Label use drugs: a charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

Refills: any refill that is more than the number of refills ordered by the Physician.

Supplements: a charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamins containing fluoride.

For More Information

If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

Summary of Pharmacy Benefits

PPO Plan

PRESCRIPTION DRUG BENEFITS		
Prescription Benefits Manager (PBM) – CVS/Caremark		
Prescription Copayment and Coinsurance Amounts apply to the Medical Out-of-Pocket Maximums.		
Amounts listed are what member pays	**IN-NETWORK**	**NON-NETWORK**
Retail (*up to a 30-day supply*)		
Generic	$10 copayment	Not Covered
Brand Name Formulary	$30 copayment	Not Covered
Brand Name Non-Formulary	$50 copayment	Not Covered
Mail (up to a *90-day supply*)		
Generic	$25 copayment	Not Covered
Brand Name Formulary	$60 copayment	Not Covered
Brand Name Non-Formulary	$120 copayment	Not Covered
Specialty and Biotech Medications**	20% after deductible	Not Covered
Diabetic Testing Supplies are covered under the prescription drug benefit.		
Specialty Biotech medications (*injectable and otherwise*) other than insulin, hemopoetics and anticoagulants are covered under Major Medical benefit. **Pre-certification is required. To obtain prior authorization for these medications, call (800) 553-6027.		

HDHP Plan

PRESCRIPTION DRUG BENEFITS		
Prescription Benefits Manager (PBM) – CVS/Caremark		
Prescription Copayment and Coinsurance Amounts apply to the Medical Out-of-Pocket Maximums.		
Amounts listed are what member pays	**IN-NETWORK**	**NON-NETWORK**
Retail (*up to a 30-day supply*)		
Generic	20% after deductible	Not Covered
Brand Name Formulary	20% after deductible	Not Covered
Brand Name Non-Formulary	20% after deductible	Not Covered
Mail (up to a *90-day supply*)		
Generic	20% after deductible	Not Covered
Brand Name Formulary	20% after deductible	Not Covered
Brand Name Non-Formulary	20% after deductible	Not Covered
Prescription Drugs listed on the High Deductible Health Plan - Health Savings Account Preventive Therapy Drug List will be covered at the appropriate coinsurance and not subject to the annual deductible.		
Specialty and Biotech Medications**	20% after deductible	Not Covered
Diabetic Testing Supplies are covered under the prescription drug benefit.		
Specialty Biotech medications (*injectable and otherwise*) other than insulin, hemopoetics and anticoagulants are covered under ***Major Medical benefit*. **Pre-certification is required**. To obtain prior authorization for these medications, call (800) 553-6027.		

SECTION V: ADMINISTRATIVE INFORMATION

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Claims Administrators; and
- what to do if a benefit claim is denied;

Plan Sponsor and Administrator

City of Columbus is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number.

Plan Administrator

City of Columbus

123 Washington St.

Columbus, IN 47201

Tel: (812) 376-2570

Fax: (812) 376-2579

The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Company, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and

operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is January 1 through December 31

Type of Plan

This Plan is called a self-funded group health plan which includes medical and prescription drug coverage.

Plan Number

501

Identification Numbers

The Employer Identification Number (EIN) for the Plan is:

EIN: 35-6000989

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators. This Plan is not insured.
Funding	This Plan is funded through a 419 Plan by directed contributions from the Employee and this Employer. Any Employee contributions toward the cost of the coverage provided by this Plan will be deducted from his/her pay, and they are subject to change.

Claims Administrators

The Plan Administrator has contracted with the following companies to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly. Your Claims Administrator is listed on your ID card.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Medical /COBRA /Utilization Review

Claims Administrator

SIHO Insurance Services
PO Box 1787
Columbus, IN 47202
800-443-2980
www.siho.org

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

City of Columbus
123 Washington St.
Columbus, IN 47201

Future of the Plan

Subject to applicable laws and regulations, the Plan Sponsor has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Plan Sponsor may also change the level of benefits provided under the Plan. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

SECTION VI: PLAN ADMINISTRATION

Plan Administrator

City of Columbus Employee Benefit Plan is the benefit plan of City of Columbus, the Plan Administrator (also called the Plan Sponsor). An individual or committee may be appointed by City of Columbus to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, City of Columbus shall appoint a new Plan Administrator or committee member as soon as reasonably possible.

The Plan Administrator shall 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 shall 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, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

Duties of Plan Administrator

The Plan Administrator will have the following duties and authority with respect to the Plan:

- to administer the Plan in accordance with its terms;
- to interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;
- to decide disputes which may arise relative to a Plan participant's rights.
- to prescribe procedures for filing a claim for benefits and to review claim details.
- to keep and maintain the Plan documents and all other records pertaining to the Plan.
- to appoint a Claim Administrator to pay claims.
- to delegate to any person or entity such powers, duties, and responsibilities as the Plan Administrator 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.

Indemnity

To the full extent permitted by law, the Plan Sponsor will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of

any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- with the care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation; and
- by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.

Named Fiduciary

A "named fiduciary" is named in the Plan and can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless the named fiduciary has established the procedures to appoint the fiduciary or continuing either the appointment or the procedures.

Claims Administrator is Not 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.

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, 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.

Amending and Terminating Plan

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

SECTION VII: PROCEDURES FOR OBTAINING OR DETERMINING BENEFITS

Claim Filing

If an Enrollee receives a bill directly from a provider, is required to pay for services at the time they are provided, or assigns his or her right to reimbursement to a provider with the consent of the Claims Administrator, the Claim may be submitted to the Claims Administrator for payment. In order to be eligible for payment, the Claim must be submitted with receipts no later than March 31st of the year following the date of service, or in the case of a Consulting or Participating Provider, within the timeframe for submitting claims set forth in the provider agreement in effect between the Consulting or Participating Provider and the Claims Administrator. If the Claims Administrator approves the Claim, the Claims Administrator will reimburse the Enrollee or provider, as appropriate, for Covered Benefits less any applicable Copayments, Deductible, Coinsurance, penalty, and any amounts that the Claims Administrator has already paid to the Enrollee or the provider prior to receiving the Claim. The Claim should describe the occurrence, character, and extent of the Medical Care provided by the provider.

Non-Participating Providers

Non-Participating Providers must submit claims to the Claims Administrator no later than March 31st of the year following the date the services were provided to be eligible for payment. Notwithstanding anything herein to the contrary, Enrollees may not assign any claims or other rights to receive Benefits hereunder to any Non-Participating Provider without the prior approval of the Claims Administrator. In the absence of such prior approval, the Claims Administrator reserves the right to pay Claims or other Benefits directly to the Enrollee, and such payment shall fully discharge the Claims Administrator's obligation under this Agreement with respect to such Claims or other Benefits. In such a case, the Enrollee is responsible for all payments that may be due to the Non-Participating Provider.

Claim Form

Submission of claims by an Enrollee must be accompanied by a claim form. These forms can be obtained from the Claims Administrator via mail, email or on the Claims Administrator's website.

Claim Determination

Pre-Service Claims

With respect to a Pre-Service Claim, the Claims Administrator will notify the claimant of its decision within 15 days of receipt of the Claim.

- This 15-day period may be extended for an additional 10 days if the Claims Administrator determines that an extension is necessary due to matters beyond the Health Plan's control and notifies the claimant of the circumstances requiring the

extension of time and the date by which the Claims Administrator expects to render a decision.

- If an extension is necessary because the claimant has not submitted information necessary to decide the Claim, the Claims Administrator will provide the claimant with a notice of extension which will specifically describe the additional information required. If the extension is necessary because the Claim does not properly identify the individual requesting a benefit, specify the medical condition or symptom, and the specific treatment, service, or product for which approval is requested, the Claims Administrator will provide the notice of extension and an explanation of the proper procedures to be followed in filing a Claim. Any notice of extension may be oral, unless the claimant requests a notice in writing. The claimant will have at least 45 days to provide any requested information.

Post-Service Claims

With respect to a Post-Service Claim, the Claims Administrator will notify the claimant of its decision within 30 days of receipt of the Claim.

- This 30-day period may be extended for an additional 10 days if the Claims Administrator determines that an extension is necessary due to matters beyond the Health Plan's control and notifies the claimant of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.
- If an extension is necessary because the claimant has not submitted information necessary to decide the Claim, the Claims Administrator will provide the claimant with a notice of extension which will specifically describe the additional information required. If the extension is necessary because the Claim does not properly identify the individual requesting a benefit, specify the medical condition or symptom, and the specific treatment, service, or product for which approval is requested, the Claims Administrator will provide the notice of extension and an explanation of the proper procedures to be followed in filing a Claim. Any notice of extension may be oral, unless the claimant requests a notice in writing. The claimant will have at least 45 days to provide any requested information.

Urgent Care Claims

With respect to an Urgent Care Claim, the Claims Administrator will notify the claimant of its determination by the earlier of seventy-two hours or two business days after its receipt of the request and all information necessary to make a determination.

If the claimant has not provided sufficient information for the Claims Administrator to determine the request for an Urgent Care Claim, the Claims Administrator will notify the claimant within 24 hours after receiving the request of the specific information that must be submitted for the Claims Administrator to complete the processing of the Claim. The claimant will have at least 48 hours in which to provide the additional information. The Claims Administrator will notify the claimant of its decision within 24 hours after it receives the additional information, or, if the

claimant does not provide the requested information, 24 hours after the end of the period of time that the claimant was given to provide the information.

Concurrent Care Claims

With respect to a Concurrent Care Claim, if the Claims Administrator reduces or terminates benefits for a course of treatment (for reasons other than amendment or termination of the Health Plan) before the end of the period of time or number of treatments, the claimant must be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of the Claims Administrator decision before it becomes effective. The claimant may request the Health Plan to extend the course of treatment beyond the already approved time or number of treatments. The Claims Administrator will notify the claimant of its decision within 24 hours of its receipt of the request, provided that the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, and within 72 hours of its receipt if the request is received less than 24 hours prior to the expiration of the prescribed period or number of treatments.

Grievances

An Enrollee may initiate a Grievance procedure by contacting us verbally or in writing. Enrollees have the right to appoint a Designated Representative to act on their behalf with respect to the Grievance by filing a signed form that may be obtained from the Claims Administrator upon request; provided, that if a provider files a Grievance relating to an Urgent Care Claim, then the Claims Administrator will treat such provider as a Designated Representative with respect to that matter even without the submission of a signed form.

The Claims Administrator will accept oral or written comments, documents or other information relating to the Grievance from the Enrollee or his/her Designated Representative by telephone, mail or other reasonable means. Enrollees are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Grievance.

Enrollees may obtain information regarding the Claims Administrator's Grievance procedures by calling the toll-free number on the back of the Enrollee's identification card during normal business hours.

Once a Grievance has been initiated by an Enrollee, the Claims Administrator will respond within 3 business days to acknowledge receipt of the Grievance. Such response will be in writing, unless the Grievance was received orally, in which case the response may be oral. Grievances will be resolved within 20 business days after they are filed if all information needed to complete a review is available. If additional information is needed and the Grievance does not involve Urgent Care matters, the Claim Administrator may notify you before the 19th business day to election to take an additional 10 business days to receive information and address the Grievance.

If an Enrollee's Grievance is denied in whole or in part, the Claim Administrator will notify the claimant, in writing or electronically, and the notice will include the following:

- the specific reason or reasons for the denial;

- reference to specific Health Plan provisions on which the denial is based;
- a description of any internal rule, protocol or similar criterion relied on in making the adverse determination (or a statement that the information will be provided free of charge upon request);
- an explanation of any scientific or clinical judgment on which the denial is based (or a statement that the explanation will be provided free of charge upon request);
- a description of any additional material or information that the claimant may need to provide with an explanation as to why the material or information is necessary;
- an explanation of the claimant's right to appeal under the Health Plan's appeal procedures, and the claimant's right to bring a civil action in federal court; and
- the name, address, and phone number of a representative who can provide the claimant with more information about the decision and the right to Appeal.

The Claim Administrator may provide the above information to the claimant orally, provided that a written notice is furnished to the claimant within 3 days after the oral notification.

Appeal Procedures

If the Claim Administrator Grievance decision is satisfactory to the Enrollee, then the matter is concluded. If, however, the Enrollee is unsatisfied with the Claims Administrator's decision, the Enrollee may initiate an Appeal of the Grievance in accordance with this Section.

General

- The claimant will have 180 days from the receipt of the Claims Administrator's decision to Appeal.
- The claimant may submit an Appeal verbally or in writing. Any Claims Administrator employee who has been unable to resolve the Grievance may take the appeal information. Written appeals should be sent to:

  SIHO Appeals Coordinator
  P.O. Box 1787
  Columbus, IN 47202

- All written notices requesting an Appeal will be forwarded to an appeals coordinator.
- All verbal requests must be documented by the Claims Administrator who is assisting the claimant. Upon request, the notice will be forwarded to the appeals coordinator.
- An acknowledgement notice will be sent to the claimant within 3 business days of receipt of the written or verbal Appeal request.

Claimant's Rights on Appeal

- The claimant will have the opportunity to submit written comments, documents, or other information relating to the Appeal. All such information must be submitted by the enrollee or provider within 180 days of receipt.
- Upon request and free of charge, the claimant will be provided with reasonable access to and copies of all documents, records and other information relevant to the Appeal.
- The review will take into account all comments, documents, records and other information the claimant submits, whether or not presented or considered in the initial determination.
- No deference will be afforded to the initial determination.
- The review will be conducted by a person or persons different from the person who made the initial determination and who is not the original decisionmaker's subordinate.
- If the decision is made on the grounds of a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination or that person's subordinate.
- The Claims Administrator will provide the claimant with the name of any medical or vocational expert who advised the Claims Administrator with regard to the Appeal.

Appeals Hearing Committee

- The appeals coordinator will investigate the issue and gather the data needed to review the circumstances surrounding the Appeal.
- The appeals coordinator will convene an Appeals Hearing Committee consisting of at least one person. None of the Committee will have been involved in any of the previous determinations, or involved in a direct business relationship with the Enrollee or health care provider whose care is at issue.
- The appeals coordinator will send notice of the hearing date, time, and location to the claimant, at least 72 hours in advance of the hearing. The hearing process will make any reasonable accommodations to convenience the claimant, including arranging for a teleconference in situations where the claimant is unable to attend.
- If the claimant attends the Appeal hearing or participates via teleconference, the claimant may present his case. The hearing provides an opportunity for the claimant to explain his

  position as well as allow the Appeals Hearing Committee members to ask the claimant any pertinent questions they may have.

Notification of Resolution of Appeal

- Pre-Service Appeals. In the case of an Appeal not involving urgent care, the Claims Administrator will notify the claimant of its decision within 30 days after it receives the request for review and sufficient information to make its determination.

- Urgent Care Appeals. In the case of an Appeal that relates to an Urgent Care matter, the Claims Administrator will notify the claimant of its decision within 48 hours after it receives the request for review and sufficient information to make its determination.
- Other Appeals. In the case of all other Appeals, the Claims Administrator will notify the claimant within 30 days after it receives the written request for review and sufficient information to make its determination.

Expedited Appeals

- A claimant may request an expedited Appeal or the Claims Administrator may independently determine that the process should be expedited. The expedited process is considered a stand-alone procedure and is in lieu of the standard Appeal procedure.
- The claimant may request an expedited Appeal orally or in writing. All information, including the Claims Administrator's decision, may be transmitted between the claimant and the Claims Administrator by telephone, facsimile, or other available similar method.
- Resolution of the expedited Appeal will be made as expeditiously as the claimant's health warrants but will occur no later than 48 hours after the filing of the Appeal.

Initial Notice of Decision on Appeal

If an Appeal is denied, the Claims Administrator will notify the claimant, in writing or electronically. The notice will contain the following information:

- the specific reason(s) for the Claims Administrator's denial;
- a reference to the specific Health Plan provision(s) on which the denial is based;
- a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination;
- an explanation of any scientific or clinical judgment on which the denial is based;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records or other information relevant to the Appeal;
- a statement describing the voluntary Appeal procedures via the external review offered by the Health Plan and the claimant's right to obtain information about the procedures;
- date and time of the hearing before the City of Columbus Insurance Review Committee at which the Member may attend and present information;
- the name, address and telephone number of the appeals coordinator whom the claimant may contact for more information.

Subsequent Appeal Participants

- If an Appeal has been denied, the Plan has designated certain bodies and committees to participate in the review, recommendation, and decisionmaking process regarding subsequent appeals of an adverse Claims Administrator Appeal decision as follows:

- The Board of Public Works and Safety ("Board of Works") will make the final determination regarding an Appeal after obtaining a recommendation from the IRC regarding the issues;
- The Board of Works has designated and directed the Insurance Review Committee ("IRC") to review automatically any Appeal denials made by the Claims Administrator; and
- The IRC has designated and directed the City of Columbus Medical Subcommittee ("Medical Subcommittee") to review the circumstances surrounding the Appeal denial, including the Claim Administrator's reasons for denying the Appeal, and make a recommendation to the IRC regarding whether to uphold the Claims Administrator's decision at a private meeting.

Subsequent Appeal Process

- *Medical Subcommittee Review and Meeting*
  - Once an Appeal has been denied, a representative for the Claims Administrator will notify the IRC Chairperson, so that he or she may schedule a meeting for the Medical Subcommittee prior to the IRC meeting.
  - The Claims Administrator will also forward any information used or relied upon in making the Claim and/or Appeal determination, including its reasons for denying the Claim and/or Appeal, to the Medical Subcommittee for its review.
  - The claimant may attend the Medical Subcommittee's meeting and, if he or she so chooses, will have an opportunity to present information to the Medical Subcommittee for its consideration.
  - The Medical Subcommittee will review all provided information relating to the Appeal and prepare its recommendation to the IRC.
- *IRC Meeting*
  - After the Medical Subcommittee meeting, the IRC will hold a meeting at which the Medical Subcommittee will determine its recommendation to the Board of Works regarding the Appeal.
  - If the claimant so chooses, he or she may also attend the IRC meeting to present information to the IRC regarding the Appeal at that time.
  - After the IRC has heard the Medical Subcommittee's recommendation and the claimant has had an opportunity to present information regarding the Appeal, the IRC will determine its recommendation to the Board of Works in the form of a vote on whether to uphold or overturn the Claim Administrator's decision on the Appeal.
- *Board of Public Works and Safety Meeting*
  - After the IRC has made its recommendation, such recommendation will be presented to the Board of Works for approval.
  - If the Board of Works upholds the Claim Administrator's decision, the claimant will receive notice as is below provided.

- If the Board of Works overturns (either in full or in part) the Claim Administrator's decision regarding the Appeal, the claimant will be notified in writing and the Claim will be reprocessed to the extent necessary.

Subsequent Notices of Decision on Appeal

If an Appeal is denied beyond the initial denial, the Claims Administrator will notify the claimant, in writing or electronically. The notice will contain the following information:

- the specific reason(s) for the Claims Administrator's denial;
- a reference to the specific Health Plan provision(s) on which the denial is based;
- a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination;
- an explanation of any scientific or clinical judgment on which the denial is based;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records or other information relevant to the Appeal;
- a statement describing the voluntary Appeal procedures via the external review offered by the Health Plan and the claimant's right to obtain information about the procedures;
- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency";
- a statement describing the claimant's right to bring a civil suit under federal law; and
- the name, address and telephone number of the appeals coordinator whom the claimant may contact for more information.

External Review of Appeals Process

- If the claimant is dissatisfied with the Appeal Hearing Committee's resolution, and the matter involves (i) an adverse determination of appropriateness, (ii) an adverse determination of Medical Necessity, (iii) a determination that the proposed service is Experimental or Investigational, or (iv) a rescission of coverage by the Claim Administrator, he or she may file a written request to initiate an External Review Appeal. This request must be filed no later than 120 days after the claimant is notified of the resolution of the Appeal Hearing Committee's decision. External Review Appeal is not available for matters other than those specified in this paragraph.
- The claimant may not file more than one (1) External Review Appeal request on the same appeal.
- Upon receipt of the request for External Review Appeal, the appeals coordinator will select an independent review organization that is certified to perform external review in the State of Indiana.
- The external review organization will assign a medical review professional who is board certified in the applicable specialty for resolution of the Appeal.

- The external review organization and the medical review professional conducting the external review may not have a material professional, familial, or financial, or other affiliation with the Claims Administrator; any officer, director, or management employee of the Claims Administrator; the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician. However, the medical review professional may have an affiliation under which the medical review professional provides health care services to Enrollees of the Claims Administrator and may have an affiliation that is limited to staff privileges at the health facility if the affiliation is disclosed to the claimant and to the Claims Administrator before commencing the review and neither the claimant nor the Claims Administrator objects to the affiliation.
- A claimant who files an Appeal under this final alternative is not subject to retaliation for exercising his or her right to an Appeal by an external review organization. The claimant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. The claimant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the external review organization by providing any requested medical information or authorizing the release of necessary medical information.
- The Claims Administrator shall cooperate with the external review organization by promptly providing any information requested by the external review organization.
- The external review organization shall make a determination to uphold or reverse the Claims Administrator's Appeal resolution based on information gathered from the claimant, the Claims Administrator, the treating physician, or any additional information that the external review organization considers necessary and appropriate. For standard Appeals, the determination shall be made within 15 business days from the filing date of the request for external review. For expedited Appeals, the determination shall be made within 72 hours after the external review request is filed.
- When making the determination of the resolution of the Appeal, the external review organization shall apply the standards of decision making that are based on objective clinical evidence and the terms of the claimant's benefit contract.
- The external review organization shall notify the Claims Administrator and the claimant of the determination made under this section within 72 hours after making the determination. For expedited Appeals, the notification will occur within 24 hours of the determination. The result of the determination is binding on the Claims Administrator.
- If at any time during the external review process the claimant submits information to the Claims Administrator that is relevant to the Claims Administrator's previous Appeal resolution and was not considered by the Claims Administrator during the Appeals hearing phase, the Claims Administrator shall reconsider the previous resolution under the Appeals hearing process. The external review organization shall cease the external review process until the reconsideration by the Claims Administrator is completed.

- If additional information from the claimant results in the Claims Administrator's reconsideration of the Appeal at the hearing level, the Claims Administrator will notify the claimant of its decision within 15 days after the information is received. If the Appeal is related to an Urgent Care Claim, the Claims Administrator will make a determination within 72 hours of receipt of the additional information.
- If the reconsideration determination made by the Claims Administrator's is adverse to the claimant, the claimant may request that the external review organization resume the external review.

Notification of Decision

- The independent review organization will communicate the decision on the Appeal, to both the claimant and SIHO, at the same time.
    - Decisions on an expedited external Appeal will be communicated within 24 hours of the decision being reached.
    - Decisions on a standard external Appeal will be communicated within 72 hours of the decision being reached.

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Standard Coordination of Benefits

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.

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

- other employers' plans;
- certain government plans (this coordination does not include Medicaid or any benefit plan like it, that, by its terms, does not allow coordination; and
- motor vehicle plans when required by law.

How Standard Coordination Works

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.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows:

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- This Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.
- 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.
- The Plan which covers a person as an Employee (neither laid off nor retired) or a Dependent of an Employee (neither laid off nor retired) would pay primary before those of a plan which covers the person as a COBRA beneficiary.
- The Plan which covers a person as an Employee (neither laid off nor retired) would pay primary before those of the Plan which covers that person as a laid-off or Retired Employee. The Plan which covers a person as a Dependent of an Employee (neither laid off nor retired) would pay primary before those of the 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.
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply:
    - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply;
    - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan);
    - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary;
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
    - When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer's plan to pay first and Medicare pays second ("secondary"). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer's coverage will be primary or secondary.

If Medicare is determined to be the primary payer, this Plan will utilize the Medicare allowable amount and base its payment upon benefits that have been paid by Medicare.

The Plan also coordinates with Medicare as follows.

- End-stage renal disease—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- Mandated coverage under another group plan—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense. The Plan shall pay excess benefits only, without reimbursement for automobile coverage deductibles. This plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

If you or your covered dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- any expense properly denied by the automobile coverage that is a covered expense; and
- any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Plan Sponsor has a right to subrogation and reimbursement, as defined in the following sections.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period you were meeting the calendar year deductible; or
- advanced during the time period you were meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for benefits that the Plan has paid. Subrogation applies when the Plan has paid benefits for an illness or injury which may be caused by the act or omission of a third party or a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan will be subrogated to, and will succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any illness or injury caused by any third party. This subrogation right allows the Plan to pursue any claim which you have against a third party, or insurer, whether or not you choose to pursue that claim.

The Plan reserves the right to employ the services of an attorney to recover money due to the Plan. You agree to cooperate with the attorney who is pursuing our right to subrogation recovery. The compensation that the Plan's attorney receives will be paid directly from the dollars recovered for the Plan.

Right to Reimbursement

The right to reimbursement means that if a third party causes an illness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to return to the Plan 100 percent of any benefits you received for that illness or injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer an illness, injury, or damages, or who is legally responsible for the illness, injury, or damages; or

- any person or entity who is or may be obligated to provide you with benefits or payments under:
    - underinsured or uninsured motorist insurance;
    - medical provisions of no-fault or traditional insurance (auto, homeowners, or otherwise);
    - Workers' Compensation coverage; or
    - any other insurance carrier or third party administrator.

Pay and Pursue

If the Plan receives claims for expenses that were either the result of the alleged negligence of another person, or which arise out of any claim or cause of action which may accrue against any third party responsible for injury or death to the Plan Participant, the Plan has no duty or obligation to pay these claims. The Plan may choose to advance benefits. When the Plan advances benefits, the Plan Participant, by accepting benefits agrees to the following terms and conditions. When the Plan advances benefits, it is doing so only because, and in reliance upon, the Plan Participant's promise to abide by the terms and conditions of the Plan and requires the Plan Participant to complete a subrogation questionnaire, sign an acknowledgment of the Plan's Subrogation rights and sign an Agreement. This is called pay and pursue. If the Plan Participant fails or refuses to sign the Agreement, the Plan has no duty to pay any and all claims incurred by the Plan Participant. The Agreement must be returned to the Plan within 30 days of receipt by the Plan Participant as the Plan will continue to deny payment of all benefits related to the date of injury. Upon receipt of the requested materials from the Plan Participant, the Plan may continue advancing claims payments according to its terms and conditions provided that said payment of claims in no way prejudices the Plan's right to recovery.

The Plan has the right to the Plan Participant's full cooperation in any matter involving the alleged negligence of a third party. The Plan Participant will also cooperate with the Plan relative to the Plan's attempts to collect from any medical payment insurance or personal injury protection coverage. In such cases, the Plan Participant is obligated to provide the Plan with whatever information, assistance, and records the Plan may require to enforce the rights in this provision.

When This Provision Applies To You

If you or any of your covered dependents, or anyone who receives benefits under this plan, becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose

and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

You or your covered dependent agrees to sign any documents requested by the Plan including but not limited to a reimbursement and/or subrogation agreement, or accident questionnaire, as the Plan or its agent(s) may request. You and your covered dependent also agree to furnish any other information as may be requested by the Plan or its agent(s). Failure to sign and return any requested documentation or information may result in the Plan's denial of claims. However, such failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received, regardless of how characterized, shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100 percent reimbursement to the Plan may be divided between you or your dependent (the Plan Participant) and your attorney if applicable.

You and/or your covered dependents agree to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against you or your dependent (the Plan Participant), then you and/or your dependent agree to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny any future benefits by the amount of any recovery received, but not reimbursed, by you or your covered dependent for an accident or injury for which the Plan paid benefits.

If you and/or your covered dependent take no action to recover money from any source, then you and/or your dependent agree to allow the Plan to initiate its own direct action for reimbursement.

SECTION VIII: YOUR HIPAA/COBRA RIGHTS

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Title II of HIPAA, as amended, and the regulations at 45 CFR Parts 160 through 164 contain provisions governing the use and disclosure of Protected Health Information ("PHI") by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate "Notice of Privacy Provisions" which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to medical and prescription drug plans. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information and its Disclosure

PHI is information created or received by HIPAA Plans that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan Sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Claims Administrator involved with the PHI in question. The Claims Administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. The Plan Sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 318), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

The following members of the City of Columbus workforce are designated as authorized to receive Protected Health Information from the City of Columbus Employee Benefit Plan in order to perform their duties with respect to the Plan:

- Benefits Coordinator
- City Attorney
- Clerk-Treasurer or designee
- Director of Operations, Finance, and Risk

Certificate of Creditable Coverage

At the request from the employee and/or employer, a Certificate of Creditable Coverage will be provided.

The standard certificate includes basic health plan participation information and a statement as to whether you and your covered dependent(s) had at least 18 months of coverage without a significant break (more than 63 days). If you or your dependent(s) had less than 18 months of coverage, the statement will include the date coverage began and ended as well as the date of any waiting period.

A certificate will never cover longer than an 18-month period without a 63-day break, which is the maximum creditable coverage that an individual would need under the pre-existing condition exclusion rules and the rules for access to the individual market. You automatically will receive the standard statement when coverage ends. A single certificate may be used for all Plan Participants in a family who are losing coverage at the same time.

If you need to establish creditable coverage to reduce any pre-existing exclusion imposed by any subsequent health plan for mental health/substance abuse treatment and/or prescription drugs, an alternative certificate also is available by request.

To request another copy of the standard certificate and/or the alternative certificate, contact the Plan Administrator within 24 months after the end of a period of continuous coverage. Your certificate will be sent in a reasonable and prompt fashion or, alternatively, if all parties agree, the Plan Administrator may provide this information by phone.

Continuing Health Care Coverage through COBRA

In special situations, you or your covered dependent(s) may continue health care coverage at your or your dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event."

If you and/or your eligible dependent(s) choose COBRA coverage, the Plan Sponsor is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same health care coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-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.

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such person losing health benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Health care coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- termination of employment (voluntary or involuntary) is for any reason other than gross misconduct; or
- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan.

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Plan Sponsor within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within 10 days of your notification.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage. (Also see "Coverage While You Are Not at Work" in the Plan Overview for additional information.)

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The Plan Sponsor terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11 month extension period.

SECTION IX: GENERAL PROVISIONS

No Obligation to Continue Employment

The Plan does not create an obligation for the Plan Sponsor to continue your employment or interfere with the Plan Sponsor's right to terminate your employment, with or without cause.

Payment of Benefits

Benefits are payable subject to the Plan's exclusions and limitations and the Plan Administrator's determination that care and treatment is Medically Necessary, that charges are Usual and Customary and that services, supplies and care are not experimental and/or investigational. Benefits will be payable to the contracted service provider unless otherwise assigned.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator.

Expenses

All expenses incurred in connection with the administration of the Plan, will be paid by the Plan except to the extent that the Plan Sponsor elects to pay such expenses.

Fraud

No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Plan Sponsor, up to and including termination of employment.

Typographical or Administrative Error

Typographical or administrative errors shall not deprive a Covered Person of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative

error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Incontestability

The validity of this Agreement may not be contested after two (2) years, except for nonpayment of premiums or if the disputed statement is in a written instrument signed by the Participant. The ineligibility of a Participant under the Contract may be disputed at any time.

Limitation of Action

Requests for reimbursement are subject to the provisions of this Agreement. No legal proceeding or action may be brought prior to the expiration of 60 days after written submission of a claim has been furnished to us as required in this Agreement and within three (3) years from the date the Health Care Services were received.

Governing Law

The laws of the State of Indiana will govern the interpretation and enforcement of this Agreement.

Conformity with Statutes and Regulations

The Plan is designed to comply, to the extent possible, with all applicable laws and regulations as amended, including but not limited to: COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), WHCRA, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, and Title I of GINA. Any provision which, on the Effective Date, conflicts with those laws and regulations is hereby amended to conform to the minimum requirements of such.

Non-discrimination

In accordance with IRC §125, the Plan is intended not to discriminate in favor of Key Employees (as defined in IRC §416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Discrimination is Against the Law

SIHO Insurance Services and/or the plan sponsors for which it administers employee welfare and benefits plans ("SIHO Insurance Services and/or the Plans it administers") comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national

origin, age, disability, sex, or sexual orientation. SIHO Insurance Services and/or the Plans it administers do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or sexual orientation.

SIHO Insurance Services (both for itself and/or on behalf of the Plans it administers):

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please contact the Compliance Officer for SIHO Insurance Services by mail at 417 Washington Street, Columbus, IN 47201, by phone at (844) 255-7120 or TTY (800) 743-3333, or by email at Compliance@siho.org.

If you believe that SIHO Insurance Services and/or the Plans it administers have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Compliance Officer. You can file a grievance in person or by mail, or email as indicated above. If you need help filing a grievance the Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at http://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

English: ATTENTION: Our Member Services department has free language interpreter services available for non-English speakers. Call 800.443.2980 (TTY: 800.743.3333)

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800.443.2980 (TTY: 800.743.3333).

Chinese:注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800.443.2980 (TTY: 800.743.3333).

Burmese:

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်
စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 800.443.2980 (TTY: 800.743.3333) သို့ ခေါ်ဆိုပါ။

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800.443.2980 (TTY: 800.743.3333).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800.443.2980 (ATS : 800.743.3333).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800.443.2980 (TTY: 800.743.3333).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800.443.2980 (TTY: 800.743.3333).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800.443.2980 (TTY: 800.743.3333)번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800.443.2980 (телетайп: 800.743.3333).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800.443.2980 (رقم هاتف الصم والبكم: 800.743.3333).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 800.443.2980 (TTY: 800.743.3333) पर कॉल करें।

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800.443.2980 TDD/TTY 800.743.3333 uffrufe.

Dutch: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 800.443.2980 (TDD/TTY 800.743.3333).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800.443.2980 (TTY: 800.743.3333) 'ਤੇ ਕਾਲ ਕਰੋ।

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800.443.2980（TTY: 800.743.3333）まで、お電話にてご連絡ください。

ADOPTION OF THE PLAN

The City of Columbus, as stated herein, is hereby adopted as of 1/01/2017. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this _____ day of _____, 201___.

BY: _____

Plan TITLE: _____

AMENDMENT # 1 and Summary of Material Modification

To revise Summary Plan Description of January 1, 2017
City of Columbus
The following change is effective August 1, 2017

Benefits for the above Non-Grandfathered Plan are hereby amended as follows:

I. Summary of Material Modification

This Amendment seeks to modify the following:

1. Update eligibility regarding Public Safety retirees
2. Change Special Enrollment notification from 31 to 60 days.
3. Correct a scrivener's error regarding the Out-of-Pocket maximum for Non-Network Providers, Tier 3. This correction is retroactive to January 1, 2017.
4. Update Coordination of Benefits language to reflect current processes.

Under Section II, Plan Overview, Eligible Retirees, page 13, the following will be deleted:

Eligible Retirees

A retired Employee will be eligible to continue coverage upon retirement from employment with City of Columbus if the following has been met:

Retired Public Safety Employees

A Public Safety Employee who, on or after June 30, 1989, retires or receives disability benefits (*under Ind. Code § 36-8-6, 7, 7.5, 8, and 10*) may elect coverage for himself, his or her spouse, and Dependents if the following criteria are met:

- he or she is not eligible for Medicare on the date that he or she retires or becomes eligible for disability payments pursuant to the statutory provisions referenced above;
- files a written request to the City of Columbus within ninety (90) days after the employee's retirement date or the date he or she begins receiving disability payments; and
- employee agrees to make timely payment for premiums in an amount determined by the Employer (which cannot exceed the total amount paid by the Employer and an active Employee for equivalent coverage).

[...]

And replaced with:

Eligible Retirees

A retired Employee will be eligible to continue coverage upon retirement from employment with City of Columbus if the following has been met:

Retired Public Safety Employees

A Public Safety Employee who, on or after June 30, 1989, retires or receives disability benefits (*under Ind. Code § 36-8-6, 7, 7.5, 8, and 10*) may elect coverage for himself, his or her spouse, and Dependents if the following criteria are met:

- he or she is not eligible for Medicare on the date that he or she retires or becomes eligible for disability payments pursuant to the statutory provisions referenced above;
- files a written request to the City of Columbus within ninety (90) days after the employee's retirement date or the date he or she begins receiving disability payments;
- employee agrees to make timely payment for premiums in an amount determined by the Employer (which cannot exceed the total amount paid by the Employer and an active Employee for equivalent coverage);

Note: A current spouse, under of the age of 65, of a retiree who meets all eligibility requirements except for age *(when the retiree is older than 65)* may join the retiree health plan at the time of the retiree's retirement. Coverage will continue for the spouse until he or she reaches age 65, and is eligible for Medicare or becomes eligible for disability benefits before age 65, and therefore is eligible for healthcare through disability status. The Working Spouse Rule *(see page 12 of this plan)* applies to retirees' spouses. The City of Columbus reserves the right to reconsider and modify this spouse eligibility rule at any time, both retiree spouse eligibility and rates for retiree spouses and other dependents if eligibility is continued, separately from evaluation of other rates.

[...]

Under Section II, Plan Overview, When Coverage Begins, page 15, the following will be deleted:

[...]

For Your Dependents

[...]

If you acquire a new Dependent, such as a through marriage, dependent birth or an adoption or placement for adoption, coverage will take effect on the date of the marriage, birth, the date of the adoption, or placement for adoption, as long as you enroll the dependent within 31 days of the date on which they became eligible.

A newborn child born while you are enrolled for medical coverage will automatically be covered on your Plan from birth for a period of thirty-one (31) days. Coverage will continue for the

newborn as long as you enroll them within thirty-one (31) days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll the newborn until the next annual enrollment period. Charges for nursery and physician care for the newborn will be applied toward the plan of the covered newborn. A separate deductible and coinsurance will apply to charges incurred by the newborn child.

[...]

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of Internal Revenue Code ("IRC") §125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Plan Sponsor nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days of the following:

- The date you have a qualifying change in status;
- The date you meet the Special Enrollment Rights criteria described.

Qualifying Change in Status

[...]

If you believe that you have experienced a Change in Status, you should report that change and fill out any necessary forms as soon as possible, but no later than 31 days, after the event occurs.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

[...]

And replaced with:

[...]

For Your Dependents

[...]

If you acquire a new Dependent, such as a through marriage, dependent birth or an adoption or placement for adoption, coverage will take effect on the date of the marriage, birth, the date of the adoption, or placement for adoption, as long as you enroll the dependent within 60 days of the date on which they became eligible.

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Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each open enrollment. However, at any time throughout the year, you can make changes to your coverage within 60 days of the following:

- The date you have a qualifying change in status;
- The date you meet the Special Enrollment Rights criteria described.

Qualifying Change in Status

[...]

If you believe that you have experienced a Change in Status, you should report that change and fill out any necessary forms as soon as possible, but no later than 60 days, after the event occurs.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

[...]

Under Section III, Your Medical Benefits, page 27, the following will be deleted:

Summary of Medical Benefits

PPO Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
MAXIMUM ANNUAL BENEFIT AMOUNT	Unlimited		
DEDUCTIBLE, PER CALENDAR YEAR			
Per Individual	$750	$750	$750
Per Covered Family	$1,500	$1,500	$1,500
NOTE: *Amounts used to satisfy the Tier 1 Deductible accumulates toward the satisfaction of the Tier 2 Deductible and vice versa. Tier 3 does not cross apply with any other Network.*			
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Individual	$4,750	$4,750	$750
Per Covered Family	$9,500	$9,500	$1,500
NOTE: *Amounts used to satisfy the Tier 1 Maximum Out-of-Pocket accumulates toward the satisfaction of the Tier 2 Maximum Out-of-Pocket and vice versa. Tier 3 does not cross apply with any other Network.*			

[…]

And replaced with:

Summary of Medical Benefits

PPO Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Non-Network Providers Tier 3
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DEDUCTIBLE, PER CALENDAR YEAR			
Per Individual	$750	$750	$750
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NOTE: *Amounts used to satisfy the Tier 1 Deductible accumulates toward the satisfaction of the Tier 2 Deductible and vice versa. Tier 3 does not cross apply with any other Network.*			
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Per Individual	$4,750	$4,750	$4,750
Per Covered Family	$9,500	$9,500	$9,500
NOTE: *Amounts used to satisfy the Tier 1 Maximum Out-of-Pocket accumulates toward the satisfaction of the Tier 2 Maximum Out-of-Pocket and vice versa. Tier 3 does not cross apply with any other Network.*			

[…]

Under Section III, Your Medical Benefits, Eligible Expenses, page 41, the following will be deleted:

[...]

- **Newborn Care**: includes services and supplies for a covered newborn who is sick or injured, including infant formula when needed for the treatment of inborn errors of metabolism while the infant is hospital-confined. Also includes hospital nursery services and routine newborn care provided during the birth confinement or on an outpatient basis for non-hospital births. A newborn child born while you are enrolled for medical coverage will automatically be covered on your Plan from birth for a period of thirty-one (31) days. Coverage will continue for the newborn as long as you enroll them within thirty-one (31) days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll the newborn until the next annual enrollment period. Charges for nursery and physician care for the newborn will be applied toward the plan of the covered newborn. A separate deductible and coinsurance will apply to charges incurred by the newborn child. Charges for a dependent child's newborn will not be covered.

[...]

And replaced with:

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- **Newborn Care**: includes services and supplies for a covered newborn who is sick or injured, including infant formula when needed for the treatment of inborn errors of metabolism while the infant is hospital-confined. Also includes hospital nursery services and routine newborn care provided during the birth confinement or on an outpatient basis for non-hospital births. A newborn child born while you are enrolled for medical coverage will automatically be covered on your Plan from birth for a period of thirty-one (31) days. Coverage will continue for the newborn as long as you enroll them within sixty (60) days of the date on which they became eligible. If you wait longer than 60 days, you may not be able to enroll the newborn until the next annual enrollment period. Charges for nursery and physician care for the newborn will be applied toward the plan of the covered newborn. A separate deductible and coinsurance will apply to charges incurred by the newborn child. Charges for a dependent child's newborn will not be covered.

[...]

Under Section VII: Procedures for Obtaining or Determining Benefits, Coordination of Benefits, page 78, the following will be deleted:

[...]

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Standard Coordination of Benefits

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.

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

- other employers' plans;
- certain government plans (this coordination does not include Medicaid or any benefit plan like it, that, by its terms, does not allow coordination; and
- motor vehicle plans when required by law.

How Standard Coordination Works

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.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows:

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- This Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.
- 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.
- The Plan which covers a person as an Employee (neither laid off nor retired) or a Dependent of an Employee (neither laid off nor retired) would pay primary before those of a plan which covers the person as a COBRA beneficiary.
- The Plan which covers a person as an Employee (neither laid off nor retired) would pay primary before those of the Plan which covers that person as a laid-off or Retired

Employee. The Plan which covers a person as a Dependent of an Employee (neither laid off nor retired) would pay primary before those of the 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.

- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply:
    - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply;
    - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan);
    - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary;
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
    - When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

[...]

And replaced with:

[...]

Coordination of Benefits (COB)

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Allowable Expense means a health care expense, including coinsurance or copayments without reduction for any applicable deductible that is covered at least in part under any of the plans covering the Participant. When a plan provides benefits in the form of services, the

reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. The following are examples of expenses or services that are ***not*** Allowable Expenses:

- The difference between the cost of a private hospital room and the cost of a semi-private hospital room is ***not*** considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice.
- When benefits are reduced under a primary plan because a Participant does not comply with the plan provisions related to: second surgical opinions; precertification of admissions or services; and preferred provider arrangements, the amount of the reduction will ***not*** be considered an Allowable Expense.
- If a plan is advised by a Participant that all plans covering the Participant are high-deductible health plans, and the Participant intends to contribute to a health savings account established in accordance with §223 of the Internal Revenue Code of 1986 ("IRC"), the primary high-deductible health plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible as described in §223 of the IRC. An expense or a portion of an expense that is not covered by any of the plans is ***not*** an Allowable Expense.
- Any expense that a provider, by law, or in accordance with a contractual agreement, is prohibited from charging a Participant is ***not*** an Allowable Expense.

Determining the Allowable Expense when this Plan is not primary

- If the Participant is covered by two (2) or more plans that both provide benefits or services on the basis of negotiated fees or contracted amounts, this Plan's payment arrangement shall be the Allowable Expense for this Plan, unless otherwise indicated below in Coordination with Medicare section.
- If a Participant's primary plan calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology, and this Plan provides its benefits or services on the basis of negotiated fees or contracted amounts, this Plan's payment arrangement shall be the Allowable Expense for this Plan, unless otherwise indicated below in Coordination with Medicare section.
- If a Participant is covered by two (2) or more plans that both calculate their benefit payments on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology, this Plan will utilize the primary plan's calculated amount as the Allowable Expense.
- If the Participant's primary plan calculates its benefits or services on the basis of negotiated fees or contracted amounts, and this Plan calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology, this Plan will utilize the primary plan's payment arrangement as the Allowable Expense.

Standard Coordination of Benefits

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 Participant is covered by this Plan and another plan, or the Participant'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.

Your medical benefits are coordinated with benefits from:

- other employers' plans;
- certain government plans (this coordination does not include Medicaid or any benefit plan like it, that, by its terms, does not allow coordination; and
- motor vehicle plans when required by law.

How Standard Coordination Works

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 Expense.

Order of Benefit Determination Rules

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- This Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.
- 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.
- The Plan which covers a person as an Employee (neither laid off nor retired) or a Dependent of an Employee (neither laid off nor retired) would pay primary before those of a plan which covers the person as a COBRA beneficiary.
- The Plan which covers a person as an Employee (neither laid off nor retired) would pay primary before those of the Plan which covers that person as a laid-off or Retired Employee. The Plan which covers a person as a Dependent of an Employee (neither laid off nor retired) would pay primary before those of the 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.
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your

spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply:
    - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply;
    - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan);
    - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary;
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
- When an Adult Dependent Child (age eighteen (18) to the limiting age), has two (2) or more plans, benefits for that Adult Child shall be determined in the following order:
    - First, the plan covering the Adult Child as an Employee;
    - Second, the plan of the Spouse or, if applicable, significant other living in the same residence covering the Adult Child as a Dependent; and
    - Third, the plan of the parent covering the Adult Child as a Dependent.

If none of the above rules determine the order of benefits, the plan that covered a person for a longer period of time shall be primary and its benefits shall be determined before benefits are determined under the plan that covered that person for the shorter period of time.

[...]

This amendment complies with Federal Civil Rights Legislation involving benefits for employees and dependents. Nothing contained in this amendment shall be considered to alter or affect any of the terms of the Summary Plan Description City of Columbus other than as specifically stated in the amendments.

IN WITNESS WHEREOF, The Plan has executed the Amendment #1 on the 29 day of August 2017.

Signature

Mayor
Official Title

Aug. 29, 2017
Date

Witness