PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

Shenandoah School Corporation Employee Benefit Trust

AMENDED AND RESTATED AS OF

July 1, 2017

IMPORTANT PLAN INFORMATION

Plan Name	Shenandoah School Corporation Employee Benefit Plan
Plan Number	501
Plan Year	The Plan Year is the twelve- (12) month period beginning on May 1st and ending on April 30th of each year.
Restatement Effective Date	July 1, 2017
Employer Name and Address	Shenandoah School Corporation 5100 North Raider Road Middletown, IN 47356
Employer Tax ID#	35-1083263
Plan Administrator	Shenandoah School Corporation
Plan Fiduciary	same as Plan Administrator
Plan Supervisor	Unified Group Services, Inc. 3131 E. 67th St. Anderson, IN 46013 Toll free (800) 291-5837 **For all correspondence please use:** Unified Group Services, Inc. P. O. Box 10 Pendleton, IN 46064 local (765) 608-6680
Utilization Review Company	Cigna
Type of Plan and Administration	The Plan is a self-funded employee welfare plan that provides health benefits for Eligible Employees and their Dependents. A third party administrator (the Plan Supervisor) provides the administration.
Role of Insurance Co	Stop-loss insurance has been obtained for indemnification against major losses from the self-funded nature of the Plan. However, benefits under the Plan in no way shall be guaranteed by any such insurance, and the issuer of any such insurance does not provide any administrative services to the Plan. Covered Persons have no right to or legal interest in the proceeds of any such insurance.

Certain information is required by law to be specifically provided to Plan participants. To help you find this information, listed below is each type of information and where you can find it in the rest of this Summary Plan Description.

Please Note: Precertification is recommended for all Inpatient Admissions including Skilled Nursing and Rehabilitation, Outpatient Spinal Procedures, and Medical observation over 23 hours.

Call 1-800-291-5837

The Precertification is designed to confirm Medical necessity; appropriateness of requested length of stay and appropriateness of proposed location or care. The Plan also uses case management to limit costs.

Eligibility	The Plan's requirements respecting eligibility for participation and for benefits are set forth in the Section *Eligibility, Enrollment and Termination of Coverage*.
QMCSO	Participants and beneficiaries in the Plan can obtain, without charge, a copy of procedures governing qualified medical child support order (QMCSO) determinations from the Plan Supervisor.
Description of Benefits	A description of benefits under the Plan is set forth in the Sections *Benefit and Information Grid*, *Medical Benefits*, *Covered Services*, *Services Not Covered*, *Organ and Tissue Transplants, and Prescription Drug Benefits.*
Preventive Services	The extent to which preventive services are covered under this Plan is described in Sections *Benefit and Information Grid*, *Covered Services*, *Services Not Covered and Prescription Drug Benefits.*
Specific Medical Benefits	Provisions regarding whether, and under what circumstances, coverage is provided under the Plan for medical tests, devices, and procedures are set forth in Sections *Benefit and Information Grid*, *Covered Services*, *Services Not Covered*, and *Organ and Tissue Transplants.*
PPO Network	Provisions governing the use of network Providers, which Providers are in network, and whether and under what circumstances coverage is provided under the Plan for out-of-network services are set forth in Sections *PPO Network Benefits* and *Benefit and Information Grid*. Access to a list of network Providers will be made available upon request.
Prescription Drug Benefits	Provisions regarding whether, and under what circumstances, existing and new drugs are covered under this Plan are set forth in Sections *Benefit and Information Grid*, *Covered Services*, *Services Not Covered*, *Organ and Tissue Transplants and Prescription Drug Benefits.*
Childbirth Benefits	Employee Benefit 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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable). This Plan's coverage of childbirth is described in the Section *Covered Services*.
Emergency Care	Conditions or limits applicable to obtaining Emergency medical care are set forth in Sections *Benefit and Information Grid*, *Covered Services* and *Services Not Covered.*
Caps/Maximums	Annual and lifetime caps or maximums and other limits on benefits under the Plan are set forth in the Sections *Benefit and Information Grid*, *Medical Benefits*, *Covered Services*, *Services Not Covered*, *Organ and Tissue Transplants and Prescription Drug Benefits.*
Cost of Plan Benefits	Provisions regarding premiums, Deductibles, Coinsurance, and Copayment amounts for which the Covered Person will be responsible are set forth in the Sections *Medical Benefits Benefit and Information Grid,* and *Funding.*

Loss of Benefits	Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits that a Covered Person might otherwise reasonably expect the Plan to provide are described in Sections *Eligibility, Enrollment, and Termination of Coverage*.
Continuation Coverage	The rights and obligations of Covered Persons with respect to continuation coverage are set forth in Section *Eligibility, Enrollment and Termination of Coverage* and *Continuation of Coverage*.
Claim Procedures	Procedures governing claims for benefits, applicable time limits, and remedies available to resolve claims that are denied in whole or in part are set forth in Section *Case Management*, *Precertification for Hospitalization & Other Medical Services*, and *Administration of the Plan*.
Termination/ Amendment of Plan	Provisions governing the authority of the Employer or others to terminate the Plan or amend or eliminate benefits under the Plan and the circumstances under which the Plan may be terminated or benefits may be amended or eliminated are set forth in Sections *Entry and Withdrawal of Employers* and *Amendment and Termination of Plan*. Provisions governing the benefits, rights, and obligations of participants and beneficiaries under the Plan upon termination of the Plan or amendment or elimination of benefits under the Plan are set forth in Section *Amendment and Termination of Plan*. If the Plan is amended in any material respect or terminated, you will be notified in writing.
Plan Status	The Plan Sponsor considers this Plan to be Non-Grandfathered.

INDEX

PREAMBLE

Shenandoah School Corporation (the "Company") provides several fringe benefits to its Eligible Employees. These benefits include health and prescription drug.

As of the Effective Date, the Company hereby establishes the **Shenandoah School Corporation Employee Benefit Trust (the "Plan")** for the benefit of Covered Persons (as defined below). This Plan is a continuation of several welfare benefit arrangements maintained by the Company. The Company hereby amends and restates the Plan as of **July 1, 2017.** This Plan is not in lieu of and does not affect any requirements for coverage under Worker's Compensation laws of any state.

ELIGIBILITY, ENROLLMENT, AND TERMINATION OF COVERAGE

Each Eligible Employee or Dependent shall become covered under this Plan in accordance with the following rules:

Eligible Employees. An employee of the Employer is eligible for coverage under this Plan if he or she:

(1) Is regularly scheduled to work at least thirty (30) hours per week (referred to as the "Hours of Service requirement").

(2) Is in an eligible class of employees which include:
   a. Custodians;
   b. Secretaries;
   c. Administrators;
   d. Certified Professionals;
   e. All retirees meeting the requirements for Retiree Coverage as stated in this Plan (the Hours of Service Requirement does not apply to retirees).

(3) Is a Qualifying Employee who, in an applicable Measurement Period (as defined in the Plan Eligibility Appendix adopted by the Employer, in a manner consistent with IRS Code Section 4980H) is determined to average at least thirty (30) hours per week.

Employee Effective Date. Coverage begins the first day of the month immediately following the completion of thirty (30) days of Full-time Employment. Coverage for retirees is effective immediately. Completion of an enrollment form is also a Plan requirement.

Dependents. A family member of an Eligible Employee will become eligible for coverage under this Plan as a Dependent on the first day that the Eligible Employee is eligible for coverage under this Plan and the family member satisfies the following requirements:

(1) Spouse. An individual is eligible for coverage under this Plan as a Dependent if legally recognized as the marital partner of a Covered Eligible Employee. The Plan Administrator may require documentation proving a legal marital relationship for verification of eligibility at any time.

(2) Child. An individual is initially eligible for coverage under this Plan as a Dependent if he or she is a biological child, adopted child, child placed for adoption, step-child or child of legal guardianship of an Eligible Employee. This is regardless of marital status, dependent or tax status, student status, place of residence or availability of other coverage. A child of an Eligible Employee remains eligible as a Dependent until the end of the Calendar Month the Dependent attains age twenty-six (26). The Plan Administrator may require documentation proving dependent relationship status for verification of eligibility at any time.

These age limits do not apply to an unmarried Dependent child who has a mental or physical disability, resides with the Eligible Employee, is unable to achieve self-sustaining employment and therefore chiefly depends on the Eligible Employee for support and maintenance, as long as the debilitating condition existed before coverage otherwise would have ended. For a Dependent child with a disability, the Plan Administrator must be furnished with proof satisfactory to it as to the Dependent child's disability within one hundred twenty (120) days after the later of the date the Dependent child is first eligible for coverage under this Plan or the date the Dependent child reaches the otherwise disqualifying age, and as may be requested by the Plan Administrator from time to time.

Child Support Order. A child may become eligible for coverage as a Dependent under this Plan as set forth in a qualified medical child support order. The Plan

Administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a qualified medical child support order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.

(3) Exceptions. The following individuals are excluded as eligible for Dependent coverage: an individual who lives in the Covered Eligible Employee's home but who is not eligible as previously described; the legally separated or divorced former spouse of the Eligible Employee; any person who is on active duty in any military service of any country; or any person who is eligible for coverage under the Plan as an Eligible Employee.

Coverage may continue for the qualifying dependent spouse and child(ren) of the Eligible Employee when the Eligible Employee retires, as long as the necessary contributions, if any, are made when due. (see subsection *Termination of Coverage*).

Multiple Family Members Eligibility. An individual cannot be covered as both an Eligible Employee and a Dependent under the Plan. Further, a Dependent may not be covered by more than one (1) Eligible Employee. The following rules govern the coordination of the eligibility rules for multiple family member Eligible Employees:

(1) Married Eligible Employees

(a) If both married Eligible Employees are eligible for coverage under the Plan, the Eligible Employees may choose which Eligible Employee shall be deemed the Employee for purposes of Plan eligibility. The covered Eligible Employee's spouse and any eligible children would then be deemed eligible Dependents.

(b) In the event of a dispute, the Eligible Employee who has been in the Plan the longest assumes status as the covered Eligible Employee under the Plan.

(c) If the coverage is terminated, COBRA (as defined in Section *Continuation of Coverage)* will not be offered to the extent coverage is available through the spouse by means of the spouse's employment at the Company. The spouse would automatically assume status as the covered Eligible Employee, and the individual whose coverage was terminated will become an eligible dependent under the Plan.

(2) Employment of a Dependent. When a child of a covered Eligible Employee becomes eligible for coverage as an Eligible Employee, she or she shall become covered as an Eligible Employee rather than a Dependent under this Plan.

Retiree Coverage. A secretary, hired before the 2005-06 school year; who retires must meet and have met all the following criteria;

(1) Be at least fifty (50) year of age;
(2) Have completed at least ten (10) years of service with Shenandoah School Corporation;
(3) Be actively enrolled in the Plan at the time of retirement;
(4) Is not eligible for Medicare.

A certified professional who retired with continuing coverage must have met all of the following criteria:

(1) Be at least fifty-five (55) years of age;

(2) Have completed at least ten (10) years of service with Shenandoah School Corporation and have completed a minimum of fifteen (15) years in the teaching profession;
(3) Be actively enrolled in the Plan at the time of retirement; and
(4) Is not eligible for Medicare.

Retiree Spouse Coverage. The legal Spouse of a retired secretary, custodian or certified professional may continue coverage by paying the required contribution when due. Coverage may continue subject to the guidelines in subsection *Termination of Coverage*.

Automatic Enrollment. An Eligible Employee or Dependent who was covered under one of the several welfare benefit arrangements in existence as of the day preceding this Plan's Effective Date remains covered under this Plan as of the Effective Date without the need for separate enrollment in this Plan.

Regular Enrollment. An individual who is not automatically enrolled in the Plan as described above may enroll in the Plan within thirty (30) days of the date he or she first becomes eligible for coverage. Coverage for a Regular Enrollee becomes effective the first day of the month immediately following the completion of thirty (30) days of Full-time Employment. Coverage for retirees is effective immediately. Submission of an enrollment form is also required.

Special Enrollment. If an Eligible Employee or Dependent declined coverage hereunder at the time of initial eligibility (and, if required, stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and applies for coverage under this Plan within thirty (30) days of the loss, such individual shall be a Special Enrollee provided such person: (1) was under a COBRA continuation provision and the coverage was exhausted; or (2) was not under such a provision and either the coverage was terminated as a result of loss or eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employer) or employer contributions toward such coverage were terminated. Individuals who lose other coverage due to non-payment of premiums or for cause (e.g., filing fraudulent claims) may not be Special Enrollees hereunder.

An Eligible Employee (and an eligible Dependent) shall be permitted to enroll in this Plan under the Plan's special enrollment provisions if: (1) the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan under Title XXI of the Social Security Act and coverage of the Eligible Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage; or (2) the Eligible Employee or Dependent becomes eligible for assistance with respect to coverage under the Plan under a Medicaid plan or State child health plan. An Eligible Employee or Dependent shall be entitled to enroll in this Plan under the preceding sentence only if the Eligible Employee requests coverage's under this Plan not later than sixty (60) days after the date the Eligible Employee's or Dependent's coverage under Medicaid or a State child health plan terminates or within sixty (60) days after the date the Eligible Employee or Dependent is determined to be eligible for assistance under Medicaid or a State child health plan.

An Eligible Employee or Dependent who seeks to enroll in the Plan as a result of the acquisition of a Dependent through marriage, birth, adoption, or placement of adoption shall be a Special Enrollee hereunder if enrolled within thirty (30) days of the acquisition of the Dependent. Coverage for a newborn or newly adopted Special Enrollee becomes effective as of the date of the adoption, birth, or placement for adoption. **Coverage for a Special Enrollee other than a newborn or newly adopted child becomes effective the first of the month following the Special Enrollment Event date.**

Late Enrollment. Notwithstanding anything in the above Subsections to the contrary, if an Eligible Employee or Dependent completes and returns the required enrollment form (and agrees to make the required contribution) more than thirty (30) days after the date on which he or she otherwise satisfies all other requirements for regular or special enrollment for coverage under the Plan, he or she shall be

considered a Late Enrollee. Late Enrollees may enroll for coverage under the Plan during the next Special or Open Enrollment Period.

Open Enrollment. Late enrollees may enroll for coverage under the Plan each year during the publicized time period that will be held in the month of April. Eligible Employees may also make any benefit election changes at this time. Coverage will become effective the next following May 1st.

Re-Enrollment after Termination of Coverage. In the event an Eligible Employee is covered under the Plan, voluntarily chooses to terminate such coverage (for himself or herself or for a covered Dependent), does not terminate employment with the Company, and thereafter desires to be covered (or to have a previously-covered Dependent covered) again under the Plan, the Employee or Dependent may do so only as a Late Enrollee as described above.

Continuation During Periods of Employer-Certified Disability. An Eligible Employee may remain eligible for a limited time if Full-time work ceases due to disability. This continuance will end as follows:

(a) the date this Plan terminates;
(b) the date of termination of employment;
(c) the date the Eligible Employee becomes eligible for Medicare unless otherwise prohibited by law;
(d) the date the Eligible Employee is no longer considered Disabled;
(e) the end of the twenty-six (26) week period immediately following the last day of active work for custodians and secretaries; and
(f) the minimum of the end of the twenty-six (26) week period immediately following the last day of active work and the maximum including any leave periods as listed in the section below plus any accumulated sick, vacation or personal days for Certified Professionals.

Please Note:

- **In all instances above, any appropriate time periods run concurrently with FMLA, if applicable.**
- **If the Employee returns to work Part-time, he or she may continue coverage under this provision, subject to approval by the Company.**

Continuing Coverage for Certified Professionals During Approved Leave of Absence. Certified Professionals have several leave options of varied lengths available (*as detailed in their union contract)* with and without pay. Application for a leave of absence must be submitted to and granted by the Superintendent. Sick, vacation and personal days may be used to continue coverage, but it is not required to do so. If the leave extends beyond the approved leave of absence period, accumulated sick, vacation and personal days, contracted salary, and, if applicable, the Family and Medical Leave Act (see subsection FMLA)), the Certified Professional will become COBRA eligible. Coverage will be reinstated on the date the Employee returns to work.

Coverage during Layoff. The Plan will pay its share of the required contribution amount for the remainder of the calendar month containing the last day of work and the next following month. If recalled to work within a six (6) month period, the Waiting Period will not apply.

Part-Time to Full-Time Employees. Part-time Employees who become full-time must satisfy the Waiting Period as a Full-time Employee.

Foreign Residence. An eligible Employee whose principle place of residence is outside of the United States shall not be eligible for benefits under this Plan. The Eligible Employee's Dependents primarily residing in the United States shall be eligible to the extent the Eligible Employee would have been eligible had his or her principle residence been in the United States.

USERRA. Federal law requires that if coverage would otherwise end because of entrance into active military duty, coverage may be continued (including Dependent coverage) for up to twenty-four (24) months in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time.

Termination of Coverage. Except as described in the Section *Continuation of Coverage*, the coverage of any Covered Person under the Plan shall terminate on the earliest of the following dates.

(1) The date this Plan is terminated;
(2) With respect to an Eligible Team Member, the end of the month that he or she ceases to be classified in an Eligible Class of Eligible Employees, whether by a change in job classification, a change in the definition of Eligible Employee, or some other modification of the Plan unless coverage must be continued in a manner consistent with IRS Code Section 4980H.
(3) With respect to an Eligible Employee, the end of the month in which the Eligible Employee's coverage ceases as a result of termination of employment with the Employer;
(4) With respect to a Dependent, the date that he or she ceases to be a Dependent, whether by a change in status, a change in the definition of Dependent, or some other modification of the Plan;
(5) With respect to a Dependent child, the earlier of the date the related Eligible Employee's coverage terminates and the end of the month the Dependent child attains age twenty-six (26);
(6) With respect to a Dependent spouse, the date the coverage of the related Eligible Employee terminates;
(7) With respect to any Covered Person, the date that he or she becomes a Full-time member of the Armed Forces of any country;
(8) With respect to any Covered Person, the date that he or she fails to pay the required contribution, if any, to the Plan;
(9) With respect to any Covered Person, the date of original ineligibility for coverage if coverage is found to be provided under the plan due to fraud or misrepresentation of fact;
(10) With respect to a Retiree, the date that he or she becomes eligible for Medicare;
(11) With respect to the eligible Dependent Spouse of a Retiree, the earlier of the date any required contributions cease, the Dependent Spouse becomes Medicare eligible, or the date the Retiree expires.
(12) With respect to any eligible Dependent children of a Retiree, the earlier of the date any required contributions cease, the Retiree becomes Medicare eligible, or the date the Retiree expires.

Change in Status. Each Eligible Employee must notify the Company of any change of address, entrance or the entrance of a Dependent into the military, loss or acquisition of a Dependent, a child ceasing to be a Dependent under the terms of the Plan, the Eligible Employee's or a Dependent's eligibility for or entitlement to Medicare, or any other change in status which might affect coverage for the Eligible Employee and/or the Eligible Employee's Dependents under the Plan. Notice must be given within thirty (30) days of the change in status, or as soon as reasonably possible whenever a change in such status occurs, except as otherwise required under Section *Continuation of Coverage.* However, the failure to provide notice to the Plan Administrator shall not permit the Eligible Employee and/or Dependent to continue coverage if otherwise ineligible.

Family and Medical Leave Act (FMLA). An Eligible Employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period or pursuant to the applicable FMLA guideline.

During this leave, the Employer will continue to pay the same portion of the Eligible Employee's contribution for the Plan. The Eligible Employee shall be responsible to continue payment for Eligible Dependent's coverage and any remaining Employee contributions. The Employer and Eligible Employee will make arrangements for payment of required contributions either during or after the FMLA leave.

If coverage under the Plan was terminated during an approved FMLA leave, and the Eligible Employee returns to work immediately upon completion of that leave, Plan coverage will be reinstated on the date the Eligible Employee returns to work as if coverage had not terminated, provided the Eligible Employee makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to work.

PPO Requirements. Subject to this Section's provisions, an Eligible Employee's eligibility under a PPO Option shall be governed by the applicable contract entered into by the Company and the applicable preferred Provider organization.

MEDICAL BENEFITS

General. Subject to the provisions and limitations of the Plan, a Covered Person shall be reimbursed for Covered Charges (other than a Copayment, Deductible or Coinsurance amount for which the Covered Person is financially responsible) resulting from an Injury or Illness Incurred by that Covered Person.

Excess Charges. Neither the Plan Administrator nor the applicable Plan Supervisor shall be liable for the payment of any benefit in excess of the Usual, Customary and Reasonable Charge. If requested by a Covered Person, the applicable Plan Supervisor shall review its initial determination with respect to a Usual, Customary and Reasonable Charge under this Plan and may attempt to reach an agreement with the applicable service Provider in order to compromise, settle or otherwise reduce the charges Incurred by the Covered Person; provided, however, that the Covered Person shall remain financially responsible with respect to such charges Incurred and for all other matters that may exist between the Covered Person and the service Provider.

Offset of Benefits. If any payment is erroneously made (either with respect to the amount, identity of the payee or the fact of payment) under this Plan, this Plan may recover that erroneous payment, whether it was made as the result of the Plan Administrator's or applicable Plan Supervisor's own error, from the person to whom it was made or from any other appropriate party. If any such erroneous payment is made directly to a Covered Person, this Plan may offset future payments made directly to that Covered Person by the amount of such erroneous payment.

Request for Additional Claim Information. The Plan Supervisor may need to request additional information from the Covered Person before a claim for benefits can be adjudicated. A request for additional information may occur:

1. when necessary information is missing from the claim (i.e. birth date, date of service, diagnosis etc.);
2. when coordination of benefits (COB) information is needed; or
3. when the claim appears to be related to an accident (see Section *Subrogation Rights*).

The Plan Supervisor will send written correspondence (letter or Explanation of Benefits (EOB)) to the Covered Person and the Provider of services (if applicable) detailing the information needed. If related claims are received, an Explanation of Benefits (EOB) will again be sent to the Covered Person and Provider (if applicable) explaining the claim (s) in question will be closed until the requested information is received from the Covered Person. When the claim information is received, the Plan Supervisor will reopen and adjudicate the claim (s) by the terms as set forth in this Plan.

Copayments. Covered Persons may pay a Copayment per occurrence of certain Preferred Provider services as outlined in Section *Benefit and Information Grid*. On the Standard Plan, In-Network medical plan Copayments accrue toward the In-Network Out-of-Pocket Maximum. Prescription Drug Copayments combined with the In-Network Out-of-Pocket Maximum will not exceed the maximums as allowed under the Affordable Care Act.

Deductibles and Coinsurance. The In-Network and Out-of-Network Deductible and Coinsurance amounts cross-accumulate. Out-of-Network Covered Charges are subject to Usual, Customary and Reasonable allowances.

Calendar Year Deductible. Covered Persons must pay an annual Deductible prior to Coinsurance payment for any benefits where it is stated in the Plan that Deductible is applicable.

Note for Plan Participants in Option C: With regard to the Deductible for a Family Unit, when the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year. Any number of Family members may help to satisfy the Deductibles for the Family Unit, however no more than the individual Deductible amount may be applied to any one Covered Person.

Note to Plan Participants in Option D: There are special rules with regard to the Family Deductible if you are participant in Option D of this Plan. Any number of Family members may help to satisfy the Deductible for the Family Unit, however no benefits are payable under this Plan until the entire Family Deductible amount shown in the schedule of benefits has been incurred.

Deductible Three-Month Carryover. Covered Charges Incurred in, and applied toward the Deductible in October, November, and December will be applied toward the Deductible in the next Calendar Year. **The three (3) month Carryover does not apply to covered persons enrolled in Option D of this Plan.**

Common Accident Deductible. If two or more members of a Family are injured in the same accident only one (1) Deductible will be applied to expenses incurred in that Calendar Year as a result of that accident.

Calendar Year Maximum Out-Of-Pocket Limits. The maximum yearly amount of Covered Charges (excluding Premiums, balanced billed charges, Precertification penalties, Out-of-Network over Usual, Customary and Reasonable Amounts, and non-Covered Charges) that a Covered Person will pay through Deductible, Coinsurance and medical Copayments. Once this maximum is met, the Plan will pay 100% of Covered Charges for the remainder of the year. Prescription Drug Copayments continue to accrue to a separate Out-of-Pocket Maximum which combined with the In-Network Out-of-Pocket Maximum will not exceed the maximum allowed by the Affordable care Act.

Secondary Payor Rules. This Plan provides for limited coordination of benefits *for the sole benefit of Covered Persons*. *This Plan will not make payments to a provider in excess of the payments to which the provider was entitled under the primary plan.* When this Plan is secondary, the Plan will coordinate benefits only up to the maximum out of pocket expenses a Covered Person would have incurred under this Plan had this Plan been primary. Specifically, the Plan will calculate the extent to which this Plan's Deductible, Copayment, Coinsurance and Maximum Out-of-Pocket expense rules produce a greater benefit than the primary plan's Deductible, Copayment, Coinsurance and Maximum Out-of-Pocket expense rules. This will be the "Benefit Maximum." After the primary carrier pays, this Plan will pay remaining eligible expenses up to 100% of the Benefit Maximum.

Charges Never Paid at 100%. The charges for the following do not apply to the 100% benefit limit and are never paid at 100%.

1. Precertification Penalties, if applicable;
2. Non-Covered Charges; and
3. Out-of-Network charges over UCR.

PPO NETWORK BENEFITS

Definitions. For purposes of this Section, the terms listed here shall have the following meanings:

Ancillary charges - Charges for additional services related to treatment that are not included in facility charges. Examples of ancillary charges include a radiologist or pathologist services and anesthesiology services.

Annual out-of-pocket maximum - The maximum yearly amount of Covered Charges (excluding Premiums, balanced billed charges, Precertification penalties, Out-of-Network over Usual, Customary and Reasonable Amounts, and non-Covered Charges) that a Covered Person will pay through Deductible, Coinsurance and medical Copayments. Once this maximum is met, the Plan will pay 100% of Covered Charges for the remainder of the year. Prescription Drug Copayments continue to accrue to a separate Out-of-Pocket Maximum which combined with the In-Network Out-of-Pocket Maximum will not exceed the maximum allowed by the Affordable care Act.

Copayment - An amount of money that is paid each time a particular service is used.

Elective treatment – A treatment or procedure not requiring immediate attention and therefore scheduled for the patient's convenience.

Emergency – Any urgent condition perceived by the patient (applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine) as requiring immediate medical evaluation or treatment.

In-Network - Services provided by Physicians or Hospitals that are members of the PPO Network.

Out-of-Network - Services provided by Physicians or Hospitals that are not affiliated with the PPO Network.

Precertification - An administrative procedure whereby a Provider explains a treatment plan to a third party for review to determine Medical Necessity and appropriateness of care before the treatment plan is initiated.

Preferred Provider Organization (PPO Network) - A group or network of Physicians and Hospitals (Providers) that contracts with employer to provide comprehensive medical service. Provider's exchange discounted service for increased volume. A Covered Person's out-of-pocket costs are usually lower than they would be under a traditional, fee-for-service plan.

Eligibility. Eligibility for the Plan is outlined in Section *Eligibility, Enrollment, and Termination of Coverage* and applies to Covered Persons at all Company locations.

Other Network-Related Plan Provisions

Eligible Employees who reside fifty (50) miles from a Network Provider. Any Eligible Employee (including any covered Dependents) residing fifty (50) miles from a Network provider will receive the In-Network level of benefits.

Procedure for seeking Elective treatment outside the PPO Network area. A Covered Person who seeks Elective medical assistance while traveling outside the Network may see any Physician. Out-of-Network percentages will apply.

Procedure for seeking Emergency treatment outside the PPO Network area. A Covered Person who requires Emergency medical assistance or after-hours care when traveling outside the Network area may obtain the necessary care. Emergency care outside of the PPO Network area will be payable at the In-Network level.

Referrals to Specialists. If a Network Physician refers a Covered Person to a specialist, it is the responsibility of the Covered Person to verify, by consulting the PPO Network directory, that the specialist is a Network participant. If the specialist is not in the Network, benefits will be paid at the lower Out-of-Network rate unless the necessary treatment is unavailable from a Network Provider or Facility.

Ancillary Services. When utilizing a PPO Network Provider, the following out-of-network services will be paid at the In-Network level: Radiologist or Pathologist services, consultation from an out-of-network Provider or ER Physician. Also, if the operating surgeon (Inpatient or Outpatient) is in the PPO Network and the anesthesiologist is not, the anesthesiologist will be paid at the In-Network level. Please Note: If the Hospital is Out-of-Network the charges will be considered Out-of-Network unless due to an Emergency or if the required services are unavailable at an In-Network facility.

Network Unavailable. Required services found to be unavailable in the chosen network will be considered at the In-Network level.

Shenandoah School Corporation
Benefit and Information Grid
Plan C

	In-Network	Out-of-Network
Calendar Year Deductible	$250 per Covered Person $500 per Family Unit	
Calendar Year Maximum Out-of-Pocket *(Including Deductible, Coinsurance and Medical Copayments)*	$1,000 per Covered Person $2,000 per Family Unit	$1,750 per Covered Person $3,500 per Family Unit
Please Note: In and Out-of-Network Deductible and Out-of-Pocket amounts accumulate. **Please Note: Prescription Drug Copayments combined with the above In-Network Out-of-Pocket Maximum cannot exceed the maximums allowed by the Affordable Care Act.**		
Coinsurance percentage paid by Plan	After Deductible, 80% paid by Plan- unless otherwise noted herein	After Deductible, 60% paid by Plan unless otherwise noted herein. All Out-of-Network expenses are subject to Usual, Customary, and Reasonable (UCR).
HOSPITAL SERVICES		
Hospital Inpatient Facility *(Semi Private Room and Intensive Care Unit)*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Hospital Outpatient Facility	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Outpatient Laboratory and X-ray charges including Nuclear Imaging *(MRA, MRI, PET, CT Scans)*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
PHYSICIAN SERVICES		
Physician Office Visit *Includes the office visit charge only.*	$15 Copayment paid by Covered Person, then 100% paid by Plan	After Deductible, 60% paid by Plan
Specialist Office Visit *Includes the office visit charge only.*	$30 Copayment paid by Covered Person, then 100% paid by Plan	After Deductible, 60% paid by Plan
All other services during office visit	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Physician Services *Inpatient visits, surgery, anesthesia, radiology, pathology*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan

	In Network	Out of Network
PREVENTIVE / WELLNESS CARE		
Preventive / Wellness Care for Adult and Child *As Required by the Affordable Care Act and as shown in section Covered Services*	100% paid by Plan *(No Deductible)*	After Deductible, 60% paid by Plan
EMERGENCY SERVICES		
Emergency Room Services	After In-Network Deductible, 80% paid by Plan	
Ambulance	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Urgent Care Facility	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
OTHER MEDICAL SERVICES		
Maternity Services *Coverage is limited to employee and covered spouse only.*	Same as any other Illness or as required by the Affordable Care Act.	
Durable Medical Equipment	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Orthopedic / Prosthetic Devices / Orthotic Devices	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Extended Care / Skilled Nursing Facilities	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Hospice *with 6-month life expectancy*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Home Health Care	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Physical, Occupational and Speech Therapy	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Chiropractic Care *Limited to the lesser of $1,000 or 25 visits per Calendar Year.*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan

SHENANDOAH Raiders	In Network	Out of Network
Other Therapy Services *(chemo, radiation, dialysis, etc)*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Organ and Tissue Transplants	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
	Please Note: This Plan has purchased a fully insured organ and tissue transplant policy which is hereby incorporated by reference as part of this health plan documents and for which any applicable transplant may be payable under.	
Hearing Aids & Related Services *Limited to $2,000 per Calendar Year.*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
TMJ/Jaw Joint *Limited to $1,500 per Calendar Year for non-surgical services.*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Inpatient Mental Health and Substance Abuse Services *Including Psychiatric Day Treatment*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Outpatient Mental Health/Substance Abuse Office Visits *Includes the office visit charge only.*	$15 Copayment paid by Covered Person, then 100% paid by Plan	After Deductible, 60% paid by Plan
All other Outpatient Mental Health/Substance Abuse Services	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
PRESCRIPTION DRUG BENEFIT		
Prescription Drugs at a Participating Pharmacy 30-day supply	**Generic – Greater of $8 or 20%** **Brand Drugs – Greater of $15 or 20%**	
Prescription Drugs through a Participating Mail Order Pharmacy Up to 90-day supply	**Generic Drugs - Greater of $12 or 20%** **Brand Drugs – Greater of $20 or 20%**	

This benefit and information grid is a summary of the plan benefits. For more complete information, please see sections *Covered Services, Prescription Drug Benefits* and *Services Not Covered.*

Shenandoah School Corporation
Benefit and Information Grid
Plan D

	In-Network	Out-of-Network
Calendar Year Deductible	$1,300 per Covered Person $2,600 per Family Unit	
Calendar Year Maximum Out-of-Pocket *(Including Deductible, Coinsurance and Medical Copayments)*	$2,800 per Covered Person $5,600 per Family Unit	$3,800 per Covered Person $7,600 per Family Unit
Please Note: For individuals enrolled in Family Coverage, no benefits are payable until the entire family deductible has been satisfied. **Please Note: In and Out-of-Network Deductible and Out-of-Pocket amounts accumulate.**		
Coinsurance percentage paid by Plan	After Deductible, 80% paid by Plan- unless otherwise noted herein	After Deductible, 60% paid by Plan unless otherwise noted herein. All Out-of-Network expenses are subject to Usual, Customary, and Reasonable (UCR).
HOSPITAL SERVICES		
Hospital Inpatient Facility *(Semi Private Room and Intensive Care Unit)*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Hospital Outpatient Facility	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Outpatient Laboratory and X-ray charges including Nuclear Imaging *(MRA, MRI, PET, CT Scans)*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
PHYSICIAN SERVICES		
Physician Office Visit *Includes the office visit charge only.*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Specialist Office Visit *Includes the office visit charge only.*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
All other services during office visit	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Physician Services *Inpatient visits, surgery, anesthesia, radiology, pathology*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan

	In Network	Out of Network
PREVENTIVE / WELLNESS CARE		
Preventive / Wellness Care for Adult and Child *As Required by the Affordable Care Act and as shown in section Covered Services*	100% paid by Plan *(No Deductible)*	After Deductible, 60% paid by Plan
EMERGENCY SERVICES		
Emergency Room Services	After In-Network Deductible, 80% paid by Plan	
Ambulance	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Urgent Care Facility	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
OTHER MEDICAL SERVICES		
Maternity Services *Coverage is limited to employee and covered spouse only.*	Same as any other Illness or as required by the Affordable Care Act.	
Durable Medical Equipment	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Orthopedic / Prosthetic Devices / Orthotic Devices	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Extended Care / Skilled Nursing Facilities	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Hospice *with 6-month life expectancy*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Home Health Care	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Physical, Occupational and Speech Therapy	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Chiropractic Care *Limited to the lesser of $1,000 or 25 visits per Calendar Year.*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan

SHENANDOAH Raiders	In Network	Out of Network
Other Therapy Services *(chemo, radiation, dialysis, etc)*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Organ and Tissue Transplants	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
	Please Note: This Plan has purchased a fully insured organ and tissue transplant policy which is hereby incorporated by reference as part of this health plan documents and for which any applicable transplant may be payable under.	
Hearing Aids & Related Services *Limited to $2,000 per Calendar Year.*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
TMJ/Jaw Joint *Limited to $1,500 per Calendar Year for non-surgical services.*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Inpatient Mental Health and Substance Abuse Services *Including Psychiatric Day Treatment*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
Outpatient Mental Health/Substance Abuse Office Visits *Includes the office visit charge only.*	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
All other Outpatient Mental Health/Substance Abuse Services	After Deductible, 80% paid by Plan	After Deductible, 60% paid by Plan
PRESCRIPTION DRUG BENEFIT		
Prescription Drugs at a Participating Pharmacy 30-day supply	**After Deductible, 80% paid by Plan**	
Prescription Drugs through a Participating Mail Order Pharmacy Up to 90-day supply	**After Deductible, 80% paid by Plan**	

This benefit and information grid is a summary of the plan benefits. For more complete information, please see sections *Covered Services, Prescription Drug Benefits* and *Services Not Covered.*

COVERED SERVICES

Subject to any limitations described elsewhere herein, the Plan shall cover the following services and supplies:

Hospital Services

(1) **Inpatient Hospital** room and board services.

(2) After **23 observation hours**, a confinement will be considered an Inpatient confinement.

(3) **Hospital ancillary and professional services.**

(4) Appropriate **Hospital rooms** required for the treatment of a condition.

(5) **Outpatient Hospital** services.

Hospital Room Limitation - Charges for a Hospital room shall be limited to the semi-private room charge in the Hospital where the Covered Person is confined; provided, however, that, if the Hospital in which the Covered Person is confined does not have semi-private rooms, charges shall be limited to the lowest private room rate in that Hospital; provided, further, that if a private or specialty care room (intensive care, coronary care, etc.) is Medically Necessary, charges for that room shall be covered at the standard rate for that room in the Hospital where the Covered Person is confined. Hospital/facility charges *(including Ambulatory Surgical Facilities)* for multiple surgical procedures are subject to the limitations described in subsection *Surgical Services*.

Specialized Treatment Facilities

(1) Charges made by an **Ambulatory Surgical Facility, Rehabilitation Facility or Birthing Center** for services and supplies furnished as deemed Medically Necessary.

(2) Charges made by a **Home Health Care Agency** for services and supplies furnished to a covered individual in his home are considered Covered Charges. The attending Physician must furnish a written program of health care and certification that proper treatment of the Illness or Injury would require Hospitalization if services and supplies were not otherwise available under a Home Health Care program. Covered Charges include:

   (a) Part-time or intermittent nursing care (up to four (4) hours per visit) by a Registered Nurse, Licensed Practical Nurse or licensed therapist;
   (b) Part-time or intermittent home health aide services which consist primarily of caring for the individual;
   (c) Physical, occupational or speech therapy; and
   (d) Medical supplies, drugs, and medicines prescribed by a Physician and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the individual had remained in the Hospital.

(3) **Extended Care Facility and Skilled Nursing Facility**. Covered Charges include Inpatient convalescent home care for the following services and supplies furnished while the patient is in an Extended Care Facility or Skilled Nursing Facility, is under the continuous care of the attending Physician and requires twenty-four (24) hour care:
   (a) Room and Board and other services and supplies furnished by the facility for necessary care (other than personal items);
   (b) Professional services;
   (c) Use of special treatment rooms;

(d) X-ray and laboratory examinations;
(e) Physical, occupational and speech therapy;
(f) Oxygen and other respiratory therapy;

(4) **Hospice care**. Benefits are subject to the maximums and limitations set forth in Section *Benefit and Information Grid.* All Hospice services must be provided in accordance with a treatment Plan devised between the attending Physician and the Hospice. It is recognized that some patients may still require services after the six (6) months have elapsed.

(a) Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal and determined that the person is not expected to live more than six (6) months.
(b) Room and board and services and supplies while confined in a Hospice or Hospice setting.
(c) Part-time nursing care by or under the supervision of a registered nurse (RN).
(d) Home health aide services.
(e) Nutrition services and special meals.
(f) Hospice care services and supplies in the Covered Persons home; and
(g) Other services as appropriate by members of the Hospice team.
(h) Bereavement counseling services by a licensed social worker (ACSW) or a licensed pastoral counselor for the Covered Person's Immediate Family.

Surgical Services

(1) **Multiple surgical procedures** during the same operative session performed through separate incisions in the same operative field will be payable according to the contracted rate or Usual, Customary and Reasonable charge for the total procedure which will not exceed, in total, the contracted rate or Usual, Customary and Reasonable charge for the greater procedure and 50% of the Usual, Customary and Reasonable charge for the lesser procedure(s).

Bilateral procedures during the same operative session performed in separate fields will be payable according to the contracted rate or Usual, Customary and Reasonable charge for the total procedure which will not exceed, in total, 150% of the contracted rate or Usual, Customary and Reasonable charge for the unilateral procedure(s).

When **2 surgeons (Co-surgeons)** work together as primary surgeons performing distinct parts of a procedure(s), benefits will not exceed 120% of the contracted rate or Usual, Customary and Reasonable amount for the procedure(s) and split between the two co-surgeons (60% each).

(2) Charges for **second and third surgical opinions** which are provided to determine the medical necessity of an elective operation (one that is not of an Emergency or life-threatening nature) and which is rendered by a Physician who is neither the operating surgeon nor associated with the Physician who recommended the surgery. Payment is subject to the benefits listed in Section *Benefit and Information Grid.*

(3) Technical assistance by a **Physician** or a **Certified Surgical Assistant (CSA)** (or S.A., S.F.A., C.F.A or P.A.) in the performance of a **surgical procedure** provided that the surgical procedure necessitates the use of an **assistant**. The assistant Physician expenses are not to exceed 25% of the contracted rate or Usual, Customary and Reasonable charge of the surgical procedure. Services of any other covered Provider are reduced to 15% of the contracted rate or Usual Customary and Reasonable charge.

(4) **Anesthetic services**, when performed by a licensed anesthesiologist or certified registered nurse anesthetist (CRNA) in connection with a surgical procedure.

(5) **Circumcision** for newborns and when Medically Necessary.

(6) Surgical treatment of **Temporomandibular Joint Dysfunction (TMJ)** when Medically Necessary and subject to the limitations set forth in section *Benefit and Information Grid.*

(7) **Outpatient surgery.**

(8) **Orthognathic surgery** with Medical Necessity.

(9) **Podiatry surgery** with Medical Necessity.

(10) **Sterilization** (for Covered Employees, Spouses, and as required by the Affordable Care Act.) Including vasectomy and tubal ligation (when elective procedure).

(11) **Reconstructive surgery** when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part, an Accidental Injury.

(12) **Regarding breast reconstruction after a total or partial mastectomy the following are covered expenses:**

(a) reconstruction of the breast on which the mastectomy has been performed;
(b) reconstruction of the other breast to produce symmetrical appearance; and
(c) coverage for prostheses and physical complications of all stages of mastectomy, including lymph edemas; in a manner determined in consultation with the attending Physician and the patient.

(13) **Nasal surgery** when Medically Necessary.

Diagnostic Services

(1) Diagnostic charges for **X-rays**.

(2) **Radiology**, ultrasound and nuclear medicine.

(3) **Pre-admission** testing (PAT).

(4) **Laboratory and pathology**.

(5) **EKG, EEG and other electronic diagnostic medical tests**.

(6) **Amniocentesis** when Medically Necessary.

(7) **Psychological** testing.

(8) **Neuropsychological** testing.

(9) **Allergy** testing.

(10) **Magnetic Resonance Imaging (MRI).**

(11) **Genetic Testing**, but only for:

(a) Diagnostic testing where the patient is showing symptoms of disease and those symptoms correspond to a medically recognized genetic disorder;

(b) Diagnostic testing when testing is performed on the DNA of an invading virus or bacterium for the purpose of identifying and treating a specific contagious disease;
(c) Predictive testing if the Covered Person's family history establishes him as at-risk for a genetic disease, but only if there are accepted treatment alternatives for that condition; and
(d) Prenatal testing when the pregnancy is categorized as high-risk, including cases where the mother is 35 years of age or older, or the mother or father has a family history that establishes that parent as at-risk for having a hereditary genetic disorder.
(e) Genetic Testing that has become a standard of care for treatment of a condition (such as, but not limited to, breast cancer).

Emergency Services

(1) Professional local **ambulance service** provided by a Hospital or by a government certified ambulance service to or from the Hospital, including both air and ground ambulance services, when such service is deemed by the Physician as Medically Necessary to safeguard the health of the Covered Person.

(2) Treatment in a Hospital **Emergency room** or other Emergency care facility for a condition that can be classified as an Emergency.

(3) **Physician services**, and the treatment of an Injury or Illness which is the result of an Emergency.

Ambulance/Emergency Service Limitation – To be treated as a Covered Charge, Emergency transportation must be:

(a) Medically Necessary;
(b) within or between the United States, Canada and Puerto Rico;
(c) by a licensed professional ambulance service, regularly scheduled airline or air ambulance; and
(d) to the nearest facility where Emergency care or treatment is rendered.

Dental Services

(1) Services performed by a **Dentist or an oral surgeon** when required for:

(a) Accidental Injury to natural teeth and jaw;
(b) Treatment of a fracture, dislocation or wound of the mouth or jaw;
(c) Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
(d) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
(e) Excision of benign bony growths of the jaw and hard palate;
(f) External incision and drainage of cellulitis;
(g) Incision of sensory sinuses, salivary glands or ducts;
(h) Treatment of infections resulting from dental care;
(i) Surgical removal of bone or tissue impacted teeth;
(j) Medically Necessary TMJ or orthognathic surgery;
(k) Facility or anesthesia charges for dental treatment in a Hospital or Ambulatory Surgical Facility, if Medically Necessary due to the Covered Person's age or health; and
(l) Necessary dental services for transplant preparation; initiation of immunosuppressives; cancer; or cleft palate.

Provider Services

(1) **Services of a Physician**, while the Covered Person is an **Inpatient**, including surgical procedures, administration of anesthesia by a second Physician during surgery, treatments and other Physician's services received in a Hospital, excluding routine services or other care not connected with treatment of an Illness or Injury unless otherwise stated herein.

(2) **Physician services**, and the cost of the use of facilities, including surgical procedures and other Physician's services received in a Physician's office, the Covered Person's home, the Outpatient department of a Hospital, an Ambulatory Surgical Center, an urgent or immediate care center or a Hospital for Inpatient services. Regarding Outpatient office visit charges, one office charge per visit is payable under this Plan unless otherwise prohibited by the Affordable Care Act.

(3) **Services of chiropractors** acting within the scope of their licenses, subject to any limitations set forth herein.

(4) Services of actively practicing **nurses** (other than persons who reside in the Covered Person's home or who are a member of the Covered Person's Immediate Family) as follows:

(a) In a Hospital, services of a Registered Professional Nurse (R.N.) or services of a Licensed Practical Nurse (L.P.N.);
(b) Other than in a Hospital, services of a Registered Professional Nurse (R.N.), a visiting nurses association, where available, or a Licensed Practical Nurse (L.P.N.)
(c) Other than in a Hospital, services of a certified Nurse Practitioner authorized to practice in the state in which services are furnished by a recognized national certifying body that has established standards for nurse practitioners

(5) The **Private Duty Nursing** care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to the extent of: a) *Inpatient Nursing Care* – Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. *b) Outpatient Nursing Care.* Outpatient nursing care is subject to the Home Health Care limitations and maximums. Outpatient private duty nursing care on a shift-basis is not covered.

(6) **Midwife** delivery services, provided:

(a) The state in which such services are performed has officially recognized midwife delivery; and
(b) The person or persons performing such midwife delivery and the facility available for these services are properly licensed by the state at the time the delivery is performed.

(7) The charges of a legally qualified **physical, speech, occupational or orthopedic therapist**, if prescribed by a Physician. Therapy is covered only for purposes of restoring speech ability or improving a bodily Injury or Illness and only if the therapy is expected to result in significant improvement of the specific defects.

Spinal Manipulation/Chiropractic Services

Chiropractic or Chiropractic Services means the diagnosis and analysis of any interference with normal nerve transmission and expression, the procedure preparatory to and complementary to the correction thereof by an adjustment of the articulations of the vertebral column, its immediate articulation, and includes other incidental means of adjustments of the spinal

column and the practice of drugless therapeutics involving the spine. However, chiropractic does not include any of the following:

(a) Prescription or administration of legend drugs or other controlled substances;
(b) Performing of incisive surgery or internal or external cauterization;
(c) Penetration of the skin with a needle or other instrument for any purpose;
(d) Use of colonic irrigations, plasmatics, ionizing radionics;
(e) Conducting invasive diagnostic tests or analysis of body fluids except for urinalysis;
(f) The taking of x-rays of an organ other than the vertebral column and extremities;
(g) The treatment or attempt to treat infectious diseases, endocrine disorders, or atypical or abnormal histology; or
(h) MRI's and CAT Scans and nerve conduction studies.

Mental Health and Substance Abuse Services

(1) **Physician services** and the cost for the use of facilities, for **Inpatient** treatment or **Outpatient** treatment of **mental health conditions.**

(2) **Physician services** and the cost for the use of facilities, for **Inpatient** treatment or **Outpatient** treatment of **substance abuse.**

(3) Professional services provided by a **Psychiatrist, Psychologist or other mental health therapist** licensed by the state where practicing and acting within the scope of such license.

(4) **Residential and Non-Residential** treatment facility services as specified herein.

(5) **Intensive Outpatient, Psychiatric Day Hospital or Partial Hospitalization** treatment services, as specified herein.

(6) Treatment for **Eating Disorders.**

(7) Treatment of **Attention Deficit Disorder.**

Covered Charges for Physician services and the use of facilities for treatment of Mental Health and Substance Abuse conditions treatment shall be subject to any limitations listed below and the limitations detailed in Section *Benefit and Information Grid.*

This Plan will pay for treatment rendered in accordance with generally accepted standards of medical practice of Mental Health and Substance Abuse Disorders. Covered Charges include:

(a) diagnostic and psychological testing;
(b) charges for room and board, services and supplies while confined as an Inpatient;
(c) individual and group therapy; and
(d) electroshock therapy.

Therapy Services Therapy services include, but are not limited to:

(1) **Radiation** therapy through treatment of disease by X-ray, radium or radioactive isotopes.

(2) **Chemotherapy** by way of treatment of disease by chemical or biological antineoplastic agents.

(3) **Dialysis** for the treatment of acute renal failure, chronic renal insufficiency or chronic irreversible renal insufficiency by removal of waste materials from the body, including,

but not limited to, hemodialysis and peritoneal dialysis and administration of erythropoiesis stimulating agents (ESA) for facilitating the growth of red blood cells.

(4) **Respiratory/inhalation** therapy.

(5) **Occupational** therapy from a licensed occupational therapist. The therapy must be ordered by a Physician and to improve a body function. Covered Charges do not include recreational programs or maintenance therapy.

(6) **Speech** therapy from a licensed speech therapist to restore speech loss due to an Illness, Injury or surgical procedure. Therapy must be ordered by a Physician and follow either:

(a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than frenectomy);
(b) an Injury or Illness.

(7) **Physical** therapy by a licensed physical therapist. Therapy must be prescribed by a Physician to improve a body function. Manual Therapy is a covered expense only when it is one component of a Medically Necessary and covered comprehensive physical therapy treatment plan to treat a specific condition or Injury. A copy of the attending Physician's prescription must be provided, upon request. Manual therapy, in absence of other therapeutic modalities, is not covered under this Plan.

(8) **Human Growth Hormone** therapy with Medical Necessity and periodic submission of growth charts.

(9) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered:

(a) under the supervision of a Physician;
(b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery or recurrent symptoms;
(c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and
(d) in a Medical Care Facility as defined by this Plan.

(10) **Home (IV) Therapy**.

Medical Equipment and Prosthetic Devices

(1) Rental of **Durable Medical Equipment** that is appropriate for the home use and is made mainly to treat the Ill or Injured, or other durable equipment required for temporary therapeutic use, or the purchase of such medical equipment and its repair and replacement if economically justified, whichever is less. Routine maintenance is not covered and charges for deluxe items are limited to the cost of features considered basic and necessary to the intended function of the device.

(2) **Orthotic devices** including initial purchase, fitting and repair of braces, splints and other appliances used to stabilize or immobilize a body part, prevent deformity, protect against injury, or assist with functions.

(3) **Orthopedic/Prosthetic devices** (except as stated as not covered in Section *Not Covered Services*) including crutches and prosthetic devices and appliances. Orthopedic shoes are covered if attached to a Medically Necessary brace. Non-prescription devices to be attached to or placed in shoes are not covered. Covered Charges also include the purchase, fitting, repair and initial placement of fitted devices which replace body parts or perform body functions, such as artificial limbs and eyes

necessary for the alleviation of or correction of conditions arising out of Accidental Injury or Illness.

Other Medical and Related Supplies Including, but not limited to, the following:

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

(2) **Surgical dressings, osmotic supplies, electronic heart pacemaker, casts, splints and trusses.**

(3) Administration of **blood and blood plasma**, **blood transfusions**, including the cost of blood and blood plasma expander.

(4) **Oxygen** and rental of equipment required for its use, not to exceed the purchase price of such equipment.

(5) **Occupational** therapy supplies.

(6) Sterile **surgical supplies** after surgery.

(7) **Diabetic** supplies, including glucose monitors.

(8) One **wig** after chemotherapy is covered with a limitation of $100 per Calendar Year.

Pregnancy

(1) Services provided for any condition of Pregnancy and the resulting childbirth, miscarriage, or involuntary abortion, including any complications there from **for Eligible Employees and Covered Spouses only.**

(2) Hospital charges Incurred by a newborn during the initial period of Hospital Confinement, but not to exceed five (5) days, will be covered as charges of the newborn. **However, the newborn child must be added to the Eligible Employees coverage (per the terms set forth in section *Enrollment, Eligibility, and Termination of Coverage*) for the newborn charges to be considered under this Plan.** In addition, the following services will be covered during the same time period: (a) professional services; and (b) circumcision.

The Plan will provide coverage for Hospital care, including room and board and pediatric visits, for a newborn infant and the mother during the first forty-eight (48) hours after a normal vaginal delivery and during the first ninety-six (96) hours after a caesarean section. This coverage is subject to the satisfaction of the newborn's Coinsurance, Deductible or Copayments where applicable and then is paid at the appropriate level of benefits subject to Case Management and accessing the PPO network. In the event of an early discharge, the Plan will cover two (2) R.N. home visits.

(3) Precertification for the condition of Pregnancy is not required for Hospital confinements which do not exceed the minimum required periods stated above. However, Precertification is required for labor induction and days beyond the above time periods.

(4) Termination of Pregnancy, only when the attending Physician states the life of the mother would be endangered if the fetus were carried to term *(with doctor's statement)* or in reported cases of rape or incest *(with police report).* Also medical

complications resulting from voluntary termination of Pregnancy, whether covered or not, are Covered Charges.

Prescription Drugs and Medicines

(1) **Drugs and medicines** which require the written prescription of a Physician which are purchased from a licensed pharmacist or from a Physician who is licensed to dispense drugs unless specifically stated as not covered herein. All prescription drugs are subject to the limitations specified in Sections *Benefit and Information Grid* and *Prescription Drug Benefits.*

(2) **Injectable drugs** and the charge for administration when in lieu of an office visit charge.

(3) **Allergy serum** and the Physician charge for the injection (when in lieu of an office visit charge).

(4) **Smoking Cessation Products,** which require a prescription under Federal Law **(limited to 180 day supply per calendar year.)**

(5) **Contraceptive Devices.**

(6) **FDA approved drugs, including self-injectable drugs,** are covered under the medical portion of this Plan unless specifically covered under the Prescription Drug Program or unless specifically stated otherwise elsewhere in this Plan.

Temporomandibular Joint Syndrome (TMJ)

(1) Reimbursements shall be limited to the applicable Copayment or Coinsurance percentage after application of the Deductible. Please Note: Orthodontia services are not covered under this benefit.

Routine/Wellness Services for Adults and Children. This plan will consider the following services under the Routine Wellness Benefit in the *Benefit and Information Grid* as recommended by a Physician. Routine Services not indicated below are not covered unless stated as covered elsewhere in this document.

(1) Routine and diagnostic mammograms
(2) Routine physical, prenatal, breast, pelvic and prostate exams
(3) Routine screenings at appropriate ages and genders
(4) Routine colorectal cancers screenings and procedures
(5) Routine test (including PSA and PAP), labs and x-rays
(6) Routine alcohol, substance abuse, tobacco abuse, obesity, diet and nutrition counseling
(7) Routine hearing loss exam for newborns
(8) Fluoride supplements for children under age 5
(9) Routine vision acuity screening for children under age 5
(10) Routine adult and child immunizations
(11) Breastfeeding education, counseling and supplies
(12) FDA approved birth control methods for woman and contraception education and counseling

This Plan covers all of the above and following items and services without any cost-sharing requirement (such as a copayment, coinsurance, or deductible) at the in-network level or as otherwise indicated in the Benefit and Information grid and within the requirements of PPACA:

(1) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. Recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

(4) With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

If an item or service described above is billed separately (or is tracked as individual encounter data separately) from an office visit, then any applicable cost-sharing requirements will apply with respect to the office visit. If an item or service described above is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then no cost-sharing requirements will apply with respect to the office visit. If an item or service described above is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then any applicable cost-sharing requirements will apply with respect to the office visit.

Organ and Tissue Transplants

(1) **Organ and tissue transplants** as set forth in Section *Organ and Tissue Transplants Transplant,* however; eligible organ and tissue transplants shall be an insured benefit under the Organ & Tissue Transplant Policy purchased by the Company, which is hereby incorporated by reference as part of this health plan document. All eligible employees and their dependents requiring human organ and tissue transplant services will have transplant-related charges covered under this separate policy, according to its terms and conditions, from the time of their evaluation through 365 days post-transplant operation. After this specified benefit period has elapsed, all transplant-related medical benefits will revert to the terms and conditions of the health coverage under this health plan document. A Transplant Case Manager will be assigned to assist and coordinate the employee or dependent's continuing transplant related needs.

Benefits available for Human Organ and Tissue Transplants are subject to the following:

a. The employee and dependent(s) are eligible for medical benefits under the group's plan document

b. The employee and dependents(s) meet all the terms and conditions outlined in the Organ and Tissue Policy/Certificate
c. The employee or dependent(s) do not have a pre-existing condition as defined in the Organ and Tissue Policy/Certificate

Those employees and their dependents who are initially excluded from human organ and tissue transplant coverage under the Organ and Tissue Transplant Policy (due to a pre-existing condition) will continue to receive health care benefits as they relate to transplantation according to the terms and conditions of the company health plan document and until eligible for benefits under the separate policy

Other

(1) Medically Necessary treatment of the **feet** subject to any limitations herein.

(2) Covered Charges include any **taxes or surcharges** imposed by a governmental entity based on the value or volume of Covered Charges provided to Covered Persons, or amount imposed or assessed against the Plan or the Employer in lieu of such taxes or surcharges. Taxes or surcharges are not subject to Deductible or Coinsurance and are payable at 100%. *(Please Note: This benefit does not include taxes, surcharges, interest, late charges, claim form completion or missed appointment charges from a Provider).*

(3) Treatment of or related to **sleep disorders** when Medically Necessary.

(4) Services or supplies related to **Acupuncture** when in lieu of anesthesia or for pain management shall be a covered expense.

(5) **Medically Necessary patient education programs** in connection with management of an Illness or Injury for which benefits are payable under this Plan *(such as diabetes, ostomy training or a cardiac condition).*

(6) **As required by the Affordable Care Act, this Plan (1) may not deny a qualified individual who is a Covered Person participating in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) may not discriminate against the individual on the basis of the individual's participation in the trial.**

A qualified individual under PHS Act section 2709(b) is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Services listed as Covered Charges in this section that are not listed in Section *Benefit and Information Grid* are payable at the applicable Coinsurance level, after satisfaction of Deductible (if applicable), subject to access of the PPO Network and the Precertification requirements of this Plan.

ORGAN AND TISSUE TRANSPLANTS

Covered Charges for organ and tissue transplant surgeries and related expenses shall be subject to Coinsurance and Deductible amounts otherwise applicable under this Plan. However, this Plan Document includes a special attachment regarding human organ and tissue transplant benefits, as explained in the transplant rider policy attached to this Plan which may be primary to this Plan.

Covered Charges for Organ and Tissue Transplants

The following services are Covered Charges:

(1) Inpatient and Outpatient Hospital services;

(2) services of a Physician for diagnosis, treatment, and surgery for a covered transplant procedure;

(3) diagnostic services;

(4) services provided to a living donor of an organ or tissue, as specified in more detail below;

(5) procurement of an organ or tissue, including services provided by a living donor of an organ or tissue for procurement of an organ or tissue. Covered Charges are limited to the actual procurement expenses and benefits are subject to the maximums stated in this section of the Plan;

(6) reasonable and necessary transportation costs for travel (including meals and lodging, up to a maximum of $200 per day) to and from the site of the surgery for a covered transplant procedure for the transplant recipient and one companion (two if the recipient is a minor), up to a maximum of $10,000 per covered transplant procedure. Itemized receipts in a form satisfactory to the Employer must be submitted for reimbursement.

(7) private duty nursing by a registered nurse or a licensed practical nurse when recommended by a Physician. The nurse cannot be a family member of the recipient or normally live in the recipient's home. Inpatient private duty nursing is a covered service only if the Hospital's regular staff cannot provide the care needed due to the recipient's condition;

(8) rental or Durable Medical Equipment for use outside the Hospital. Covered Charges are limited to the purchase price of the same equipment;

(9) prescription drugs, including immunosuppressive drugs;

(10) oxygen;

(11) speech therapy, autotherapy, visual therapy, occupational therapy, physical therapy, and chemotherapy, as defined in herein. Speech therapy for voice training or to correct a lisp is not a covered service;

(12) services and supplies for high dose chemotherapy when provided as part of the treatment plan which includes stem cell transplantation;

(13) surgical dressings and supplies; and

(14) Home Health Care.

Donor Coverage

Charges for obtaining donor organs are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by that payable under the donor's plan. If the organ donor is a Covered Person and the recipient is not, the Plan will not cover charges Incurred for obtaining donor organs from the Covered Person

(1) evaluating the organ;
(2) removing the organ from the donor;
(3) transportation of the organ from within the United States and Canada to the place where the transplant is to take place;
(4) transportation of the patient and a companion (two companions if the patient is a minor) to and from the site of the transplant including the cost of meals and necessary lodging, up to a maximum of $200 per day, not to exceed $5,000;
(5) private nursing care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for any transplant procedure; and
(6) procurement of donor organ or tissue.

Limitations

Transplant limitations include the following:

(1) If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefit will be paid for transplant services until the earlier of a) the recipient's death; or b) the date the decision is made by the recipient's Physician not to perform the transplant.

Exclusions

In addition to the exclusions stated in Section *Services Not Covered*, no benefits are provided for:

(1) Services and supplies for a transplant which is Experimental and/or Investigational;

(2) Services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received; or

(3) Services and supplies of any Provider located outside the United States of America, except for procurement services. The maximums for procurement services will apply to procurement services provided by a Provider located outside of the United States of America.

PRESCRIPTION DRUG BENEFITS

Participating Pharmacy Discount

Prescription drugs that require a Physician's prescription and that are dispensed by a Pharmacist are covered under this portion of the Medical Plan unless specifically stated otherwise herein. 100% will be payable after satisfaction of the appropriate Copayment. Discounts are acquired through participating pharmacies of the chosen pharmacy network. Any one prescription is limited to a 30-day supply, unless the medication is a maintenance drug (those medications that are taken for long periods of time such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc). Maintenance medications will be defined as any prescription drug taken more than thirty (30) days.

Limits to this Benefit. This benefit applies only when a Covered Person Incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.
(2) Refills up to one year from the date of order by a Physician.
(3) Any one-prescription drug is limited to a thirty (30) day supply through a local pharmacy or, if purchasing a maintenance medication, a ninety (90) day supply which is available through the mail order drug benefit option.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those medications that are taken for long periods of time such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc). Because of volume buying, the pharmacy network is able to offer significant savings on prescription drugs. Maintenance medications will be defined as any prescription drug taken more than thirty (30) days.

Non-Pharmacy Network Benefit

Submit to the pharmacy network for reimbursement of the discounted drug amount less the appropriate Copayment.

PLEASE NOTE: Prior Authorization

Some prescription drugs may be covered only if approved by Prior Authorization. If you find your prescription requires Prior Authorization, please place a telephone call to your claims account manager at Unified Group Services, Inc. so he/she may assist you with this process.

PLEASE NOTE: Some prescription drugs may be purchased only through the medical portion of this Plan.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) A charge excluded under Medical Plan Exclusions.
(2) A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
(3) Devices, even though such devices may require a prescription. These include therapeutic devices, artificial appliances, braces, support garments, or any similar device unless stated otherwise herein.
(4) A drug or medicine labeled "Caution – limited by federal law to investigational use".
(5) Experimental drugs and medicines, even though a charge is made to the Covered Person.
(6) Any charge for the administration of a covered Prescription Drug.
(7) Any drug or medicine that is consumed or administered at the place where it is dispensed.

(8) A drug or medicine that is to be taken by the Covered Person, 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.
(9) A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
(10) A charge for fertility medication.
(11) Immunization agents or biological sera.
(12) A charge for vitamins that do not require a prescription under Federal Law.
(13) A charge for hypodermic syringes and/or needles, injectable's or any prescription directing administration by injection (other than insulin and insulin syringes).
(14) A charge for Viagra beyond six (6) pills per month.
(15) A charge for smoking cessation products beyond the 180 day maximum per Calendar year.

SERVICES NOT COVERED

The Plan does not cover charges for any of the following services:

Note: A list of exclusions related to Organ and Tissue Transplants is shown in the Section *Organ and Tissue Transplants*.

Note: A list of exclusions related to Prescription Drugs is shown in the Section *Prescription Drug Benefits*.

Note: These lists of excluded benefits are detailed, but are not a comprehensive listing.

(1) Services and supplies rendered for any condition, disability, or expense resulting from Injury or Illness caused by **war**, declared or undeclared, or any act of war or by participating in **civil insurrection or a riot**. An act of terrorism will not be considered an act of war, declared or not declared.

(2) Services and supplies in a Hospital owned or operated by **the United States government or any government outside the United States** in which the Covered Person is entitled to receive benefits, except for Usual, Customary and Reasonable Charges for services, and supplies which are billed, pursuant to federal law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are covered herein and which are not Incurred during or as a result of service in the Armed Forces of the United States.

(3) Services and supplies rendered while a member of the **armed forces** of any state or country.

(4) Services, medicines or supplies paid or payable under any **Other Plan**, except as provided herein under Section *Coordination with Other Plans and Benefits*, of the Plan. This exclusion shall apply, regardless of whether the person covered under this Plan is covered under such Other Plan, or is merely the spouse or dependent of such person.

(5) Services and supplies provided to the extent that the Covered Person is reimbursed, entitled to reimbursement, or in any way indemnified for these expenses by or **through any public plan, including Medicare**, in accordance with applicable laws.

(6) Services provided for which payment or reimbursement is received by or for the account of the Covered Person as the result of a **legal action or settlement**.

(7) To the extent permitted by applicable law, services and supplies rendered for any condition, Disability or expense resulting from or sustained as a result of being engaged in an **illegal occupation**, **commission of or attempted commission of a misdemeanor or felonious act (regardless of whether a conviction is obtained)** unless resulting from a physical or mental medical condition or domestic violence as would be prohibited under the Health Insurance Portability and Accountability Act of 1996.

(8) Services or supplies that are **prohibited by any law** of the jurisdiction in which the Covered Person resides at the time the charge is Incurred.

(9) Services and supplies rendered as a result of a voluntary **self-inflicted Injury or attempted suicide** unless resulting from a physical or mental medical condition or domestic violence as would be prohibited under the Health Insurance Portability and Accountability Act of 1996.

(10) Services, medicines or supplies for any Injury received in an **Accident** *(except for Covered Charges not payable by any other policy).*

(11) Services or supplies rendered for an Illness or Injury that is an **occupational Illness** or **an occupational Injury which are payable by another Plan or policy.**

(12) Services or supplies for any **occupational condition, Accident, disease, ailment, Illness or Injury arising out of and in the course of employment,** if covered under a Worker's Compensation policy, or services, medicines or supplies which are furnished without cost to a Covered Person under the laws of the United States or any other country or of any state or political subdivision thereof.

(13) Services and supplies rendered to an individual prior to the **Effective Date** of the Plan or the Covered Persons Effective Date of coverage.

(14) Services and supplies provided for any operation, procedure, treatment, facility, drug, device or supply **not** generally accepted as **standard medical treatment** under the professional standards of medical practice for the condition being treated at the time Incurred for the geographic location of the principal office of the Company, or any items requiring United States federal or other United States governmental agency approval which approval has not been granted as of the time services are provided.

(15) Care and treatment that is either **Experimental / Investigational**.

(16) Services and supplies which are **not Medically Necessary** for the diagnosis or treatment of Illness or Injury.

(17) **No Physician or Provider recommendation**. Care, treatment, services or supplies not recommended and approved by a Physician or Provider; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician or Provider. Regular care means ongoing medical supervision or treatment, which is appropriate care for the Injury or Sickness.

(18) Any **limitation** as defined under the Section *Covered Services.*

(19) **Expenses used to satisfy Plan Deductibles or Copayments** (if applicable).

(20) **Out-of-Network services** for which Covered Charges are made which are in excess of the **Usual, Customary and Reasonable Charges**.

(21) Services and supplies **not specifically listed** as Covered Charges in this Plan.

(22) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under this Plan, unless otherwise required by law.

(23) **Room and board** charge for days in which the Covered Person is permitted to leave a health care facility (a weekend pass, for example).

(24) **Organ transplant** expenses as defined in non-Covered Charges in the Section *Organ and Tissue Transplants.*

(25) Services rendered or performed or supplies ordered by anyone **other than a Physician or Dentist or other Provider** as defined herein.

(26) **Professional services** performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person's Immediate Family, whether the relationship is by blood or exists by law.

(27) Professional services billed by a **Physician or nurse** who is an Eligible Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(28) Standby charges of a **Physician.**

(29) Any **chiropractic services** in excess of the amount shown in the covered benefits for Chiropractor/Spinal Manipulation Limitations.

(30) **Laboratory testing** in connection with services performed by a **licensed chiropractor** other than urinalysis.

(31) **Pre-marital laboratory testing.**

(32) **Genetic testing and counseling** other than as stated in Section *Covered Services.*

(33) **Radial keratotomy** or other **eye** surgery to correct near-sightedness, far-sightedness or other refractive error. **Eye examinations for the diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses, orthoptics, vision therapy, or supplies,** unless such treatment is due to a covered Illness or Accidental Injury or is otherwise covered as specified herein. This exclusion does not apply to aphasic patients and soft lenses or sclera shells intended for use as corneal bandages.

(34) **Orthopedics/Orthotics/Prosthetics**, replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or unless growth and development of a child necessitates replacement.

(35) Services and supplies for the **removal of bunions (except by capsular or bone surgery), toe nails (except for surgery for ingrown nails), corns or calluses or the trimming of toenails**, unless needed in treatment of a metabolic or peripheral-vascular disease.

(36) **Orthopedic** shoes, orthopedic **non**-prescription devices to be attached to or placed in shoes; **treatment of weak, strained, flat, unstable or unbalanced feet.**

(37) **Speech therapy** for behavioral or learning disabilities unless specifically stated otherwise elsewhere in this document.

(38) **Marriage counseling.**

(39) **Infertility treatment.** For the diagnosis or treatment of, including, but not limited to**, in vitro fertilization, artificial insemination, embryo implantation, gamete intra fallopian transfer (GIFT),** and any related expenses, medications, or testing beyond the period to diagnose the condition.

"Treatment of infertility" means the use of methods which do not correct the inability to conceive, but create the conditions for the individual to conceive by stimulating the individual's natural reproductive system or by implementation. Methods used to correct the inability to conceive are not subject to the limitation.

(40) **Reversal of voluntary or elective sterilization and for hiring, or for services of, a surrogate mother.**

(41) **Services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.**

(42) Cosmetic surgery **or related Hospital admissions unless Medically Necessary for:**

(a) Correction of congenital deformity resulting from disease, birth defects or previous medical treatment or for conditions resulting from Injuries or traumatic scars; or
(b) Reconstructive surgery as Medically Necessary for the treatment of a diseased condition, functional disorder, Accidental Injury or to restore bodily function.

(43) Any services performed in connection with the enlargement, reduction or change in **appearance of a portion of the body**, including, but not limited to the breasts, lips, jaw, chin, nose or ears unless Medically Necessary.

(44) **Surgical excision or reformation** of any sagging skin of or on any part of the body, including, but not limited to the face, eyes, neck, abdomen, arms, legs or buttocks unless Medically Necessary.

(45) Care and treatment for **hair loss** including hair transplantation, wigs (other than one (1) wig following chemotherapy) or any drug that promises hair growth, unless Medically Necessary and prescribed by a Physician.

(46) **Chemical face peels or abrasion** of the skin.

(47) **Electrolysis.**

(48) **Personal hygiene, environmental control and convenience items**, including, but not limited to, air conditioners, humidifiers, hot tubs, whirlpools, swimming pools, diapers, under pads, bed tables, tub bench, bedpans, physical exercise equipment, stair glides, elevators, heating pads, heating and cooling units, ice bags or cold therapy units, even if such items or prescribed by a Physician.

(49) Hospitalization for environmental change or Physician charges connected with prescribing an **environmental change.**

(50) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(51) Hospital and surgical services rendered for the treatment of **obesity and/or weight control unless Medically Necessary due to diagnosis of Morbid Obesity.**

(52) **Weight control** programs, amphetamines and appetite suppressants **unless Medically Necessary due to diagnosis of Morbid Obesity.**

(53) **Illegal use** of narcotics or use of hallucinogens in any form (unless prescribed by a Physician) unless otherwise prohibited by HIPAA;

(54) Charges for **Laetrile** and its administration.

(55) Vitamins, aspirin, nutritional supplements and other substances **not requiring a prescription by federal law.**

(56) Relative to **prescription drugs:**

- Any drug which is consumed at the time and place of the **prescription** order;
- Any **drug or medicine** which is not required in and for the treatment of bodily Injury or Illness, unless stated otherwise herein;
- **Drugs, medicines** or injectable insulin dispensed in a quantity or an amount, which is in excess of that quantity or amount specified by the prescribing Physician;

- **Drugs, medicines** or injectable insulin, which are not approved under the United States Food and Drug Act, or its successor;
- The **administration of** drugs, medicines or injectable insulin unless stated otherwise herein;
- **Drugs, medicines** or injectable insulin to the extent that benefits are payable for the same Covered Charge under the provisions of another section of this Plan;
- **Drugs, medicines** or injectable insulin which are obtained for any condition, disease, ailment or Accidental Injury for which coverage is available in whole or in part under any Worker's Compensation laws or similar legislation.

(57) Care and treatment for **smoking cessation** drugs, devices and programs beyond 180 days. *(See Covered Prescription Drug Section)*

(58) **Hypnosis or Biofeedback**.

(59) **Hearing aids** and exams for their fitting or related supplies unless loss of hearing is due to a covered Illness or accidental Injury.

(60) **Custodial care**, which is care whose primary purpose is to meet personal rather than medical needs and which can be provided by a person with no special medical skill or training.

(61) **Telephone or email consultations, charges for the completion of claim forms or charges for failure to keep scheduled appointments**. **Radio, television, telephone, and guest meals**.

(62) **Travel expenses** for a Covered Person, whether or not recommended by a Physician, or for a Physician other than as described in Section *Organ and Tissue Transplants*.

(63) Charges for **self-help training** or other forms of non-medical self-care other than specifically listed in the Plan.

(64) Treatment of **sleep disorders** that is **not** Medically Necessary.

(65) Charges for which the Covered Person has **no legal obligation to pay**.

(66) Care and treatment for which **there would not have been a charge if no coverage had been in force.**

(67) Charges for Illnesses or Injuries suffered by a Covered Person due to the action or inaction of any party if the **Covered Person fails to provide information as specified in Section *Subrogation.***

(68) Claims **not submitted within the Plan's filing limitation** as specified in Section *Administration of the Plan.*

(69) Charges for services rendered **outside the United States *if*** the Covered Person traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

(70) **Recreational or diversional therapy** and including, but not limited to similar therapies such as, equine therapy, art therapy, music therapy, dance therapy, wilderness therapy or aversion therapy.

(71) **Court ordered treatment** lacking a corresponding diagnosis from a Physician.

(72) Expenses **covered by medical coverage provided through "no fault" auto coverage**.

(73) Treatment in any **Intermediate Facility** that is located more than one hundred (100) miles from **(a)** the primary place of work of the Covered Person (if the Covered Person is an Employee), or **(b)** the primary place of work of the Employee to whom the Covered Person is related (if the Covered Person is a Dependent of an Employee) **(c)** in the case of a COBRA qualified beneficiary who was an Employee immediately before his or her qualifying event, his or her current primary place of residence, unless the current primary place of residence was established primarily for the purpose of obtaining treatment at the Intermediate Facility, in which case the one hundred (100) mile rule shall apply by reference to his or her primary place of work while an Employee, or **(d)** in the case of a COBRA qualified beneficiary who was not an Employee immediately before his or her qualifying event, his or her current primary place of residence, unless the current primary place of residence was established primarily for the purpose of obtaining treatment at the Intermediate Facility, in which case the one hundred (100) mile rule shall apply by reference to the last primary place of work of the Employee to whom the COBRA qualified beneficiary is related while an Employee, *unless* determined otherwise by the assigned Case Manager as a result of Medical Necessity or availability of Intermediate Facilities within the designated geographic territory.

(74) **Structural changes to a house or vehicle, even if such items are prescribed by a Physician**.

(75) Services or supplies used to treat conditions related to **autism, learning disabilities, hyperkinetic disorders, behavioral problems, intellectual disabilities or senile deterioration** beyond the period necessary to diagnose the condition.

(76) All Services or supplies in connection with treatments or medications **where the patient either is in non-compliance with or is discharged from a Hospital or Intermediate Facility against medical advice.**

(77) A charge for Viagra beyond six (6) pills per month.

PRECERTIFICATION FOR HOSPITALIZATION & OTHER MEDICAL SERVICES

The Company shall designate an entity or individual to perform Utilization Review services. In addition to the general requirements described in the *Case Management* Section, Covered Persons are asked to take the following steps with respect to review of proposed medical care:

PLEASE NOTE: Precertification is recommended for all Inpatient Admissions including Skilled Nursing and Rehabilitation, Outpatient Spinal Procedures, and Medical observation over 23 hours. The Precertification is designed to confirm Medical Necessity; appropriateness of requested length of stay and appropriateness of proposed location or care. The Plan also uses Case Management to limit costs.

Precertification does not guarantee coverage and/or payment for respective Hospital admission or related charges. Eligibility, as well as any applicable limitations or exclusions on coverage are determined by Plan benefits. This process should be completed seven (7) days in advance of the planned procedure, but not less than one (1) day prior to the planned admission. For Emergency admissions, certification is recommended within forty-eight (48) hours (or the next business day). **There is no financial penalty for failure to precertify any of the above mentioned services**.

PLEASE NOTE: Precertification for the condition of Pregnancy is not required for Hospital confinements which do not exceed the minimum required periods of forty-eight (48) hours for a normal delivery and ninety-six (96) hours for a caesarean section. Precertification is recommended for labor induction and days beyond the above time periods.

Concurrent Stay Review / Discharge Planning. Concurrent stay review and discharge planning are parts of the Utilization Review program. The Utilization Review administrator will monitor the Covered Person's Hospital stay and coordinate with the attending Physician, Hospital, and Covered Person. If the attending Physician feels that it is Medically Necessary for a Covered Person to stay in the Hospital for a greater length of time than has been Precertified, the attending Physician should request the additional days.

Precertification Services Phone Number.

Call 1-800-291-5837

The patient or family member should call this number to receive certification of the above listed cost management services. This call should be made at least one (1) day in advance of a non-Emergency Hospitalization or within two (2) business days after an Emergency Hospitalization. Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

The following information will be expected at time of Precertification:

(1) the name of the patient and relationship to the Covered Eligible Employee;
(2) the name, Social Security number and address of the Covered Eligible Employee;
(3) the name of the Employer;
(4) the name and telephone number of the attending Physician;
(5) the name of the Hospital and proposed date of admission;
(6) the diagnosis and/or type of surgery and;
(7) the proposed length of Hospital stay.

CASE MANAGEMENT

The purpose of this Case Management Section is to protect the financial integrity of the Plan by limiting coverage, in those instances in which there are alternative courses of medical treatment, to services and supplies Incurred in connection with the most cost effective course of medical treatment.

Case Management. "Case Management" means with respect to a Covered Person:

(1) the review by the Plan Supervisor or Case Manager of the course of medical treatment proposed with respect to that Covered Person;

(2) consideration of available alternative courses of medical treatment; and

(3) the determination of the extent to which:

(a) services and supplies that would otherwise be Covered Charges shall be limited because there is a more cost effective course of medical treatment; and

(b) services and supplies Incurred with respect to an alternative course of medical treatment should be covered under this Plan in lieu of those services and supplies Incurred with respect to the proposed course of medical treatment.

Case Manager. "Case Manager" means the individual or entity appointed by the Plan Supervisor to provide Case Management services. The appointment of a Case Manager shall be evidenced by a written agreement between the Case Manager and this Plan.

Applicability. Case Management shall apply with respect to services or supplies rendered to any Covered Person to the extent that the Plan Supervisor or Case Manager, in its sole discretion, determines that the cost to the Plan of reimbursing such Covered Person for Covered Charges may be reduced as a result of the application of Case Management.

Effect of Case Management. Notwithstanding anything in this Plan to the contrary, with respect to any Covered Person to whom Case Management applies, Covered Charges shall be limited to those services and supplies approved in advance by the Plan Supervisor or Case Manager. In addition, services and supplies that are not otherwise described in Section *Covered Services* (or that are described in Section *Services Not Covered*) shall be treated as Covered Charges if such services and supplies are Incurred with respect to a course of medical treatment that, in the sole discretion of the Plan Supervisor or Case Manager, is more cost effective than the other available alternative courses of medical treatment.

No Liability. Each Covered Person shall be responsible for all decisions relating to his medical care, and nothing in this Plan (including this Case Management Section) shall be construed to restrict or prohibit a Covered Person from choosing a particular course of medical treatment. No Case Management decision made by the Plan Supervisor or Case Manager shall be deemed to be the rendering of medical advice or the prescribing of a course of medical treatment.

CONTINUATION OF COVERAGE

In order to comply with the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, this Plan allows for continuation of coverage for certain individuals whose coverage otherwise would terminate.

Qualifying Events. The right to elect continuation of coverage is triggered by the occurrence of one of the following "Qualifying Events" which otherwise would cause a Covered Person to lose coverage under the Plan:

1. Death of the Eligible Employee;
2. The Eligible Employee's termination of employment (for a reason other than gross misconduct) or reduction in hours to less than the minimum required for eligibility;
3. Divorce or legal separation of the Eligible Employee from the Eligible Employee's spouse;
4. The Eligible Employee becoming entitled to Medicare benefits;
5. A dependent ceasing to be an Eligible Dependent Child as described in the Section Eligibility, Enrollment, and Termination of Coverage;
6. The end of a leave of absence by the Eligible Employee under the Family and Medical Leave Act of 1993; or
7. The beginning of a military leave of absence by the Eligible Employee.

Notification Requirements / Election. The Eligible Employee or Dependent must notify the Company of a divorce, legal separation, or loss of Eligible Dependent Child status within sixty (60) days of the Qualifying Event. This notice must be provided to the attention of the Human Resource Department, Shenandoah School Corporation, 5100 North Raider Road, Middletown, IN 47356, 765-354-2266 and must be accompanied by written documentation proving that such an event has occurred. Failure to provide such notice to the Company will result in a forfeiture of rights to continuation of coverage under this Section.

Within fourteen (14) days of a Qualifying Event (or of receiving notice of a Qualifying Event), the affected Covered Persons will be notified of their rights to continuation of coverage and the process required to elect continuation of coverage. The affected Covered Persons will have sixty (60) days from the date coverage under the Plan otherwise would terminate or the date the notification is received, whichever is later, to decide whether to elect continuation of coverage. Such an election must be received or postmarked on or before the last day of the sixty (60) day period.

For families that would lose coverage without an election, each family member separately can elect continuation of coverage. However, unless otherwise specified in the election, an employee's election to continue coverage will be deemed to include an election of continuation for the employee's spouse and dependent children. Similarly, a spouse's election to continue coverage will be deemed to include an election of continuation for any dependent children covered by the Plan. Such an election on behalf of a family member is binding on that family member. Although an employee and spouse can elect by default to continue coverage on behalf of other family members, they cannot elect by default to decline coverage on behalf of other family members. For example, if an employee declines continuation coverage but does not address coverage for a spouse and dependent children, the spouse and dependent children still can elect to continue their coverage.

Cost. Except as provided below in the Subsection Extension for Disability, anyone who elects continuation of coverage must pay the entire cost of the coverage plus a two percent (2%) administrative fee. For purposes of determining such costs, a person originally covered as an employee or as a spouse must pay only the rate applicable to an employee if coverage is continued for only that one person. Similarly, each child continuing coverage independent of a family unit must pay only the rate applicable to a single employee.

The first payment is due within forty-five (45) days after the election for continued coverage, and will apply from the date continued coverage begins through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are due monthly by the first day of each month.

Effective Date. When continued coverage is elected and the costs paid within the required time limit, the continued coverage becomes effective retroactively to the date of the loss of normal coverage so that no break in coverage occurs.

Family Members Acquired During Continuation. A spouse or Eligible Dependent Child newly acquired during continuation coverage may be enrolled as a dependent. The standard enrollment provisions of the Plan apply during the period of continuation coverage.

Length of Continuation Period. Upon election and subsequent payment of premiums, continuation coverage may be continued on a monthly basis for up to thirty-six (36) months unless normal coverage under the Plan was lost because of termination of employment or reduction in hours. In that case, continuation coverage may be continued for up to eighteen (18) months. If, during that eighteen (18) months, another Qualifying Event occurs, coverage may be continued up to another eighteen (18) months. In no case may the total period of continued coverage be more than thirty-six (36) months total.

When the Qualifying Event is the termination of employment or reduction of the employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, continuation coverage for persons who lose coverage other than the Eligible Employee lasts until 36 months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Extension for Disability. Coverage may be extended beyond an initial eighteen (18) months based on disability. If the initial Qualifying Event was termination of employment or reduction of hours, and a person who has elected continuation coverage is determined – within the first eighteen (18) months of continuation coverage – to have been disabled under Social Security rules at any time during the first sixty (60) days of continuation coverage, that person and covered family members may obtain an additional eleven (11) months of coverage, at not more than one hundred fifty per cent (150%) of the regular cost of coverage. The Plan Administrator must be notified within 60 days of the disability determination. This notice must be provided to the Human Resource Department, Shenandoah School Corporation, 5100 North Raider Road, Middletown, IN 47356, 765-354-2266 and must be accompanied by written documentation proving that such an event has occurred and must be accompanied by the written determination of the Social Security Administration. If the disabled person is determined thereafter to be no longer disabled, the Plan Administrator must be notified within thirty (30) days, and the additional period of coverage will end.

End of Continuation Coverage. Continuation of coverage will end upon the earliest of the following dates:

1. The end of the applicable 18-month, 29-month, or 36-month period;
2. If the Qualifying Event was a military leave of absence, the day after the date on which the Eligible Employee fails to apply for or return to a position of employment with the Company.
3. The end of the period for which premiums have been paid if a subsequent premium is not paid;
4. The date the Company no longer sponsors this Plan or another Employee Benefit Plan;
5. The date the Covered Person first becomes entitled to Medicare benefits; or
6. The date the Covered Person first becomes covered under any other Employee Benefit Plan which does not have an exclusion or limitation on a condition of the Covered Person.

COORDINATION WITH MEDICARE

Secondary Coverage to Medicare. To the greatest extent allowable under applicable law, coverage under the Plan for a Covered Person who is also covered under Medicare shall be secondary to coverage of such Covered Person under Medicare. If a Covered Person's coverage under this Plan is secondary to his or her coverage under Medicare, the benefits payable under this Plan shall be reduced in the manner described in Section *Coordination with other Plans and Benefits*, Subsection *Effect on the Benefits of this Plan* (applying that Section by treating Medicare as an "Other Plan").

Primary Coverage to Medicare. If, in accordance with the above Subsection *Secondary Coverage to Medicare*, a Covered Person's coverage under this Plan is not permitted to be secondary to his or her coverage under Medicare, that Covered Person shall be reimbursed for Covered Charges in accordance with Section *Medical Benefits* of this Plan without regard to that Covered Person's coverage under Medicare.

Medicare Coverage Election. Notwithstanding any provision in this Section to the contrary, if a Covered Person is covered by Medicare and chooses not to be covered by this Plan, coverage under this Plan shall terminate.

Eligibility for Medicare. A Covered Person is considered covered under Medicare for the purposes of the Plan during any period such Covered Person has actual coverage under Medicare or, while otherwise qualifying for actual coverage under Medicare, does not have such coverage solely because he or she has refused or failed to make any necessary application for Medicare coverage.

COORDINATION WITH OTHER PLANS AND BENEFITS

Definitions. For purposes of this Section, the following terms shall have the following respective meanings:

(1) "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, which is covered (without regard to any applicable deductible or Coinsurance limit) at least in part by one or more plans covering the person for whom the claim is made.

(2) "Other Plan" means any of the plans, programs or policies listed below that provides benefits or services with respect to medical, dental, vision, prescription drug treatment, supplementary accident or weekly income:

(a) Group insurance or group-type coverage, whether insured or uninsured, including prepayment, group practice or individual practice coverage, but excluding school Accident-type coverage;

(b) Coverage under a governmental plan, required or provided by law, excluding any state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time) and any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program; and

(c) Coverage under any other individual insurance policy or arrangement that provides payment or reimbursement for medical, dental, vision, prescription drug supplementary accident, or weekly income expenses, including but not limited to, coverage under any automobile liability insurance policy (including no-fault coverage), any homeowners insurance policy, or any individual health insurance policy (including any policy issued by or through a state risk pool or similar arrangement).

Each contract or other arrangement for coverage under paragraphs (a), (b), or (c) shall be a separate Other Plan. If only part of a contract or other arrangement is subject to coordination of benefit rules, that part of such contract or other arrangement that is subject to coordination of benefit rules shall be treated as one Other Plan and the remainder of such contract or other arrangement shall be treated as a separate Other Plan.

(3) "Claim Determination Period" means, with respect to each person subject to this Section, a Calendar Year; provided, however, that a Claim Determination Period shall not include any part of a Calendar Year during which such person has no coverage under this Plan or any part of a Calendar Year before the date this Section or a similar coordination of benefits provision is effective with respect to such person.

Order of Benefit Determination Rules. With respect to a Covered Person who is covered under this Plan and an Other Plan described in the above Subsection *Definitions* (2)(c), this Plan shall be, in all instances, a secondary plan that has its benefits determined after those of the Other Plan. With respect to a Covered Person who is covered under this Plan and an Other Plan described in the above Subsection, *Definitions* (2)(a) or (b), this Plan shall be a secondary plan that has its benefits determined after those of the Other Plan, unless the Other Plan has rules coordinating its benefits with those of this Plan and both those rules and this Subsection, *Order of Benefit Determination Rules,* require that this Plan's benefits be determined before those of the Other Plan. For purposes of the preceding sentence, this Plan shall determine its order of benefits using the first of the following rules that applies:

(1) Eligible Employee/Dependent. The plan that covers the person as an Eligible Employee shall be primary and its benefits shall be determined before those of the plan that covers the person as a Dependent.

(2) Dependent Child/Parents Not Separated or Divorced. Except as otherwise provided in Subsection (c) below, when this Plan covers a child as the Dependent of one natural

parent and an Other Plan covers the same child as a dependent of another natural parent:

(a) the plan covering the parent whose birthday falls earlier in a year shall be primary and its benefits shall be determined before those of the plan covering the parent whose birthday falls later in that year; provided, however, that
(b) if both parents have the same birthday, the Plan that covered a parent for a longer period of time shall be primary and its benefits shall be determined before those of the plan that covered the other parent for the shorter period of time; provided, further, that
(c) if the Other Plan does not apply the rule described in paragraphs (a) and (b) and instead applies the rule commonly known as the "gender rule," the rule of the plan that has covered a parent for the longer period of time shall be applied to determine the order of benefits.

(3) Dependent Child/Separated or Divorced Parents. If two or more plans cover as a dependent the natural child of divorced or separated parents, benefits for that child shall be determined in the following order:

(a) First, the plan covering the parent with custody of the child;
(b) Second, the plan covering the spouse of the parent with custody of the child;
(c) Third, the plan covering the parent not having custody of the child; and
(d) Fourth, the plan covering the spouse of the parent not having custody of the child;
(e) Fifth, if joint custody,
    (i) the plan covering the parent whose birthday falls earlier in a year; or
    (ii) if both parents have the same birthday, the Plan that covered a parent for a longer period of time; or
    (iii) if the Other Plan does not apply, the rule described in (i) and (ii) and instead applies the rule commonly known as the "gender rule," the rule of the plan that has covered a parent for the longer period of time shall be applied to determine the order of benefits.

provided, however, that, if a court order or court-approved settlement specifically provides that one of the parents is responsible for the health care expenses of the child and that parent's plan (or the plan administrator, trustee, or agent, Eligible Employee or designee of either) has actual knowledge of that court order or court-approved settlement, the benefits of the plan covering that parent shall be determined first; provided, further, that any benefits that are actually paid or provided before such plan (or the plan administrator, trustee, or agent, Eligible Employee or designee of either) has actual knowledge of that court order or court-approved settlement shall not be retroactively adjusted to reflect the preceding provision.

(4) Active/Inactive Eligible Employee. A plan that covers a person as an active Eligible Employee (or as that active Eligible Employee's dependent) shall be primary and its benefits shall be determined before those of a plan that covers that person as an inactive or retired Eligible Employee (or as that inactive or retired Eligible Employee's dependent). If an Other Plan does not apply the rule of this Subsection, and if, as a result, this Plan and that Other Plan do not agree on the order of benefits, this Subsection shall be ignored.

(5) Adult Dependent Child with Dual Coverage**.** If two (2) or more plans cover an Adult Child (age eighteen (18) to the limiting age, as stated herein), benefits for that Adult Child shall be determined in the following order:

(a) First, the plan covering the Adult Child as an Employee;
(b) Second, the plan of the Spouse or, if applicable, significant other living in the same residence covering the Adult Child as a Dependent; and
(c) Third, the plan of the parent covering the Adult Child as a Dependent.

(6) Coordination with COBRA. The plan covering the individual as an Eligible Employee, or retiree, or as a dependent of an Eligible Employee will be primary, and the plan

providing continuation coverage will be secondary. If the two plans do not have this rule and the plan COB rules disagree on the order of benefits, this rule would not apply.

(7) Longer/Shorter Length of Coverage. If none of the above Subsections of this Subsection, *Order of Benefit Determination Rules,* determines 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.

Effect on the Benefits of this Plan. If, after application of the above Subsection *Order of Benefit Determination Rules*, this Plan is a secondary plan with respect to (and its benefits are determined after those of) one or more Other Plans, reimbursements for Covered Charges under this Plan shall be payable only in accordance with the formula set forth under the caption "Secondary Payor Rules" in Section *Medical Benefits.* For purposes of applying such formula, when an Other Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit payable. When Covered Charges of this Plan are reduced in accordance with the preceding sentence, each separate Covered Charge shall be reduced in the same proportion and then charged against any applicable benefit limit of this Plan.

Right to Obtain and Provide Information. The applicable Plan Supervisor may obtain or provide (without the prior consent of, or notice to, any party) information that the applicable Plan Supervisor, in its sole discretion, determines if necessary or helpful with respect to the application of this Section. As a necessary condition to receiving benefits under this Plan, each Covered Person shall provide to the applicable Plan Supervisor any information the applicable Plan Supervisor requests.

Payment of Coordinated Benefits. If payment made under an Other Plan includes an amount that should have been paid under this Plan, the applicable Plan Supervisor may pay that amount directly to that Other Plan. Any amount paid under the preceding sentence shall be treated as a Covered Charge paid under this Plan, and such amount shall not be paid again. With respect to benefits provided in the form of services, the amount of a "payment made" shall equal the reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of any payment made by the Plan is more than should have paid under the coordination of benefit rules of this Section, the Plan may recover the excess from:

(1) the Covered Person to whom, or on whose behalf, payment was made;
(2) any insurance company that should have made such payment;
(3) any Other Plan that should have made such payment;
(4) any service Provider to whom such payment was erroneously made; or
(5) any other individual or entity which should have made such payment or which received the benefit of such erroneous payments.

With respect to benefits provided in the form of services, the amount of payments made shall equal the reasonable cash value of any benefits provided in the form of services.

FUNDING

Employer Contributions. The Company has established and maintains a trust into which Company and Employee contributions are made and from which Plan benefits are paid. The name of the trust and the names, address and telephone number of the trustees are:

Shenandoah School Corporation
Health & Welfare Grantor Trust

Scott Trennepohl
Michelle Fries
Beth Goff
Ron Green
Julie Miller

Shenandoah School Corporation
5100 North Raider Road
Middletown, IN 47356
(765) 354-2266

Employee Contributions. The Plan Administrator sets the level of any Employee contributions. The required amount of contributions, if any, shall be communicated by the Company to the Eligible Employees and their Dependents. The Company hereby reserves the right to increase or decrease Eligible Employee or Dependent contributions from time to time. In the event that an Eligible Employee makes an overpayment of contributions due to a mistake in determining the eligibility of one or more of his family members, the Plan Administrator, in its sole discretion, shall determine whether a refund is appropriate and, if appropriate, the amount of the refund. For Eligible Employees and their Dependents, the enrollment application for coverage may include a payroll deduction authorization, if applicable. This authorization must be filled out, signed and returned with enrollment application.

Funding Mechanism. Benefits under this Plan will be paid from the Employer's general assets unless the Employer determines that the Employer and Eligible Employee contributions should be held in a trust, in which case the benefits will be paid from such trust.

ADMINISTRATION OF PLAN

Section 1.1. Plan Administrator. Except as otherwise specifically provided in the Plan, in any insurance contract or in any trust document pursuant to which Plan benefits are funded, the Plan Administrator shall have the full, discretionary, and exclusive authority to control and manage the operation and administration of the Plan and shall be the named fiduciary of the Plan. The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Plan Administrator may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator may accept service of legal process for the Plan and shall have full discretionary power to take all actions necessary or proper to carry out the duties required, including, but not limited to, the power:

(1) To employ one (1) or more persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;

(2) To construe and interpret this Plan;

(3) To adopt such rules, regulations, forms and procedures as from time to time it deems advisable or appropriate in the proper administration of this Plan;

(4) To decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;

(5) To prescribe procedures to be followed by any person in applying for any benefits under this Plan and to designate the forms, documents, evidence or such other information as the Plan Administrator may reasonably deem necessary to support an application for any benefits under this Plan;

(6) To authorize, in its discretion, payments of benefits properly payable pursuant to the provisions of this Plan;

(7) To prepare and to distribute, in such manner as it deems appropriate, information explaining this Plan;

(8) To apply consistently and uniformly its rules, regulations, determinations and decisions to all Covered Persons in similar circumstances;

(9) To prepare and file such reports and to complete and to distribute such other documents as may be required; and

(10) To retain counsel (who may, but need not, be counsel to the Company), to employ agents and to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of this Plan.

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

Section 1.2. Delegation of Responsibility. The Plan Administrator may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed necessary or convenient. However, both the ultimate responsibility for the administration of this Plan and the authority to interpret this Plan shall remain with the Plan Administrator. The Company shall indemnify any Eligible Employee to whom duties are delegated by the Plan Administrator pursuant to this Subsection from and against any liability that such Eligible Employee may incur in the administration of this Plan, except for liabilities arising from the recklessness or willful misconduct of such Eligible Employee.

Section 1.3. Plan Supervisor. The Plan Administrator, in its sole discretion, may from time to time appoint one (1) or more Plan Supervisors to provide consulting services to the Company and the Plan Administrator in connection with the operation of the Plan and to perform such other functions and services (including the processing and payment of claims) as may be delegated to it by the Plan Administrator. Any Plan Supervisor shall be entitled to reasonable compensation for its services.

The duties and responsibilities delegated to the Plan Supervisors shall be reflected in the separate written agreements between the Plan Administrator and the Plan Supervisors. The Plan Administrator

may remove a Plan Supervisor, subject to any notice or other requirements set forth in such separate written agreement. Upon its removal, a Plan Supervisor shall transfer to any successor Plan Supervisor (or to the Plan Administrator, in the absence of a successor Plan Supervisor) all Plan records or other documents in its possession, as requested by the Plan Administrator. A Plan Supervisor shall be entitled to reimbursement of all reasonable expenses (including copying charges) Incurred in connection with the transfer of Plan records or other documents to a successor Plan Supervisor (or to the Plan Administrator, in the absence of a successor Plan Supervisor).

Section 1.4. Claims Procedure. Upon receipt of proof satisfactory to the Plan Supervisor that a Covered Person has Incurred Covered Charges for which he is entitled to reimbursement covered under this Plan, the Plan shall reimburse such Covered Person for such Covered Charges pursuant to the claims review and appeals procedure set forth below.

(1) All claims for benefits under this Plan shall be submitted to the Plan Supervisor on forms furnished for that purpose, or otherwise approved, by the Plan Supervisor. **Such claim form, along with a billing statement or invoice of the Covered Charges must be submitted within twelve (12) months from the date of service.** Failure to submit written proof of loss with respect to a claim for Covered Charges before the deadline for submission of claims shall invalidate that claim, unless the affected Covered Person demonstrates to the satisfaction of the Plan Administrator that it was not reasonably possible to furnish such proof within the required time and that proof was furnished as soon as was reasonably possible.

(2) The Plan Supervisor may select a Physician to examine any Covered Person whose Injury or Illness is the basis of a claim. The costs of any medical examination required under this provision shall be paid by the Plan. The Plan Supervisor may also question the health care Provider or other professional person who performs services or provides supplies that are the basis of a claim for reimbursement of Covered Charges.

Section 1.5. **Foreign Claims**. In the event a Covered Person Incurs an expense in a foreign country, the Covered Person shall be responsible for providing the following to the Plan Administrator before payment of any benefits due are payable:

(1) The claim form, Provider invoice and any other documentation required to process the claim must be submitted in the English language.

(2) The charges for services rendered must be converted into dollars.

(3) A current conversion chart validating the conversion from the foreign country's currency into dollars.

Section 1.6. Deadlines for Processing Claims. The Plan Administrator shall notify a claimant of the Plan's benefit determination in accordance with the following rules.

(a) Urgent care claims. In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Plan Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of: (1) the Plan's receipt of the specified information, or (2) the end of the period afforded the claimant to provide the specified additional information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with Form of Claim Denial Section.

(b) Concurrent Care Decisions. If this Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments --

(1) Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan Administrator shall notify the claimant, in accordance with Form of Claim Denial Section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(2) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Form of Claim Denial and appeal shall be governed by Appeal of Claim Denials.

(c) Other Claims. In the case of a claim not described in subsections (a) or (b) of this Section, the Plan Administrator shall notify the claimant of the Plan's benefit determination in accordance with the following rules.

(1) Pre-Service Claims. In the case of a pre-service claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (1) shall be made in accordance with Form of Claim Denial.

(2) Post-Service Claims. In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with Form of Claim Denial, of the Plan's adverse benefit determination, within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

Section 1.7. **Form of Claim Denials**. Except as otherwise provided in this Section, the Plan Administrator shall provide a claimant with written or electronic notification of any adverse benefit

determination. The notification shall be set forth, in a manner calculated to be understood by the claimant –

(a) The specific reason or reasons for the adverse determination, including information sufficient to identify the claim involved (including the date of service, the health care Provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(b) Reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures following an adverse benefit determination on review;

(e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

(f) If the adverse benefit determination is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(g) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims; and

(h) With respect to a non-grandfathered health option, a statement that questions about or assistance with the claimant's appeal rights or the adverse determination can be directed to or obtained from the Employee Benefits Security Administration at 1-866-444-3272.

In the case of an adverse benefit determination concerning a claim involving urgent care, the information described in this section may be provided to the claimant orally within the prescribed time frame, provided that a written or electronic notification in accordance with this section is furnished to the claimant not later than three (3) days after the oral notification.

Section 1.8. **Appeal of Claim Denials**. Each claimant shall be provided a reasonable opportunity for a full and fair review of a claim and adverse benefit determination in accordance with the following procedures –

(a) Claimants shall have one hundred and eighty (180) days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(b) Claimants shall have the opportunity to submit written comments, documents, records, testimony and other information relating to the claim for benefit;

(c) Each claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(d) Any review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(e) Any review shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(f) In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(g) The Plan Administrator shall identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(h) The health care professional engaged for purposes of a consultation under subsection (f) shall be an individual who is neither an individual who has consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(i) In the case of a claim involving urgent care, there shall be an expedited review process pursuant to which –

(1) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(2) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

As part of providing an opportunity for a full and fair review, the Plan Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

Before a final adverse benefit determination is made based on a new or additional rationale, the Plan Administrator shall provide the claimant, free of charge, with the rationale. The rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

Section 1.9. Time Deadlines for Determinations on Appeal. The Plan Administrator shall notify a claimant of the Plan's benefit determination on review in accordance with the following rules.

(a) Urgent Care Claims. In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant, in accordance with Form of Notice of Determination on Appeal, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.

(b) Pre-Service Claims. In the case of a pre-service claim, the Plan Administrator shall notify the claimant, in accordance with Form of Notice of Determination on Appeal Section, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than fifteen (15) days after receipt by the Plan of the claimant's request for review of the adverse determination.

(c) Post-Service Claims. In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with Form of Notice of Determination on Appeal, of the Plan's benefit determination on review within a reasonable period of time. Such notification shall be provided not later than thirty (30) days after receipt of the Plan of the Claimant's request for review of the adverse determination.

Section 1.10. **Form of Notice of Determination on Appeal.** The Plan Administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –

(a) The specific reason or reasons for the adverse determination, including information sufficient to identify the claim involved (including the date of service, the health care Provider, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(b) Reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures;

(e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or their similar criterion will be provided free of charge to the claimant upon request;

(f) If the adverse benefit determination is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(g) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;" and

(h) With respect to a non-grandfathered health option, a statement that questions about or assistance with the claimant's appeal rights or the adverse determination can be directed to or obtained from the Employee Benefits Security Administration at 1-866-444-3272.

Section 1.11. **Additional Rules.** In the case of a failure by a claimant or his authorized representative to follow the Plan's procedures for filing a "pre-service claim," the claimant or his representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to file a "claim involving urgent care") following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

This Section shall apply only in the case of a failure that:

(a) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(b) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Section 1.12. **Calculation of Time Limits**. For purposes of this section, the period of time within which a benefit determination or review of a benefit determination is required to be made shall begin at the time a claim (or appeal, as the case may be) is filed in accordance with this Plan's procedures, without a regard to whether all the information necessary to make benefit determination (or review of a benefit determination) accompanies the filing. In the event that a period of time is extended as

permitted under the Plan due to a claimant's failure to submit information necessary to decide a claim (or appeal), the period for making the benefit determination (or review of a benefit determination) shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Section 1.13. **Definitions**. The following terms shall have the following meaning whenever used in the context of the claims review and appeal procedures in this Plan:

(a) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations –

(1) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

(2) 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 without the care or treatment that is the subject of the claim.

Except as provided in the following sentence, whether a claim is a "claim involving urgent care" within the meaning of paragraph (1) is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a Physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care' within the meaning of this subsection (a) shall be treated as a "claim involving urgent care." For purposes of Section 1.6 (a), the Plan shall defer to the attending Provider as to whether a claim is a "claim involving urgent care."

(b) The term "pre-service claim" means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(c) The term "post-service claim" means any claim for a benefit that is not a pre-service claim.

(d) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. For a non-grandfathered health option, an "adverse benefit determination" also includes a retroactive rescission of coverage (for reasons other than failure to pay timely any required contributions or premiums), even if there is no adverse effect on any particular benefit at the time of the rescission.

(e) The term "health care professional" means a Physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(f) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

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

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

(3) demonstrates that the Plan provisions have been consistently and uniformly applied with respect to similarly situated claimants; or

(4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Section 1.14. **Actions.** No person may bring any action at law or in equity to recover benefits under the Plan:

(1) prior to a final determination under the claims review procedures,

(2) after the expiration on one (1) year from the date of the final determination.

Any determination made or action taken by the Plan Administrator pursuant to this Section shall be deemed to be conclusive with respect to any Covered Person or other individual to whom that determination or action relates, any such determination or action may be reversed by a court of competent jurisdiction only upon a finding by the court that such determination or action was arbitrary and capricious.

Section 1.15. **Absence of Conflicts of Interest**. The Plan Administrator shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Section 1.16. **Additional Rules Regarding Notice of Adverse Determinations**. The Plan must ensure that any notice of adverse benefit determination under Section 1.7 or final internal adverse benefit determination under Section 1.8 includes information sufficient to identify the claim involved (including the date of service, the health care Provider, the claim amount (if applicable), and the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

The Plan shall provide claimants, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination under Section 1.7 or final internal adverse benefit determination under Section 1.10. The Plan shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under Section 1.8 or an external review under Section 1.17 or 1.18.

(2) The Plan shall ensure that the reason or reasons for the adverse benefit determination under Section 1.7 or final internal adverse benefit determination under Section 1.10 includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination under Section 1.10, this description must include a discussion of the decision.

(3) The Plan shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(4) The Plan shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes.

Section 1.17. Non-Expedited External Review. If a claimant appeals an adverse benefit determination under Section 1.8 and that adverse benefit determination is upheld on appeal, the claimant may, but is not required to request an external review of the Plan's benefit determination. External review is not available to review a determination that a claimant failed to meet the Plan's eligibility requirements or to any adverse benefit determination (including a final internal adverse benefit determination) by the Plan other than one that involves medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer. Any external review will be conducted as follows.

(a) The Plan must allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of a final adverse benefit determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

(b) Within five (5) business days following the date of receipt of the external review request, the Plan Administrator shall complete a preliminary review of the request to determine whether:

(1) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(2) The final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

(3) The claimant has exhausted the Plan's internal appeal process; and

(4) The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan Administrator shall issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification shall describe the information or materials needed to make the request complete and the Plan Administrator shall allow a claimant to perfect the request for external review within the four (4) month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

(c) The Plan Administrator shall assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan shall contract with at least three (3) IROs for external review assignments and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection).

(1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(2) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

(3) Within five (5) business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the final adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the final adverse benefit determination. Within one (1) business day after making the decision, the IRO must notify the claimant and the Plan.

(4) Upon receipt of any information submitted by the claimant, the assigned IRO must within one (1) business day forward the information to the Plan Administrator. Upon receipt of any such information, the Plan Administrator may reconsider its final adverse benefit determination that is the subject of the external review. Reconsideration by the Plan Administrator must not delay the external review. The external review may be terminated as a result of the

reconsideration only if the Plan Administrator decides, upon completion of its reconsideration, to reverse its final adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan Administrator must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

(5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(i) The claimant's medical records;

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

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating Provider;

(iv) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(vi) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(vii) The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents that the clinical reviewer or reviewers consider appropriate.

(6) The assigned IRO must provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

(7) The assigned IRO's decision notice will contain:

(i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant;

(vi) A statement that judicial review may be available to the claimant; and

(vii) A statement that questions about or assistance with the external review can be directed to or obtained from the Employee Benefits Security Administration at 1-866-444-3272.

(8) After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

(d) Upon receipt of a notice of a final external review decision reversing the final adverse benefit determination, the Plan immediately shall provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Section 1.18. **Expedited External Review**. A claimant may make a request for an expedited external review with the Plan at the time the claimant receives:

(a) an adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited Plan appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(b) a final adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan must determine whether the request meets the reviewability requirements set forth in Section 1.17(b) above for standard external review. The Plan Administrator shall immediately send a notice that meets the requirements set forth in Section 1.17(b) above for standard external review to the claimant of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan Administrator shall assign an IRO pursuant to the requirements set forth in Section 1.17(c) above for standard review. The Plan Administrator shall provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO shall provide notice of the final external review decision, in accordance with the requirements set forth in Section 1.17(c) above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO shall provide written confirmation of the decision to the claimant and the Plan.

Section 1.19. **Deemed Exhaustion of Internal Claims and Appeals Processes**. The following rules shall apply to the extent the Plan fails to follow the internal claims and appeals processes of this Article I.

(a) If the Plan fails to adhere to all the requirements of Sections 1.4 through 1.11 with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process of this Article I, except as provided below.

(b) Notwithstanding Section 1.19(a), the internal claims and appeals process of this Article I will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan. The claimant may request a written explanation of the violation from the Plan, and the Plan shall provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process of this Article I to be deemed exhausted. If an external reviewer or a court rejects the claimant's request for immediate review under Section 1.19(a) on the basis that the Plan met the standards for the exception under this Section 1.19(b), the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the Plan shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon the claimant's receipt of such notice.

Section 1.20. Charge for External Review. A claimant may be required to pay a $25 filing fee for each requested external review, not to exceed $75 in total filing fees in a Plan Year. Any filing fee must be refunded to the claimant if the adverse benefit determination is reversed through the external review. In addition, the filing fee must be waived if it would cause undue financial hardship on the claimant, as determined by the Plan Administrator based on evidence submitted by or on behalf of.

ENTRY AND WITHDRAWAL OF EMPLOYERS

Entry Into Plan. With the consent of a duly authorized officer of the Company, any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Code shall become an Employer as of that date approved by the Executive Director, or other duly authorized officer of the Company, and shall be subject to the terms and provisions of this Plan as then in effect and thereafter amended.

Withdrawal from the Plan. An Employer may withdraw from the Plan by delivering to the applicable Plan Supervisor written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

Addition or Deletion of Employers. Upon the addition or deletion of Employers, the Plan Administrator shall instruct the applicable Plan Supervisor to make appropriate modifications to this Plan (including a statement as to the Effective Date of such addition or deletion) without the need for a Plan amendment.

SUBROGATION RIGHTS

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 Covered Employee or Dependent of the Covered Employee (hereinafter named the Covered Person), the Plan has no duty or obligation to pay these claims.

The Plan may choose to advance benefits. If the Plan advances benefits, the Covered Person, by accepting benefits agrees to the following terms and conditions. If the Plan chooses to advance expenses, it is doing so only because, and in reliance upon, the Covered Person's promise to abide by the terms and conditions of the Plan and the Agreement the Plan requires the Covered Person to sign.

The Covered Person agrees that the Plan will be reimbursed first out of any recovery by the Covered Person for all injury-related benefits paid by the Plan. The Covered Person agrees that the Plan has a secured proprietary interest in any settlement proceeds that the Covered Person receives or may have an entitlement to receive. The Covered Person confesses that the Plan is entitled to a constructive trust interest in the proceeds of any settlement or recovery. The Covered Person consents to the imposition of said trust, the funding of said constructive trust using any settlement proceeds and the payment of said funds held in said trust directly to the Plan or its authorized representative. The Plan will be reimbursed in full prior to the Covered Person receiving any monies recovered from any party or their insurer as a result of judgment settlement or otherwise. The duty and obligation to reimburse the Plan also applies to any money received from any underinsured or uninsured motorist policy of insurance or any medical payment insurance or personal injury protection coverage. The obligation to repay the Plan remains in force even if the Covered Person is not fully compensated or made-whole from any settlement or verdict or judgment.

The Plan has the right to the Covered Person's full cooperation in any matter involving the alleged negligence of a third party. The Covered Person 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 Covered Person is obligated to provide the Plan with whatever information, assistance, and records the Plan may require to enforce the rights in this provision. The Covered Person further agrees that the Plan requires the Covered Person to complete a subrogation questionnaire, sign an acknowledgment of the Plan's Subrogation rights and sign an Agreement before the Plan considers paying, or continuing to pay, any claims. If the Covered Person fails or refuses to sign the Agreement, the Plan has no duty to pay any and all claims Incurred by the Covered Person. If the Covered Person is represented by an attorney, the attorney must also sign the Agreement. Failure by the attorney to sign the Agreement will result in the Plan denying payment of the Covered Person's claims. This Agreement must be returned to the Plan within 30 days of receipt by the Covered Person or the Plan will deny payment of all benefits Incurred between the date of injury and the receipt of this Agreement. Upon receipt of the requested materials from the Covered Person, the Plan may commence or may continue advancing claims payments according to its terms and conditions provided that said payment of claims in no way prejudices the Plan's rights to recovery.

The Covered Person agrees to include the Plan's name as a co-payee on any settlement check or check from any other party or insurer. The Covered Person specifically agrees to instruct any and all insurance companies who may issue any type of settlement check to place the Plan's name on the settlement check or in the alternative to issue a separate settlement check directly to the Plan.

The Plan may, but is not obligated to, take any legal action it sees fit against the third party or the Covered Person, to recover the benefits the Plan has paid. The Plan's exercise of this right will not affect the Covered Person's right to pursue other forms of recovery, unless the Covered Person and his legal representative consent otherwise. This includes a right of subrogation under which the Plan may file its own independent suit to collect its expenses from any applicable insurance policy.

The Plan retains the right to employ the services of an attorney to recover money due to the Plan. The Covered Person agrees to cooperate with the attorney who is pursuing the subrogation recovery.

The compensation that the Plan's attorney receives will be paid directly from the dollars recovered for the Plan.

The Plan specifically states that it has no duty or obligation to pay a fee to the Covered Person's attorney for the attorney's services in making any recovery on behalf of the Covered Person. The Covered Person consents to this provision and by accepting any advance of benefits agrees to instruct their attorney to not assess any fees against the Plan in the event of settlement or recovery.

The Covered Person is obligated to inform their attorney of the subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan. The Covered Person agrees that they will instruct their attorney to reimburse the Plan out of any sums the attorney holds or may hold in his trust account.

The Covered Person agrees that they will not release any party or their insured without prior written approval from the Plan, and will take no action which prejudices the Plan's rights.

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

The Plan Administrator retains discretionary authority to interpret this and all other plan provisions and the discretionary authority to determine the amount of the lien.

The Covered Person agrees that the Plan's right to receive its expenditures from any settlement is an equitable right. In the event that the Covered Person fails to abide by the terms and conditions of this provision, the Covered Person agrees to the following:

1. The Plan may discontinue paying for ongoing claims until the Plan has refrained from paying an amount of claims equivalent to the Plan's lien.
2. The Plan may sue the Covered Person in state or federal court to receive reimbursement. The Covered Person agrees to pay the Plan's attorney fees associated with bringing said suit.
3. The Covered Person consents to the imposition of a temporary injunction restraining the Covered Person from spending, dissipating or transferring ownership in any settlement proceeds. The Covered Person also agrees to hold such proceeds in a separate account pending any order from the Court.
4. If the Covered Person receives a settlement and refuses to repay the Plan, the Covered Person understands that they have unlawfully converted the assets of an employee benefit plan and that they are subject to the statutory penalties for such conversion under either state or federal law.

The Plan pays secondary as to any and all PIP, Med-Pay or No-Fault coverage. The Plan has no duty or obligation to pay any claims until PIP, Med-Pay or No-Fault coverage is exhausted. In the event that the Plan pays claims that should have been paid by PIP, Med-Pay or No-Fault coverage under this provision, then the Plan has a right of recovery from the PIP, Med-Pay or No-Fault carrier.

In the event that the Covered Person receives any form or type of settlement and either fails or refuses to abide by the terms of this agreement, in addition to any other remedies the Plan may have, the Plan retains a right of equitable offset against future claims.

No Fault coverage. In the case of a Covered Person who is covered by a No-Fault policy, required by the state in which the Covered Person resides, the Plan will not pay claims until and unless all of the No-Fault coverage is first exhausted.

HIPAA PRIVACY & SECURITY REGULATIONS

Use and Disclosure of Protected Health Information

This Plan, in order to disclose Protected Health Information to the Employer or to provide for or permit the disclosure of Protected Health Information to the Employer by a health insurance issuer or HMO with respect to the Plan, shall restrict uses and disclosures of such information by the Employer consistent with the requirements set forth in this Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of:

(1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

(2) modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to the Employer information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

This Plan may:

(1) disclose Protected Health Information to the Employer to carry out Plan Administration Functions that the Employer performs only to the extent consistent with the provisions of this Amendment;

(2) not permit a health insurance issuer or HMO with respect to the Plan to disclose Protected Health Information to the Employer except as permitted by this Amendment;

(3) not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to the Employer as otherwise permitted by this Amendment unless a statement to that effect is included in the appropriate notice of privacy practices; and

(4) not disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

Employer Certification

This Plan will disclose Protected Health Information to the Employer only upon receipt of a certification by the Employer that the Plan documents have been amended to incorporate the provisions of this Section. With respect to Protected Health Information disclosed to the Employer by the Plan, the Employer agrees to:

(1) not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;

(3) ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(4) not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(5) report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(6) make available Protected Health Information in accordance with 45 CFR § 164.524;

(7) make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR §164.526;

(8) make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

(9) make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with this Section;

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

(11) ensure that the adequate separation required in this Section is established.

Separation Between Plan and Employer

A list of those employees or classes of employees or other persons under the control of the Employer who are permitted to have access to the Protected Health Information to be disclosed is made available upon request and will be updated as necessary. Any employee or person who receives Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business shall be deemed to have been included in such list.

Access to and use by such employees and other persons described in this Section shall be restricted to the Plan Administration Functions that the Employer performs for the Plan.

The Plan Administrator shall investigate any allegations by a participant, beneficiary or other person of a breach of the Employer's or Plan's obligations under this Section. If the Plan Administrator determines there has been such a breach, the Plan Administrator shall provide a summary report of such breach, identifying the person responsible for such breach, to the Employer. If the person responsible for the breach is an employee of the Employer, the Employer shall take such disciplinary action against that person as required under the Employer's employment policies and practices.

Definitions

The following capitalized terms shall have the following meanings:

"Authorization" means consent by an individual that allows the Plan to use or disclose Protected Health Information that complies with the requirements of 45 CRF §164.508(c).

"HIPAA" means the security and privacy requirements applicable to health plans as reflected in 42 U.S.C. 1320d *et seq.* and such regulations as may be promulgated thereunder from time to time (currently, 45 CFR §164.102 through §164.534).

"Plan Administration Functions" means administrative functions performed by the Employer on behalf of the Plan and excludes functions performed by the Employer in connection with any of its other benefits or benefit plans.

"Protected Health Information" means individually identifiable health information of the Plan that is (i) transmitted by electronic media, (ii) maintained in any medium described as electronic media, or (iii) transmitted or maintained in any other form or medium. "Protected Health Information" does not include individually identifiable health information in: (i) education records covered by the Family Educational Right and Privacy Act (20 U.S.C. section 1232g(a)(4)(B)(iv)), or (ii) records described at 20 U.S.C. section 1232g(a)(4)(B)(iv).

"Summary Health Information" means information, that may be individually identifiable health information, and:

(1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided health benefits under this Plan; and from which the following information has been deleted:

(a) names;

(b) all geographic subdivisions smaller than a State, including street address, city, county precinct, zip code, and their equivalent geocodes, except for the initial five digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(i) The geographic unit formed by combining all zip codes with the same five initial digits contains more than 20,000 people; and

(ii) The initial five digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(c) all elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(d) telephone numbers;

(e) fax numbers;

(f) electronic mail addresses;

(g) social security numbers;

(h) medical record numbers;

(i) health plan beneficiary numbers;

(j) account numbers;

(k) certificate/license numbers;

(l) vehicle identifiers and serial numbers, including license plate number;

(m) device identifiers and serial numbers;

(n) Web Universal Resource Locators (URLs);

(o) Internet Protocol (IP) address numbers;

(p) biometric identifiers, including finger and voice prints;

(q) full face photographic images and any comparable images; and

(r) any other unique identifying number, characteristic, or code, except a code or other means of de-identifying and re-identifying information permitted under HIPAA.

AMENDMENT AND TERMINATION OF PLAN

Plan Amendment. A duly authorized officer of the Company shall have the right, in his or her sole discretion, to amend or modify the Plan at any time and from time to time and to any extent deemed advisable, subject to the terms and conditions of any applicable collective bargaining agreement. Such modification or amendment shall be in writing and shall be effective as of the date indicated in such written amendment or modification.

Plan Termination. All or any part of this Plan may be terminated at any time by the Executive Director (or any duly authorized officer) of the Company, except to the extent otherwise prohibited under the terms of a collective bargaining agreement. In the event of such termination, the Employers' sole obligation under the Plan shall be to pay the Covered Charges Incurred (even though later filed) and expenses of the Plan accrued through the date of termination. Any such termination may be effective retroactively. Subrogation rights (as described in Section *Subrogation Rights*) shall also apply through the date of termination and applicable run-out payment periods.

MISCELLANEOUS PROVISIONS

Non-Alienation and Assignment. The Plan shall not be liable for any debt, liability, contract or tort of any Eligible Employee or Covered Person. The Plan shall pay all benefits due and payable for Covered Charges directly to the Covered Person who Incurred the Covered Charges, and no Plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided, however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician or other service Provider; provided, further, that any such assignment of benefits by a Covered Person to a Hospital, Physician or other service Provider shall be binding on the Plan only if:

(1) the Plan Administrator or applicable Plan Supervisor is notified of such assignment prior to payment of benefits;
(2) the assignment is made on a form provided by, or approved by, the applicable Plan Supervisor; and
(3) the assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator or applicable Plan Supervisor.

Fiduciary Responsibilities. No fiduciary of the Plan shall be liable for any act or omission in carrying out his or its responsibilities under the Plan.

Allocation of Fiduciary Responsibilities. Each fiduciary under the Plan shall be responsible only for the specific duties assigned to it, him, or her under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary.

Headings. Any headings or subheadings in the Plan are for convenience and shall be ignored in the construction of any provisions of the Plan.

Choice of Law. The Plan shall be construed, enforced and administered in accordance with the laws of the State of Indiana or any other state in which this Plan shall be enforced.

Limitation of Rights and Obligations. Neither the establishment, nor the maintenance of this Plan, nor any amendment thereof, nor the purchase of any insurance contract, nor any act or omission under this Plan or resulting from the operation of the Plan shall be construed:

(1) As conferring upon any Eligible Employee, beneficiary or any other person, a right or claim against an Employer or the Plan Administrator, except to the extent that such right of claim shall be specifically expressed and provided in the Plan;
(2) As creating any responsibility or liability of the Plan Administrator for the validity or effect of the Plan; or
(3) As a contract or agreement between any Employer and any Eligible Employee or to be consideration for, or as affecting in any manner or to any extent whatsoever, the rights or obligations of an Employer or any Eligible Employee to continue or terminate the employment relationship at any time. Nothing in the Plan shall be deemed to give any Eligible Employee the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge any Eligible Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements between any Employer and the bargaining representatives of any Eligible Employee.

Facility of Payment. If, in the opinion of the applicable Plan Supervisor, a valid release cannot be obtained from a Covered Person with respect to the payment of any Plan benefit, such payment may be made directly to a Hospital, Physician or other service Provider; the Covered Person's guardian, conservator or estate; the parents of a minor child or an individual or individuals who have custody or provide care and principal support of the Covered Person. Any payment made by the applicable Plan Supervisor in good faith pursuant to this Subsection shall fully discharge all Plan liability to the extent of such payment.

Employment of Consultants. The Plan Administrator, or a fiduciary named by the Plan Administrator pursuant to the Plan, may employ one or more persons to render advice with regard to its respective responsibilities under the Plan.

Notice. Any notice given under this Plan shall be sufficient if:

(1) to the Plan Administrator when addressed to it at its office;
(2) to the applicable Plan Supervisor when addressed to it at its office or;
(3) to a Covered Person when addressed to the Covered Person at his or her address as it appears on the records of the applicable Plan Supervisor.

Misrepresentation. Any material misrepresentation on the part of the Covered Person in applying for coverage, in applying for a reclassification to an Eligible Class or in filing a claim for benefits shall render the Covered Person's coverage null and void.

Disclaimer of Liability. Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, applicable Plan Supervisor, Company or any Employer for the acts or omissions of any health care Provider from whom a Covered Person receives care, or for the acts or omissions of any Physician from whom the Covered Person receives service under this Plan, or for any acts or omissions of any Provider of services or supplies under this Plan.

Certification of Prior Health Care Coverage. The Plan Administrator, or its designee, will provide to Covered Persons certification of their coverage under this Plan as required by the Health Insurance Portability and Accountability Act of 1996.

Entire Plan. This Plan Document and Summary Plan Description shall constitute the only legally governing document for the Plan. All statements made by the Company, Plan Administrator or applicable Plan Supervisor shall be deemed representations and not warranties. No such statement shall void or reduce coverage under this Plan or be used in defense to a claim unless in writing signed by the Plan Administrator or applicable Plan Supervisor.

Construction. In the construction of this Plan, the masculine includes the feminine, the feminine includes the masculine, and the singular includes the plural where appropriate.

Time Effective. The effective time with respect to any dates used in this Plan shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the Plan Administrator.

No Guarantee of Tax Consequences. Neither the Plan Supervisor nor the Plan Administrator makes any commitment or guarantee that any amounts paid under this Plan will be excludible from income for federal or state income tax purposes.

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

DEFINITIONS

Accident. The term "Accident" means a sudden, unforeseen and unintended event arising from an external cause.

Actively at Work or Active Work. The term "Actively at Work" or "Active Work" means, that, on the day that coverage's under the Plan would begin, an Eligible Employee is not absent from work due to an unapproved absence, which is not related to the health of the Eligible Employee.

Affordable Care Act. The term "the Affordable Care Act" or "PPACA" refers to The Patient Protection and Affordable Care Act of 2010, as may be amended from time to time.

Ambulatory Surgical Center. The term "Ambulatory Surgical Center" means a freestanding surgical facility licensed as an ambulatory surgical center under the laws of the state at the time and place Covered Charges are Incurred.

Ancillary Charges. Charges for Hospital services that are exclusive of such routine services as room and board and nursing. Examples of Ancillary Charges include X-rays and laboratory charges.

Annual Out-of-Pocket Maximum. The maximum yearly amount of Covered Charges (excluding Premiums, balanced billed charges, Precertification penalties, Out-of-Network over Usual, Customary and Reasonable Amounts, and non-Covered Charges) that a Covered Person will pay through Deductible, Coinsurance and medical Copayments. Once this maximum is met, the Plan will pay 100% of Covered Charges for the remainder of the year. Prescription Drug Copayments continue to accrue to a separate Out-of-Pocket Maximum which combined with the In-Network Out-of-Pocket Maximum will not exceed the maximum allowed by the Affordable care Act.

Birthing Center. The term "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.

Calendar Year. The term "Calendar Year" means January 1st through December 31st of the same year.

Case Manager. As defined in Section *Case Management*

Case Management. As defined in Section *Case Management.*

COBRA. The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code. The term "Code" means the Internal Revenue Code of 1986, as amended from time to time.

Coinsurance. The term "Coinsurance" means with respect to a Covered Person the percentage of Covered Charges for which he or she is financially responsible and which shall not otherwise be payable under the terms of the Plan; provided, however, any such Coinsurance shall be determined after any Deductible amount is applied. The Coinsurance percentage is specified in the *Benefit and Information Grid* Section.

Copayment. An amount of money that is paid each time a particular service is used.

Cosmetic Surgery. The term "Cosmetic Surgery" means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered Charges. The term "Covered Charges" means with respect to a Covered Person the Usual, Customary and Reasonable Charges for those Covered Charges that are:

(1) specified in Section *Covered Services*;
(2) Medically Necessary for the care and treatment of an Injury or Illness and recommended by a Physician;
(3) Incurred while that Covered Person is covered under this Plan; and
(4) Covered Charges include any taxes or surcharges imposed by a governmental entity based on the value or volume of Covered Charges provided to Covered Persons, or amount imposed or assessed against the Plan or the Employer in lieu of such taxes or surcharges.

Covered Person. The term "Covered Person" means each Eligible Employee or Dependent who is covered under the Plan as set forth in Section *Eligibility, Enrollment, and Termination of Coverage*.

Custodial Care. The term "Custodial Care" means personal care that does not require the continuing attention of trained medical or paramedical personnel and that serves to assist an individual in the activities of daily living. Custodial Care includes, but shall not be limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that can usually be self-administered.

Deductible. The term "Deductible" means with respect to a Covered Person the amount of Covered Charges for which he or she is financially responsible each Calendar Year before benefits are payable under this Plan. The amount of the Deductible for each Covered Person is specified in the *Benefit and Information Grid* Section.

Dentist. The term "Dentist" is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent. The term "Dependent" means the spouse of an Eligible Employee (other than a spouse who is legally separated from the Eligible Employee under state law) and each child of an Eligible Employee who is described in Section *Eligibility, Enrollment, and Termination of Coverage* under the Subsection *Eligible Dependent Children*; provided, however, that no person who is a full-time member of the armed forces shall be considered a Dependent.

Disability (Disabled). The term "Disability" means in the case of an Active Eligible Employee, the complete inability to perform any and every duty of his or her occupation as a result of Injury or Illness.

Effective Date. The term "Effective Date" means the date that coverage becomes effective for the Covered Person.

Eligible Class. The term "Eligible Class" means each employment classification of Eligible Employees eligible to participate in the Plan as set forth in Section *Eligibility, Enrollment, and Termination of Coverage*.

Eligible Employee. The term "Eligible Employee" means an Eligible Employee of the Employer who is meets the requirements listed in Section *Eligibility, Enrollment, and Termination of Coverage.*

Emergency. The term "Emergency" means the following:

1) **Accident:** A sudden and unforeseen event which includes all of the following:
   (a) causes Injury to the physical structure of the body;
   (b) results from an external agent or trauma;
   (c) is definite as to time and place; and

(d) happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.

2) **Emergency Illness:** A medical condition that is not Accident related and that is characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in any of the following:
   (a) permanently placing the participant's health in jeopardy;
   (b) causing other serious medical consequences;
   (c) causing serious impairment of bodily function; or
   (d) causing serious and permanent dysfunction of any bodily organ or part.
   (e) a mental health or chemical dependency condition when the lack of medical treatment could reasonably be expected to result in the patient harming self and/or other persons.

Employer. The term "Employer" means the Company and any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Code, that adopts this Plan for the benefit of its Eligible Employees, whose participation in the Plan is approved by the Executive Director (or any other duly authorized officer) of the Company.

Employment Termination Date. The term "Employment Termination Date" means, with respect to a particular Eligible Employee, the date that Eligible Employee's employment with an Employer is voluntarily or involuntarily terminated.

Enrollment Date. The term "Enrollment Date" means the date on which a Covered Person becomes covered under the Plan or, if earlier and applicable, the first day of the Waiting Period.

Essential Benefits. The term "Essential Benefits" shall mean:

1. Ambulatory patient services
2. Hospital Emergency services
3. Hospitalization
4. Laboratory services
5. Maternity and newborn care
6. Mental health and substance abuse services
7. Rehabilitative and habilitative services and devices
8. Pediatric services, including oral and vision care
9. Prescription drugs
10. Preventive and wellness services
11. Other services or supplies as established and defined in guidance issued by the Department of Health and Human Services (HHS).

Experimental and/or Investigational. The term "Experimental and/or Investigational" means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished the drug or device will be considered Experimental; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval the drug, device, medical treatment or procedure will be considered Investigational; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research,, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis the drug, device, medical treatment or procedure will be considered Experimental; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trails are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis the drug device, medical treatment or procedure will be considered Experimental.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility. The term "Extended Care Facility" means an institution, or a distinct part of an institution, which is licensed to provide Inpatient care to persons convalescing from Injury or Illness including, but not limited to:

(1) Professional nursing services rendered by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN);

(2) Physical restoration services assisting patients in reaching a degree of bodily function permitting self-care in essential daily living activities;

(3) Providing 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse; or

(4) Maintaining a complete medical record on each patient.

The term Extended Care Facility shall not include a place that provides, other than incidentally, for: rest, the aged, drug addicts, alcoholics, mentally handicapped, custodial or educational care, or care of mental disorders.

Family Unit. The term "Family Unit" means an Eligible Employee and his or her Dependents.

Generic Drug. The term "Generic Drug" means a Prescription Drug, which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the profession al standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

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

Home Health Care. The term "Home Health Care: means services and supplies provided to a Covered Person in his home by a Home Health Care Agency as an alternative to Hospital Confinement, provided that such services and supplies are recommended by a Physician.

Home Health Care Agency. The term "Home Health Care Agency" means an institution which is operated primarily for the purpose of providing skilled nursing care and therapeutic services in a

person's home, provided that the Home Health Care Agency is approved and licensed by a state licensing agency and meets the requirements of the Social Security Amendments of 1965, as amended.

Hospice. The term "Hospice" means a free-standing or Hospital affiliated facility which provides short periods of stay for the terminally ill (i.e., individuals with life expectancies of less than six (6) months) in a home-like setting for either direct care or respite. The facility must operate as an integral part of a formal Hospice Care Program directed by a Physician for the purpose of caring for a terminally ill person. The Hospice Care Program must meet the standards set by the National Hospice Organization and be approved by the Plan Supervisor. If the Hospice Care Program is required by a state to be licensed, certified or registered, the Program must also meet that requirement to be considered an eligible Hospice Care Program.

Hospital. The term "Hospital" means an institution that is licensed as a Hospital under the laws of the state at the time and place Covered Charges are Incurred; and is accredited by the Joint Commission on Accreditation of Hospitals or by the American Osteopathic Association; provided, however, that the term "Hospital" shall not include an institution that is primarily a nursing home or a place for rest for the aged, drug addicts, alcoholics, treatment of tuberculosis or mental disorders.

Hospital Confinement. The term "Hospital Confinement" means the period of time during which a person is an Inpatient at a Hospital.

Human Growth Hormone. The term "Human Growth Hormone" means an adenohypophyseal hormone that promotes growth and also has direct influence on the metabolism of carbohydrates, fats, and proteins.

Illness. The term "Illness" means a sickness or disease that requires treatment by a Physician, is sustained by a Covered Person and is not due to an Injury.

Immediate Family. The term "Immediate Family" is defined as the patient's spouse and the parents, siblings and children of the patient or his spouse.

Incurred. The term "Incurred" means the date on which a service or supply was rendered or furnished, without regard to when a Covered Person is formally billed or charged, or pays for, the service or supply. In the absence of due proof to the contrary, when a single charge is made for a series of identical services, each service shall be considered to bear a pro rata share of the charge.

Injury. The term "Injury" means a physical or mental condition that is the direct or indirect result of an Accident (other than an occupational Accident) sustained by a Covered Person.

Inpatient. The term "Inpatient" means a Covered Person who is admitted and registered to an Inpatient bed in a Hospital and for whom a room and board charge is Incurred.

Intensive Care Unit. The term "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". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Intensive Outpatient Program. **(IOP)** The term "Intensive Outpatient Program" is defined as an Outpatient program **in a Hospital or Intermediate Facility, as defined herein,** that is operated according to the law, which provides a more intense level of treatment in a structured Outpatient setting for patients who are seeking treatment for mental health or substance disorders. The program is designed to meet three to five times a week in a two to three hour time segment per meeting. The program must be operated or supervised by a licensed Physician certified in psychiatry by the American Board of Psychiatry and Neurology or Psychologist licensed in the state in which the services are rendered and operated according to the law. The program must be certified or licensed by the

state Department of Health for treatment of Mental Disorders or Substance Abuse and be Accredited by the Join Commission on Accreditation of Hospitals.

Intermediate Facility. The term "Intermediate Facility" means an Ambulatory Surgical Center, a Birthing Center, a Skilled Nursing Facility, a Rehabilitation Facility, an Extended Care Facility, a Psychiatric Day Treatment Facility, a Non-Residential Treatment Facility, or a Residential Treatment Facility.

Late Enrollee. The term "Late Enrollee" means any Eligible Employee or Dependent who enrolls in the Plan after the initial eligibility period as described in Section *Eligibility, Enrollment, and Termination of Coverage*, Subsection *Individual Enrollment and Effective Dates*, herein. However, a Special Enrollee shall not be considered a Late Enrollee.

Lifetime. The term "Lifetime" references benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medically Necessary. The term "Medically Necessary" means, with respect to health care services or supplies, those services or supplies that (a) are essential to the care and treatment of an Illness or Injury, (b) are no more than required to meet the needs of the patient, (c) could not have been omitted without adversely affecting the patient's medical condition or the quality of the health care rendered under generally accepted professional standards of medical practice at the time and place Incurred, (d) are rendered in the least intrusive setting that is appropriate for the delivery of health care, and (e) are of demonstrated medical value. Health care services to improve personal appearance are not considered Medically Necessary unless necessitated by an Injury or otherwise stated as covered herein.

Medicare. The term "Medicare" means Part A and Part B of Title XVIII of the Social Security Act, as amended from time to time.

Mental Illness/Disorder. The term "Mental Illness/Disorder" means a disease or condition 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. The term "Morbid Obesity" is a diagnosed condition in which the body weight exceeds the medically recommended weight by 100 pounds or is at least twice the normal weight of a person the same height and build and conventional weight reduction measures have failed. The excess weight must cause serious medical conditions such as physical trauma, pulmonary and circulatory insufficiency, diabetes or heart disease.

Non-Residential Treatment Facility. The term "Non-Residential Treatment Facility" shall mean a facility that can provide medical and other services for the treatment of Mental Illness, Substance Abuse or behavioral disorders to individuals who do not require Inpatient status and are free from acute physical and mental complications. Care or treatment must be provided by a health care provider acting within the scope of his or her license or certification and under the direct supervision of a Physician. The facility must maintain an organized program of treatment which may be limited to less than twelve (12) hours per day and not be available seven (7) days a week. The facility must be certified or licensed by the state Department of Health for treatment of Mental Disorders or Substance Abuse and be accredited by the Joint Commission on Accreditation of Hospitals. It does not include any facility which provides only minimal care, custodial care, ambulatory services or part-time care services.

No-Fault Auto Insurance. The term "No-Fault Auto Insurance" is the basic reparation provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthopedic Device. The term "Orthopedic Device" means any device used for the prevention or correction of disorder involving locomotor structures of the body, especially the skeleton, joints, muscles, fascia, and other supporting structures as ligaments and cartilage.

Orthotic Device. The term "Orthotic Device" means any device added to the body to stabilize or immobilize a body part, prevent deformity, protect against injury, or assist with functions.

Outpatient. The term "Outpatient" means a Covered Person who receives medical care, treatment, services or supplies while not registered as an Inpatient.

Partial Hospitalization. The term "Partial Hospitalization" is an Outpatient program **in a Hospital or Intermediate Facility, as defined herein,** specifically designed for the diagnosis or active treatment of a serious mental disorder where there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse. This program shall be administered in a psychiatric facility, which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial Hospitalization services, if required by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day and no charge is made for room and board.

Pharmacy. The term "Pharmacy" means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician. The term "Physician" means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed to practice medicine, surgery or obstetrics at the time and place a service is Incurred with respect to a Covered Person, other than an individual who ordinarily resides in that Covered Person's home, or who is a member of the Immediate Family.

Plan. The term "Plan" means the plan as embodied herein, including all Sections attached hereto, as amended from time to time.

Plan Administrator. The term "Plan Administrator" means the Company. The Plan Administrator shall be the named fiduciary under the Plan.

Plan Supervisor. The term "Plan Supervisor" means Unified Group Services, Inc., the applicable third party administrator of any benefits provided under this Plan, or any successor as may be appointed from time to time by the Plan Administrator under Section *Administration of the Plan*, Subsection *Plan Supervisor* of this Plan.

Plan Year. The term "Plan Year" means the 12-month period beginning on each **May 1st** and ending on **April 30th.**

Precertification. The term "Precertification" means an administrative procedure whereby a Provider explains a treatment plan to a third party designated by the Company to perform Utilization Review services for review before the treatment plan is initiated. The Precertification is designed to confirm Medical Necessity, appropriateness of requested length of stay, and appropriateness of proposed location of care.

Pre-Existing Condition. The term "Pre-Existing Condition" means a physical or mental condition of a Covered Person, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received.

Pregnancy. The term "Pregnancy" is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug. The term "Prescription Drug" means any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription.

Primary Care Physician. The term "Primary Care Physician" means any Physician of medicine who is legally qualified to practice medicine at the time and place a service is Incurred with respect to a Covered Person, other than an individual who ordinarily resides in the Covered Person's home, or who is the spouse, child or parent of that Covered Person, and is a General Practitioner, Family Practitioner, Pediatrician, or a General Internist whose practice is at least 70% General Medicine.

Prosthetic Device. The term "Prosthetic Device" means any device used to replace missing or non-functional body parts.

Psychiatric Day Treatment Facility. The term "Psychiatric Day Treatment Facility" means a public or private facility, licensed and operated according to the law, which provides: treatment for all its patients for not more than eight (8) hours in any 24-hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and supervision by a Physician certified in psychiatry by the American Board of Psychiatry and Neurology. The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Hospitals.

Psychiatrist. The term "Psychiatrist" means a person who is legally qualified and licensed to practice psychiatry at the time and place services are rendered to a Covered Person, other than an individual who ordinarily resides in that Covered Person's home, or who is a member of the Immediate Family.

Psychologist. The term "Psychologist" means a person who is legally qualified and licensed to practice psychology at the time and place services are rendered to a Covered Person, other than an individual who ordinarily resides in that Covered Person's home, or who is a member of the Immediate Family.

Qualifying Employee. The term "Qualifying Employee" means any Employee who is classified by the Employer on both payroll and personnel records, if determined in an applicable Initial Measurement Period (as defined in the *Plan Eligibility Appendix* adopted by the Employer, in a manner consistent with IRS Code Section 4980H) that coverage should be offered.

Reconstructive Surgery. The term "Reconstructive Surgery" is a procedure performed to restore the anatomy and/or functions of the body, which are lost or impaired due to an Injury or Illness.

Regular Enrollee. The term "Regular Enrollee" means an Eligible Employee or Dependent who enrolls in the Plan other than through special or late enrollment as described in Section *Eligibility, Enrollment, and Termination Coverage*, Subsection *Individual Enrollment and Effective Dates*.

Regularly Scheduled Hours. The term "Regularly Scheduled Hours" is defined as the normal scheduled hours of the location, at which the Eligible Employee works and is not based on the department or position in which the Eligible Employee works.

Rehabilitation Facility. The term "Rehabilitation Facility" means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental/nervous disorders, substance abuse or tuberculosis.

Residential Treatment Facility. The term "Residential Treatment Facility" means an institution that provides residential care and treatment for mental Illness, substance abuse and behavioral disorders for children, adolescents and adults that is not a Hospital, as defined herein. Care or treatment must be provided by a health care provider acting within the scope of his or her license or certification and under the direct supervision of a Physician. The facility must be certified or licensed by the state Department of Health for treatment of Mental Disorders or Substance Abuse and be accredited by the

Joint Commission on Accreditation of Hospitals. It does not include any facility which provides only minimal care, custodial care, ambulatory services or part-time care services.

Sickness. The term "Sickness" is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility. The term "Skilled Nursing Facility" means an institution, or distinct part of an institution, which

(1) is primarily engaged in providing to residents
  (a) skilled nursing care and related services for residents who require medical or nursing care, or
  (b) rehabilitation services for the rehabilitation of Injured, disabled, or Ill persons, and is not primarily for the care and treatment of mental diseases;
(2) has in effect a transfer agreement with at least one (1) Hospital; and
(3) meets the requirements for a Skilled Nursing Facility as described in Title XVIII of the Social Security Act, as amended.

Special Enrollee. The term "Special Enrollee" means an Eligible Employee or Dependent who is entitled to and does request special enrollment as described in Section *Eligibility, Enrollment, and Termination of Coverage*, Subsection *Special Enrollment.*

Specialty Drug. The term "Specialty Drug" means injectable and non-injectable drugs that have one or more of several key characteristics, including:

(a) Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes.
(b) Need for intensive patient training and compliance assistance to facilitate therapeutic goals.
(c) Limited or exclusive product availability and distribution.
(d) Specialized product handling and or administration requirements.
(e) Cost in excess of $500 for a 30 day supply.

Spinal Manipulation/Chiropractic Care. The term "Spinal Manipulation/Chiropractic Care" means skeletal adjustments, manipulation, or other treatment in connection the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

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

Summary Plan Description. (SPD) The term "Summary Plan Description" shall also mean the Plan as defined in the above Subsection *Plan*.

Temporomandibular Joint. (TMJ) The term "TMJ" is the treatment of jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled). For a non-employed child, "Total Disability" or "Totally Disabled" means an unmarried Dependent child who has a mental or physical disability, resides with the Eligible Employee, is unable to achieve self-sustaining employment and therefore chiefly depends on the Eligible Employee for support and maintenance as long as the debilitating condition existed before coverage otherwise would have ended.

Usual, Customary and Reasonable Charge. The term "Usual, Customary and Reasonable Charge" means the charge made by a Physician or supplier of services or supplies to the extent such charge is reasonable both in amount and scope and does not exceed the general level of charges made by others rendering or furnishing such services or supplies within the same area in which the charge is

Incurred for Illnesses or Injuries comparable in nature and severity to the Illness or Injury being treated. The term “area” as it applies to any particular service or supply means a county or such greater area as is necessary to obtain a representative cross section of charges. If the Usual, Customary and Reasonable Charge for a service or supply cannot be easily determined because of the unusual nature of the service or supply, the determination shall be made by the Plan Supervisor based on information it deems pertinent. The Plan Administrator may determine the Usual, Customary and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all Providers of the same services and/or supplies by all types of plans in the applicable market during the preceding Calendar Year, based upon reasonably available data. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

Utilization Review. The term “Utilization Review” means the process by which it is determined whether health care diagnosis and treatment are medically necessary for a patient or patients. Utilization Review can lead to utilization management. URAC (formerly the Utilization Review Accreditation Commission) defines utilization management as "the evaluation of the medical necessity, appropriateness and efficiency of the use of health care services, procedures and facilities under the provisions of the applicable health benefits plan." If a Physician determines a Covered Person needs a particular procedure done, the approval will presumably be based on the degree to which it will meet the criteria established by previous reviews and practice standards. The review done after treatment is provided is designed to determine if the criteria were met.

Waiting Period. The term “Waiting Period” means the period of time that the Eligible Employee must be employed prior to becoming eligible (and having any Dependents become eligible) for coverage under the Plan.

Shenandoah School Corporation has adopted this **Shenandoah School Corporation Employee Benefit Trust** as of the first day of **July, 2017**. I have read the document herein and certify that the contents reflect the terms and conditions of the Employee welfare benefit plan as established by **Shenandoah School Corporation.**

Executed on this _____ day of _____, 2017.

Shenandoah School Corporation
"The Company"

By: _____

Printed Name: _____

Title: _____

Attested by:

_____

_____

_____