Plan Document and Summary Plan Description for the School City of Mishawaka Employee Health Benefit Plan

- Medical Benefits
- Prescription Drug Benefits

INTRODUCTION

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

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

*The Plan is **not** subject to the Employee Retirement Income Security Act of 1974 (ERISA).*

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

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

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

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SECTION I: DEFINITIONS

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

Active Employee: an employee who is capable of carrying out their regular job duties and who is present at their place of work. Additionally, Subscribers who are absent from work due to a health related absence or disability and those on maternity leave or scheduled vacation, are considered Actively At Work.

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

Ambulatory Surgical Center: a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

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

Appeal: a resort to a higher authority or greater power, as for sanction or a decision or a request to have a determination of the Plan be reviewed or reconsidered in accordance with the procedures set forth in the Plan.

Birthing Center: means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name: means a trade name medication.

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

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

Chiropractic Care: refers to skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Chiropractor (D.C.) or licensed physician (M.D. or D.O.) to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

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

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

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

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

Confinement: an inpatient admission to a healthcare facility.

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

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

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

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

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

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that usually can be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

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

Diagnostic (Service/Testing): a test or procedure performed on a Participant, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening tests that may be required for a Participant who is not displaying any symptoms. However, this must be ordered by a Provider. Examples of covered Diagnostic Services are listed in the Eligible Expenses section.

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

Domiciliary Care: care provided in a treatment center, halfway house, or school because a Participant's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Durable Medical Equipment ("DME"): equipment which:

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

Effective Date: The date that an Employee's coverage begins under the Plan. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work. A dependent's coverage also begins on the Employee's Effective Date.

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

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

Medical Emergency as defined means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant individual, the health of the individual or the unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part.

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

The Employee Retirement Income Security Act of 1974 ("ERISA"): a Federal law, as amended, that governs group benefit plans.

Employer: School City of Mishawaka.

Enrollment Date: the day the Employer or Employee signs up for coverage or, when there is a waiting period, the first day of the waiting period (normally the date that employment begins).

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

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

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

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

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

Fee(s): the periodic charges which are required to be paid by you and/or the Employer to maintain benefits under this Plan.

FDA: the United States Food and Drug Administration.

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

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

Foster Child: means a child for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency. A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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

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

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

Grievance: an expression of dissatisfaction, either oral or written regarding an Adverse Benefit Determination from a Covered Participant or Covered Participant's Authorized Representative.

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

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

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

Home Infusion Facility: a facility which provides a combination of skilled nursing services, prescription drugs, and medical supplies and appliances in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

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

Hospital: a legally licensed facility that:

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

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

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

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

In-Network Provider: an Eligible Provider who has either signed an agreement with or been designated by the Network and/or Plan (as applicable) as an independent contractor to provide certain health care services and supplies to Participants. Such a designation may be limited to specified services.

Inpatient: a Participant who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. This does not apply to a Participant who is placed under observation for fewer than 24 hours.

Intensive Care Unit: is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit."

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

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

Legal Separation: an arrangement to remain married but live apart, following a court order.

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

Medical Condition: an Injury or Illness.

Medically Necessary/Medical Necessity: to be medically necessary, all care must be:

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

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

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

Medicare: The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Disorder: means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity: a bodily disorder or disease in which a person's body mass index (BMI) is thirty five (35) or higher and is associated with underlying health conditions, such as diabetes or hypertension; or a person's BMI is forty (40) or higher (regardless of underlying health conditions).

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

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

NMHPA: The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for

any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

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

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

Out-of-Network Provider: an Eligible Provider who has neither signed an agreement with nor been designated by the Network and/or Plan (as applicable) as an independent contractor to provide certain health care services and supplies to Participants.

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

Outpatient Care and/or Services: is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

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

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

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

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

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

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

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

Primary Care Physician ("PCP"): a Family Practice Physician, General Practice Physician, a Pediatrician, a Geriatrician, an OB/GYN, or a General Internist. All other physicians are considered specialists. A PCP supervises, coordinates and provides initial care and basic medical services to a Participant and is responsible for ongoing patient care.

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

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

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

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

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

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

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

Specialty Drugs: Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Patients using a specialty drug often must be monitored closely to determine if the therapy is working and to watch for side effects. Specialty drugs might be covered through either medical or the prescription drug benefit. How a specialty drug is covered usually depends on where the patient receives the drug.

Spousal Surcharge: the Spousal Surcharge is an additional charge that is added to the Employee's premium if that Employees spouse has the opportunity to receive insurance through his or her employer but does not choose to do so.

Stabilize: the provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an Emergency department or other care setting to another facility; or
- your transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

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

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

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

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

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

Urgent Care Center: a licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

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

- could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed.

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

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

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

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

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

SECTION II: PLAN OVERVIEW

Your Eligibility

You are eligible for benefits if you are:

- a full-time Active Employee of the Employer and work at least 30 hours per week;
- on the regular payroll of the Plan Sponsor; and
- in a class of employees eligible for coverage.

Note: You are also eligible for coverage if you are:

- a Retiree who is eligible to continue coverage under the Plan
- a grandfathered Employee participating in the School City of Mishawaka Health Plan prior to the dissolution of the union in 2014 may continue coverage under the School City of Mishawaka Health Plan; or
- a member of the School City of Mishawaka Board of School Trustees; or
- an Active Employee of the Employer's Transportation Department.

The following individuals are not eligible for benefits: part-time employees, leased employees, employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, and other individuals who are not on the Plan Sponsor payroll, as determined by the Plan Sponsor, without regard to any court or agency decision determining common-law employment status.

Eligible Requirement for Retiree Coverage

A retired Employee will be eligible to continue coverage upon retirement from employment with School City of Mishawaka if the following criteria is met:

- must be enrolled in the School City of Mishawaka Employee Health Plan at the time of retirement; and
- for Administrators, Guidance Counselors, and Teachers, the following apply:
    - if you have been employed with School City of Mishawaka for 15 years, you are eligible to retire at age 50.
    - if you have been employed with School City of Mishawaka for 10 years, you are eligible to retire at age 60.
- for all other Employees, the following will apply:
    - if you have been employed with School City of Mishawaka for 15 years, you are eligible to retire at age 55.
    - if you have been employed with School City of Mishawaka for 10 years, you are eligible to retire at age 60.

Coverage is available to all retired Employees who meet the defined criteria listed above and to all eligible dependents of the retired Employee.

Coverage will terminate for the retired Employee and any eligible dependents when the retired Employee turns 65 and is eligible for Medicare. The eligible dependents will have the option to elect COBRA.

Eligible Dependents

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

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

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

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

For purposes of the Plan, your child includes:

- your biological child;
- a step child as long as you are married to the child’s natural parent; or
- a never married child for whom the Covered Employee and/or spouse have been named Legal Guardian;
- your legally adopted child (*including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support*);
- an eligible child for whom you are required to provide coverage under the terms of a QMCSO or a NMSN.

An eligible dependent does ***not*** include:

- a person enrolled as an Employee under the Plan;
- any person who is in active military services;
- your Foster Child;

- a former spouse;
- your Legally Separated spouse;
- a domestic partner; and
- a domestic partner's child(ren).

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

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

Proof of Dependent Eligibility

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

Working Spouse Carve Out

Note: This applies to new hires starting the day after school ends in June, 2014 and new hires starting the 2014/15 school year and after.

The purpose of the Working Spouse Carve Out is to share the costs of the medical expenses with other plans or insurance carriers when the spouse of an Employee is eligible for medical coverage where the spouse is employed.

- If a spouse of an eligible Employee is employed with a company which offers group medical insurance coverage and that spouse is eligible for that plan, that spouse will not be eligible for this Plan.
- If the spouse is employed with a company that does not offer group medical coverage or is ineligible to be enrolled, the spouse may be enrolled in this Plan at the current applicable rate. (A statement from the spouse's employer that verifies they have no coverage available with that employer will be required).

It is the Employer's responsibility to determine who is eligible for this coverage on a non-discriminatory basis.

Spousal Surcharge

Note: the Spousal Surcharge applies to Employees hired for the 2013/2014 school year and prior.

- If a spouse of an eligible Employee has the opportunity to receive health coverage through his or her employer and declines coverage through his or her employer, in order

for the spouse to be covered under this health Plan, an additional charge will be added to the Employee's premiums each month.

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

When Coverage Begins

Monthly Measurement Method for Determining Full-Time Employee Status

Your Employer uses a monthly measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The monthly measurement method is based on Internal Revenue Service (IRS) final regulations. The monthly measurement method involves a month-to-month analysis where full-time employees are identified based on their hours of service for each calendar month. In general, an employee will be treated as full-time for any month in which he or she averages at least 30 hours of service per week (or 130 hours of service in a calendar month). An employee will generally be ineligible for the Plan's health care benefits for any month in which he or she averages less than 30 hours of service per week (or 130 hours per calendar month). Special rules apply for Food Service Employees, School Board Members and the Transportation Department.

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

Your Employer intends to follow applicable IRS guidance when administering the monthly measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

For You

Your health care coverage begins the first day of the month following your hire date and after you meet all eligibility requirements.

For Your Dependents

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

If both parents are Employees, their children will be covered as dependents of the mother or father, but not of both. Additionally, if the subscriber and the spouse work for School City of Mishawaka, they cannot be both subscriber and dependent.

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

If you acquire a new dependent, such as through birth, marriage, adoption or placement for adoption, coverage will begin on the date they become an eligible dependent as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll them until the next open enrollment period.

Newborn Coverage

A newborn child born while you are enrolled for medical coverage will automatically be enrolled in the Plan. Coverage will be effective with the newborn's date of birth, provided the child is enrolled within 31 days of birth. Charges for nursery and physician care services for the newborn, while confined, will be applied toward the plan of the covered mother up until the mother's discharge date. After the mother's discharge, covered services will apply to the covered newborn's deductible and coinsurance, as long as the newborn is enrolled in the Plan. If you wait longer than 31 days, you may not be able to enroll them until the next open enrollment period.

If timely notice is given, an additional Fee for the coverage of the newborn child will not be charged for the duration of the notice period. However, if timely notice is not given, the Plan may charge an additional Fee from the child's date of birth. Even if no additional Fees are required, you should still submit an application/change form to the Employer to add the newborn to your Plan, to make sure the Claims Administrator has accurate records and are able to cover your claims.

If the child is not enrolled within 31 days of birth, coverage will cease.

Adopted Child Coverage

Any dependent child adopted while the Employee or Employee's spouse is eligible for coverage will be covered from the date of placement for purposes of adoption for a period of 31 days. Coverage will continue as long as the child is enrolled within 31 days of the placement of the child.

If timely notice is given, an additional Fee for the coverage of the newborn child or adopted child will not be charged for the duration of the notice period. However, if timely notice is not given, the Plan may charge an additional Fee from the child's date of placement for adoption. Even if no additional Fees are required, you should still submit an application/change form to the Employer to add the child to your Plan, to make sure the Claims Administrator has accurate records and are able to cover your claims.

If the child is not enrolled within 31 days of the placement for adoption, coverage will cease.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you, and will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Legal Custody or Guardianship

If an Employee or the Employee's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If the Claims Administrator does not receive an application within the 31-day period, the child will be treated as a Late Enrollee.

Your Cost for Coverage

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

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

Enrolling for Coverage

New Hire Enrollment

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

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

Late Enrollee

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

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

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

Open Enrollment

During the month of October and/or November, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage, if

applicable, you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on January 1 and stay in effect through December 31, unless you have a qualifying change in status.

During the annual open enrollment period, covered Employees and their covered dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them. Additionally, Employees and their dependents who are Late Enrollees will be able to enroll in the Plan.

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

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

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

Effect of Section 125 Tax Regulations on this Plan

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

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

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

Qualifying Change in Status

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

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

- change in marital status (e.g., marriage, legal separation, annulment, or divorce);
- changes in the number of dependents (e.g., increase through birth, adoption, or placement of adoption, or decrease through death);
- a change in a dependent child's eligibility due to age or eligibility for other coverage;
- a reduction or loss of your or a dependent's coverage under this or another plan;
- your spouse's open enrollment period differs and you need to make changes to account for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- if you have a change in employment status to less than 30 hours per week on average even if reduction does not result in loss of Plan eligibility, you may revoke your election of coverage under the health plan under the following conditions:
    - the revocation of the election of coverage under the group health plan must correspond to the intended enrollment for you (and any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage; however, the new coverage must be effective no later than the first day of the second month after the month in which the original coverage is revoked.
- a change in your company work location or home address that changes your overall benefit options and/or prices;
- significant mid-year Plan changes (e.g., significant changes in the cost of coverage or significant curtailment of coverage);
- judgment, decree or court order, such as a QMCSO or NMSN, that mandates coverage for an otherwise eligible dependent;
- eligibility for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or seeking to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period;
- any of the HIPAA special enrollment events (please see section titled "Special Enrollment Rights");
- if you, your spouse or dependent lose or become entitled to coverage under Medicare or Medicaid, you may commence, change, or cancel coverage for you, your spouse or dependent under the health plan, as is consistent with the circumstances; and
- if you take a leave under the Family and Medical Leave Act of 1993 ("FMLA") you may revoke an existing election of accident or health plan coverage and make another election for the remaining portion of the period of coverage as may be provided for under the FMLA.

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change as soon as possible, but no later than 31 days, after the event occurs.

If there is an ambiguity or error in the above list of potential qualifying events, to the extent that that list does not represent the broadest range or number of qualifying events permitted by relevant Federal law or regulation (IRS/Treasury Dept.), the Plan intends to and will use the broadest permissible interpretation possible. Keep in mind that certain qualifying events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

Special Enrollment Rights

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

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

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

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

When Coverage Ends

For Teachers under contract, your coverage under this Plan will terminate at the end of the contract, unless benefits are extended through COBRA.

For all other Employees, your coverage under this Plan ends on the last day of the calendar month which you last worked as an Active Employee, unless benefits are extended through COBRA.

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the day your dependent is no longer eligible for coverage.

For a dependent child who reaches the limiting age, coverage will end on the last day of the calendar month of their birthday, unless your coverage ends before the dependent reaches the limiting age.

Coverage will also end for you and your covered dependents as of the date the Plan Sponsor terminates this Plan or, if earlier, the date you request termination of coverage for you and your covered dependents. Coverage will also end as of the date you or a covered dependent has a claim denied due to exceeding a maximum benefit, if applicable, under the Plan.

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

Reinstatement of Coverage

If you terminate employment and are subsequently rehired, your coverage will begin the first day of the month following your re-hire date and after you meet all eligibility requirements.

Cancellation of Coverage

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

Rescission of Coverage

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

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

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

Coverage While Not at Work

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

Human Resources what options are available for paying your share of costs while you are absent from work.

Continuation during Family and Medical Leave

This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

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

If You Take a Military Leave of Absence

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

SECTION III: YOUR MEDICAL BENEFITS

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

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

Network Information

Network Providers include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with the Plan Administrator to perform services for you. PCPs include general practitioners, internists, family practitioners, geriatricians, pediatricians, obstetricians & gynecologists or other Network Providers as allowed by the Plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange your health care services. SCP's are Network Physician who provide specialty medical services not normally provided by a PCP.

Your Networks for medical services are as follows:

Network:	Select Health Network/Trinity Health
Telephone:	(800) 263-2656
Website:	www.daprovider@selecthn.com

Network:	Encircle EPO*
Telephone:	(888) 446-5844
Website:	www.encoreconnect.com

Your Network for Mental Health/Substance Abuse is:

Network:	New Avenues *(Midwest Behavioral Health Network)*
Telephone:	(800) 223-6246
Website:	www.newavenuesonline.com

Out of Area Retirees

Network:	PHCS Network
Telephone:	(888)-656-7427
Website:	www.multiplan.com

Emergency Travel Network & Members living outside the Select service area:

Network:	PHCS *(Logo on back of ID Card)*
Telephone:	(888)-656-7427
Website:	www.multiplan.com

*Select Health Network Referral Requirement for Encircle Providers

To receive services at the highest benefit level from an Encircle provider, an approved referral must be obtained from a Select Health Network participating provider through SIHO Medical Management at (800) 443-2980. If an approved referral is not on file, a 30% reduction to the Employer Coinsurance will apply for services received by an Encircle provider. Exceptions are as follows:

- If a Plan Participant resides outside the service area, as determined by the Employer and Select Health, no referral will be required, and the Plan Participant will have additional access to PHCS Network *(Logo on back of ID Card).*
- Chiropractic Services provided by an Out-of-Network Provider and/or Encircle provider will be paid at the In-Network level with no penalty.

Therefore, when a Plan Participant uses a Network Provider, the Plan Participant will receive a higher payment from the Plan than when using an Out-of-Network Provider. It is the Plan Participant's choice as to which Provider to use.

Special Circumstances for Paying an Out-of-Network Provider at the In-Network Provider Level

Under the following circumstances, an In-Network payment will be made for certain Out-of-Network services.

- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the PPO service area.
- If a Plan Participant has a Medical Emergency requiring immediate care;
- If a Plan Participant receives Physician services from an Out-of-Network Radiologist, ER Physician, Pathologist or Anesthesiologist at an In-Network facility.
- If the Plan Participant has lab work taken by a network Physician, but the Physician sends it to an Out-of-Network facility for evaluation.

Out of Service Area Dependent Child Coverage

Benefits for Covered Services will be provided for enrolled dependent children who reside outside of the service area due to such children attending an out of service area educational institution or residing with another parent. Benefits are payable at the In-Network level and are limited to the Usual and Customary amounts unless the Claims Administrator accesses additional network vendors through other contractual arrangements. Payment is subject to any Coinsurance, Copayment and/or Deductible. You may be responsible for any amount in excess of the Usual and Customary amounts.

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

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

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

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

Your Deductible

A deductible is money you must pay for certain covered expenses before the Plan pays benefits. It is calculated on a calendar year basis. Each January 1st a new deductible amount will be required. However, Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year. Consult the Summary of Medical Benefits chart for more information.

PPO Deductible Accumulation: Embedded

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

Your Copayment

Some services may require a copayment – a fixed dollar amount you must pay before the Plan pays for that service. Any copayments will be shown in the Summary of Medical Benefits Chart.

Coinsurance Amount

Coinsurance is the shared costs for Covered Expenses between the Plan Participant and the Plan. The amounts shown in the Summary of Medical Benefits are the percentages that the Plan will pay for Covered Expenses after the Deductible has been met, unless otherwise noted. The Plan Participant is responsible for the remaining percentage amount. The Coinsurance

Amount is the total amount a Plan Participant or Covered Family must pay (after the Deductible) before the Plan begins paying 100% for Covered benefits for the remainder of the Calendar Year.

Out-of-Pocket Limit

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

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

- Premiums;
- Balance Billed Charges;
- Non-Referral Penalties;
- Out-of-Network Transplant Services;
- Precertification Penalties; and
- Healthcare this Plan does not cover.

Value Based Insurance Design Benefits

Diabetes and CAD Program

The St. Joseph's Health System Accountable Care Organization is offering the School City of Mishawaka health plan enrollees a program designed to engage and improve the health of covered Participants with diabetes and coronary artery disease (CAD). This program is referred to as a Value Based Insurance Design Program (VBID) and is completely voluntary.

Participants identified with diabetes or CAD can participate in a chronic condition management program, where our Health Coaches will assist them with self-management and coordination of care. Participants who actively engage in the program, as determined by the Health Coach, will be eligible for the following benefit enhancements:

- waived copays for Primary Care Office Visits related to Chronic Condition Management.
- waived copays, deductible, and coinsurance for related lab service.
- for diabetic Participants, waived copays, deductibles, and coinsurance for insulin, oral diabetic medications, injectable diabetic medications, insulin pumps, diabetic supplies, and hyperlipidemia and hypertension medications.
- for CAD Participants, waived copays for diuretic, hyperlipidemia, hypertension, and beta blocker medications.

The above benefits are designed to work in conjunction with active health coaching to maximize your resources for optimal health management. In order to continue receiving the above

benefits, you will need to continue engaging with a health coach at least quarterly. Your participation will be assessed each quarter and those who do not meet this level of engagement, will be dis-enrolled from the program and lose the above benefits for the remainder of the plan year.

The drug classifications included as a part of your VBID benefit are listed below. **Please refer to the formulary list for the specific drugs/supplies discounted through this program via the following web address** http://www.siho.org/files/siho_drug_list.pdf. This list may have updates quarterly.

Disease State	Drug Classifications
Coronary Artery Disease (CAD)	Antianginals - Nitrates
	Antianginals - Other
	Nadolol
	Metoprolol
	Amlodipine
	Diltiazem
	Nicardipine
	Nifedipine
	Verapamil
	Antihyperlipidemics
	Calcium channel blocker & HMG CoA reductase inhibitors
	Thienopyridine derivatives
	Direct-Acting P2Y12 Inhibitors
Hypertension – CAD and Diabetes	Beta Blockers
	Calcium Channel Blockers (CCB)
	ACE Inhibitors
	Angiotensin II Receptor Antagonists (ARBs)
	Direct Renin Inhibitors
	Antiadrenergic Antihypertensives
	Agents for Pheochromocytoma
	Vasodilators
	Antihypertensives – Misc.
	Diuretics/Diuretic Combinations
	Antihypertensive Combinations
Diabetes	Insulins
	Amylin Analogs
	Incretin Mimetic Agents
	Sulfonylureas
	Biguanides
	Meglitinide Analogues
	Alpha-Glucosidase Inhibitors
	Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

Disease State	Drug Classifications
	Dopamine Receptor Agonists - Antidiabetic
	Insulin Sensitizing Agents (TZDs)
	Sodium Glucose Co-Transporter 2 Inhibitors (SGLT2's)
	Combination Products
Diabetic Supplies	Glucose Oral/Glucagon Kits
	Urine Testing Strips: Acetone
	Urine Testing Strips: Albumin
	Blood Testing Strips: Glucose
	Urine Testing Strips: Glucose
	Ketone Testing Strips
	Insulin Injection Devices
	Insulin Administration Supplies
	Insulin Infusion Pump Supplies
	Urine Glucose Monitor
	Blood Glucose Calibration Liquid
	Insulin Needles and Syringes
	Blood Glucose Monitoring Unit – Disposable
	Blood Glucose Monitoring Unit - Continuous
	Blood Glucose Monitoring Watch
	Lancets and Devices
	Glucose Monitor & Blood Pressure Monitor Combination
	Blood Glucose & Blood Cholesterol Monitor Combination
	Alcohol Swabs
	Blood Glucose Monitoring Unit
Cholesterol (Hyperlipidemia) CAD & Diabetes	Bile Acid Sequestrants
	Fibric Acid Derivatives
	Intestinal Cholesterol Absorption Inhibitors
	HMG CoA Reductase Inhibitors (Statins)
	Nicotinic Acid Derivatives
	Antihyperlipidemics – Misc.
	Intest Cholest Absorp Inhib-HMG CoA Reductase Inhib
	HMG CoA Reductase Inhibitors + Calcium Channel Blocker

Summary of Medical Benefits

PPO Plan

	Select Network & Encircle Network Providers	Out-of-Network Providers
MAXIMUM ANNUAL BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Individual	$750	$2,000
Per Covered Family	$1,500	$4,000
NOTE: *Amounts used to satisfy In-Network deductible does **not** accumulate toward satisfying the Out-of-Network deductible and vice versa.*		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR *(Includes Deductible)*		
Per Individual	$2,000	$5,000
Per Covered Family	$4,000	$10,000
NOTE: *Amounts used to satisfy In-Network Out-of-Pocket Maximums do **not** accumulate toward satisfying the Out-of-Network Out-of-Pocket Maximums and vice versa.*		
NOTE: *The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the medical out-of-pocket maximum and are never paid at 100%: premiums, balance-billed charges, non-referral penalties, out-of-network transplant services, precertification penalties, and services this Plan does not cover.*		
***Note**: Visit and/or Annual Maximums, if applicable, are a combined maximum for services provided In-Network and/or Out-of-Network, unless listed otherwise.*		
COVERED CHARGES		
Facility Services		
Inpatient Hospital/Facility Services		
Room and Board*	90% after deductible	50% after deductible
Intensive Care Unit*	90% after deductible	50% after deductible
Pre-Admission Testing	90% after deductible	50% after deductible
All Other Services	90% after deductible	50% after deductible
Sub-Acute Inpatient Facility*	90% after deductible	50% after deductible
Acute Rehabilitation Hospital*	90% after deductible	50% after deductible
Skilled Nursing Facility*	90% after deductible	50% after deductible
***Precertification required.**		

Summary of Medical Benefits (*continued*)

PPO Plan

	Select Network & Encircle Network Providers	Out-of-Network Providers
Outpatient Facility Services		
Outpatient Surgery	90% after deductible	50% after deductible
Diagnostic Lab & X-Rays	90% after deductible	50% after deductible
MRI/MRA/PET/CT Scans*	90% after deductible	50% after deductible
Precertification required for MRI, MRA, and Pet Scans.		
Anesthesia	90% after deductible	50% after deductible
Chemotherapy/Radiation*	90% after deductible	50% after deductible
Precertification required.		
Specialty Medication*	90% after deductible	50% after deductible
Precertification required.		
All Other Services	90% after deductible	50% after deductible
Ambulance Services		
Emergency Ambulance*	100% no deductible	
Note: ***Emergent Ambulance charges will apply to the In-Network benefit level. This includes non-emergent transportation from one facility to another facility.***		
Non-Emergency Ambulance	Not Covered	Not Covered
Emergency Room Services		
True Emergency		
Facility Charges	$250 copayment	
All Physician Charges	100% no deductible	
NOTE: *True Emergency ER services will apply to the In-Network benefit level*		
Non-Emergent		
Facility Charges*	Not Covered	Not Covered
All Physician Charges	Not Covered	Not Covered
Physician Services		
Primary Care – *(Services performed and billed in the Office)*		
Office Visit	$20 copayment	50% after deductible
Allergy Injections	100% no deductible	50% after deductible
Allergy Testing	100% no deductible	50% after deductible
Allergy Serum	90% after deductible	50% after deductible
Diagnostic Labs & X-rays	100% no deductible	50% after deductible
MRI/MRA/PET/CT Scans*	90% after deductible	50% after deductible
Precertification required for MRI, MRA, and Pet Scans.		
Surgery in the Office	90% after deductible	50% after deductible
Chemotherapy/Radiation*	90% after deductible	50% after deductible
Precertification required.*		
Specialty Medication*	90% after deductible	50% after deductible
Precertification required.*		
All Other Services in the Office	90% after deductible	50% after deductible

Summary of Medical Benefits (*continued*)

PPO Plan

	Select Network & Encircle Network Providers	Out-of-Network Providers
Specialist Care & Urgent Care Services – *(Services performed and billed in the Office)*		
Office Visit	$40 copayment	50% after deductible
Allergy Injections	100% no deductible	50% after deductible
Allergy Testing	100% no deductible	50% after deductible
Allergy Serum	90% after deductible	50% after deductible
Diagnostic Labs & X-rays	100% no deductible	50% after deductible
MRI/MRA/PET/CT Scans*	90% after deductible	50% after deductible
Precertification required for MRI, MRA, and Pet Scans.		
Surgery in the Office	90% after deductible	50% after deductible
Chemotherapy/Radiation*	90% after deductible	50% after deductible
Precertification required.		
Specialty Medication*	90% after deductible	50% after deductible
Precertification required.		
All Other Services in the Office	90% after deductible	50% after deductible
Inpatient Physician Services		
Surgery	90% after deductible	50% after deductible
Diagnostic Lab & X-Rays	90% after deductible	50% after deductible
MRI/MRA/PET/CT Scans*	90% after deductible	50% after deductible
Precertification required for MRI, MRA, and Pet Scans.		
Anesthesia	90% after deductible	50% after deductible
Chemotherapy/Radiation*	90% after deductible	50% after deductible
Precertification required.		
Specialty Medication*	90% after deductible	50% after deductible
Precertification required.		
All Other Services	90% after deductible	50% after deductible
Outpatient Physician Services		
Outpatient Surgery	90% after deductible	50% after deductible
Diagnostic Lab & X-rays	90% after deductible	50% after deductible
MRI/MRA/PET/CT Scans*	90% after deductible	50% after deductible
Precertification required for MRI, MRA, and Pet Scans.		
Anesthesia	90% after deductible	50% after deductible
Chemotherapy/Radiation*	90% after deductible	50% after deductible
Precertification required.		
Specialty Medication*	90% after deductible	50% after deductible
Precertification required.		
All Other Services	90% after deductible	50% after deductible
Preventive Health Benefits (PHB)*		
Wellness Benefit	100% no deductible	Not Covered
NOTE: * For more complete information, please consult the **Saint Joseph Health System Comprehensive Preventive Health Benefit guidelines** which can be found on SIHO's website (*www.siho.org*) or by contacting SIHO Member Services at 1-800-443-2980.		

Summary of Medical Benefits (*continued*)

PPO Plan

	Select Network & Encircle Network Providers	Out-of-Network Providers
Mental Health/Substance Abuse		
Office Visit**	$20 copayment	50% after deductible
***Office Visit includes Counseling/Therapy, Evaluation/Interview,Testing & Medication Management.*		
Inpatient*	90% after deductible	50% after deductible
Residential Care (RES)*	90% after deductible	50% after deductible
Partial Hospitalization (PHP)*	90% after deductible	50% after deductible
Intensive Outpatient (IOP)*	90% after deductible	50% after deductible
***Precertification required for Inpatient, Residential Care, Partial Hospitalization and Intensive Outpatient.**		
Therapy Services		
Occupational Therapy*	$30 copayment	50% after deductible
**Annual Maximum: 60 Visits*		
Physical Therapy*	$30 copayment	50% after deductible
**Annual Maximum: 60 Visits*		
Speech Therapy*	$30 copayment	50% after deductible
**Annual Maximum: 20 Visits*		
***For Occupational, Physical and Speech Therapy, Precertification required after the first 12 treatments (not including the Evaluation).**		
Chiropractic Services* *(Excludes Massage Therapy)*	$30 copayment	Paid as In Network
X-ray's in the Chiropractor Office*	90% after deductible	Paid as In Network
**Annual Maximum: 12 Visits. Note: Select Health Primary members may see any provider in any network at the In-Network Benefit level subject to Usual and Customary.*		
ABA Therapy*	90% after deductible	50% after deductible
***Precertification required.**		
Cardiac Rehabilitation	90% after deductible	50% after deductible
Pulmonary Rehabilitation	90% after deductible	50% after deductible
Other Services		
Podiatry *(Foot Care)*	Based on where services are rendered	50% after deductible
Morbid Obesity Services*	Based on where services are rendered	50% after deductible
***Precertification required.** *Limited to 1 surgery - Lifetime Maximum: $125,000*		
Temporomandibular Joint Disorder	Based on where services are rendered	50% after deductible
Clinical Trials	Based on where services are rendered	50% after deductible
Second Surgical Opinion	Based on where services are rendered	50% after deductible

Summary of Medical Benefits (*continued*)

PPO Plan

	Select Network & Encircle Network Providers	Out-of-Network Providers
Maternity Care*	Based on where services are rendered	50% after deductible
**Dependent Daughter Maternity is Covered.*		
Dialysis*	90% after deductible	50% after deductible
****Precertification required.***		
Orthotics	90% after deductible	50% after deductible
Durable Medical Equipment (DME)*	90% after deductible	50% after deductible
****Precertification required for purchases over $750 and all rentals.***		
Prosthetics*	90% after deductible	50% after deductible
****Precertification required for purchases over $750 and all rentals.***		
Home Health Care*	90% after deductible	50% after deductible
****Precertification required.*** *Annual Maximum: 100 Visits.*		
Private Duty Nursing*	90% after deductible	50% after deductible
*******Annual Maximum: 82 Visits.*		
Hospice Care *(including bereavement counseling)**	90% after deductible	50% after deductible
****Precertification required.***		
Wig*	90% after deductible	50% after deductible
**Annual Maximum: 1 Wig*		
Human Organ and Tissue Transplants*		
Pre-Transplant Services	Based on where services is rendered	50% after deductible
During Transplant Period	100% no deductible	50% after deductible
Post-Transplant Services	Based on where services is rendered	50% after deductible
****Precertification required.***		

Eligible Expenses

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

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

- **Abortions:** including elective abortions are covered if the pregnancy is a result of rape or incest or if continuing the pregnancy is life-threatening to the mother.
- **Acute care (inpatient) and rehab hospitals**: At an acute rehabilitation facility located in a freestanding hospital, or a rehabilitation unit in an acute care hospital. To qualify as an acute rehabilitation facility, the following must be available: medical care, physical therapy, occupational therapy, speech-language therapy, vocational rehabilitation, therapeutic recreation, psychological services, 24-hour nursing care and other services as needed. Patient must be capable of performing at least 3 hours of therapy a day, at least 5 days a week.
- **Allergy testing and treatment**: includes allergy testing, serum and injections as shown in the Summary of Medical Benefits.
- **Ambulance**: includes medically necessary ambulance services. A charge for this item will be a covered charge only if the service is to the nearest hospital or skilled nursing facility where necessary treatment can be provided unless the Claims Administrator finds a longer trip was medically necessary, and when the following criteria is met:
  - you are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
  - for a ground, air or water ambulance, if you are taken:
    - from your home, the scene of an accident or medical Emergency to a Hospital;
    - between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital;
    - between a Hospital and a Skilled Nursing Facility or other approved Facility.

  Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.
- **Ambulatory Surgical Center**: includes services and supplies provided by an Ambulatory Surgical Center in connection with a covered outpatient surgery. A Center is a licensed facility used mainly for performing outpatient surgery and does not provide for overnight stays.
- **Anesthesia**: includes anesthetics and the services of a licensed physician or certified registered nurse anesthetist (C.R.N.A.)

- **Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder**: includes diagnosis and treatment.
- **Autism and Asperger's Syndrome (*also known as Pervasive Developmental Disorders*)**: Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

  Coverage also includes Applied Behavior Analysis Therapy (ABA) for Autism. ABA Therapy requires Precertification and involves the modification of situational events that typically precede the occurrence of a target behavior. These alterations are made to increase the likelihood of success or reduce the likelihood of problems occurring.
- **Behavioral Health Services**: includes care, supplies and treatment of Mental Health and Substance Abuse. Coverage for mental health and substance abuse treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008. Covered Services include:
  - **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy.
  - **Partial hospitalization** - an intensive structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.
  - **Intensive Outpatient treatment or day treatment** - a structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs generally provide 3 hours of treatment per day, and the program is generally available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.
  - **Outpatient treatment, or individual or group treatment** - office-based services, for example Diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

  Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

  This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates and that provides treatment for Mental Health Disorders. There must be an MD/psychiatrist on staff. Coverage does not include services provided at a group home. Treatment in a residential treatment facility may not be for the purpose of providing custodial care. If outside the United States, the residential treatment facility

must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- **Blood**: includes blood and blood derivatives (if not replaced by or on behalf of the patient), including blood processing and administration services.
- **Cardiac Rehabilitation Phase I and II**: as deemed Medically Necessary provided services are rendered under the supervision of a Physician, in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery, initiated within 12 weeks after other treatment for the medical condition ends, and is performed in a Medical Care Facility. ***Phase III is not covered*.**
- **Chemotherapy**: includes medically necessary and appropriate drugs and services of a physician or medical provider.
- **Chiropractic Care/Manipulation Therapy**: services by a licensed M.D., D.O or D.C. Chiropractic Care is intended to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interfaces from or related to distortion, misalignment or subluxation of the vertebral column. Manipulations, massage, other therapies, whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractic Care.
- **Circumcision**
- **Clinical Trials**:
    - Routine patient care costs that are covered:
        - those that would be covered for a patient not enrolled in a clinical trial
        - services required for the provision of the investigational item or service
        - services needed for reasonable and necessary care arising from the provision of the investigational item or service.
    - Routine patient care costs that are not covered:
        - investigational item, device, or service, itself;
        - items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
        - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
    - In order to be considered a Covered Service the following criteria must be met:
        - a physician must determine and document that the member is appropriate for a clinical trial; and
        - the member must meet the eligibility criteria of the trial.
    - The trial must be:
        - conducted for the prevention, detection or treatment of cancer or other life threatening disease or condition; **and is**
        - Federally-funded;
        - sponsored by FDA; or

        - a drug trial exempt from Investigational New Drug (IND) requirements.
    - A trial is considered federally funded if it is approved and funded by one or more of these agencies:
        - National Institutes of Health
        - Centers for Disease Control
        - Agency for Healthcare Research Quality
        - Centers for Medicare and Medicaid Services
        - Department of Defense
        - Veterans Administration; or the
        - Department of Energy.
    - If the Covered Person is eligible to participate in a clinical trial that is offered by both a network provider and an out-of-network provider, only the trial offered by the network provider (and otherwise meeting the criteria of this section) will be considered a Covered Benefit.
- **Contraceptives**: all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered under the Preventive Health Benefit as required by the Affordable Care Act.
- **Dental Services**: dental services will be covered as follows:
    - **Related to Accidental Injury**: coverage will include Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury unless the chewing or biting results from an act of domestic violence or directly from a medical condition. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair. Covered services for accidental dental include, but are not limited to:
        - oral examinations.
        - x-rays.
        - tests and laboratory examinations.
        - restorations.
        - prosthetic services.
        - oral surgery.
        - mandibular/maxillary reconstruction.
        - anesthesia.

- **Other Dental Services**: Anesthesia and Hospital charges for dental care for a Participant that is less than 19 years of age or a Participant who is physically or mentally disabled, are covered if the Participant requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Participant's condition under general anesthesia. This coverage does not apply to treatment for temporomandibular joint disorders (TMJ).

- **Diabetic Education, Equipment and Supplies**: diabetes self-management training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when Medically Necessary, ordered in writing by a Physician or podiatrist, and provided by a Health Care Professional who is licensed, registered, or certified under state law. Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Diabetic Supplies not purchased through the pharmacy will be covered under major medical.

  For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

- **Diagnostic Services**: diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for diagnostic services, including when provided as part of physician home visits and office services, inpatient services, outpatient services, home health care services, and hospice services includes but is not limited to:
  - X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
  - Magnetic Resonance Angiography (MRA).
  - Magnetic Resonance Imaging (MRI).
  - CAT scans.
  - Laboratory and pathology services.
  - Cardiographic, encephalographic, and radioisotope tests
  - Nuclear cardiology imaging studies.
  - Ultrasound services.
  - Allergy tests.
  - Electrocardiograms (EKG).
  - Electromyograms (EMG) except that surface EMG's are not Covered Services.
  - Echocardiograms.
  - Bone density studies.
  - Positron emission tomography (PET scanning).

- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

- **Dialysis**: treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage the Plan will not require you to receive dialysis treatment at a Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at an Out-of-Network Dialysis Facility nearest to your home as an authorized service. Patients in the Select Health Network service area are required to use an In-Network provider and facility.
- **Durable Medical or Surgical Equipment**: The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of Illness or Injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

  Covered services may include, but not limited to:

  - hemodialysis equipment.
  - crutches and replacement of pads and tips.
  - pressure machines.
  - infusion pump for IV fluids and medicine.
  - glucometer.
  - tracheotomy tube.

- cardiac, neonatal and sleep apnea monitors.
- augmentive communication devices are covered when the Claims Administrator approves based on the Participant's condition.

Non-Covered items may include but are not limited to:

- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats.
- Rental of equipment if the Participant is in a Facility that is expected to provide such equipment.
- Translift chairs.
- Treadmill exerciser.
- Tub chair used in shower.

- **Emergency Room Services**: includes medical treatment for an emergency. An emergency is an accident or the sudden and unexpected onset of an acute condition, Illness, or severe symptoms that require immediate medical care. Examples include fractures, lacerations, motor vehicle accidents, hemorrhage, shock, poisoning, or other conditions associated with deterioration of vital life functions.

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

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

  Emergency Care rendered by an Out-of-Network Provider will be covered as an In Network service, however the Participant **may** be responsible for the difference between the Out-of-Network Provider's charge and the Usual and Customary amount, in addition to any applicable Coinsurance, Copayment or Deductible. In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. Your Physician will need to contact the Claims Administrator. **Follow-up care is not considered Emergency Care.**

  Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from an Out-of-Network Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as an Out-of-Network service unless the Claims Administrator authorizes the continuation of care and it is Medically Necessary.

- **Foot Care/Podiatry**: Covered services include the following:
  - care and treatment of fractures and dislocations of bones of the foot and surgical treatments (incision and drainage, removal of lesions, removal of infected toenails or nail roots);
  - in the case of metabolic (diabetes) or peripheral-vascular disease, coverage will include, treatment for corns, calluses, nail trimming, cutting and debriding of the toenails; and
  - other services performed when there is a localized Illness, Injury or symptom involving the foot.

  Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses are ***not*** covered.
- **Hearing Services**: charges for cochlear implant.
- **Home Health Care Services and Supplies**: charges for home health care services and supplies are covered only for care and treatment of an Injury or Illness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan. Services include but are not limited to:
  - Intermittent skilled nursing services (by an R.N. or L.P.N.).
  - Medical/social services.
  - Diagnostic services.
  - Nutritional guidance.
  - Home Health Aide Services. The Participant must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by the Claims Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
  - Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Health Care Visit limits specified in the Summary of Medical Benefits for Home Health Care services apply when Therapy Services are rendered in the home.
  - Medical/Surgical Supplies.
  - Durable Medical Equipment.
  - Prescription Drugs (only if provided and billed by a Home Health Care Agency).
  - Private Duty Nursing. Home Health Care Visit limits do not apply to Private Duty Nursing.
  - Home Infusion Therapy. Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain

management and chemotherapy. Home Health Care visits limits do not apply to Home Infusion Therapy.

Non-Covered services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.

Home Health Care must meet the following qualifications: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient. A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

- **Hospice Care Services and Supplies**: charges for hospice care services and supplies listed below are covered when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered services include:
  - Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
  - Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
  - Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
  - Social services and counseling services from a licensed social worker.
  - Nutritional support such as intravenous feeding and feeding tubes.
  - Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
  - Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
  - Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Participant's death.
  - Bereavement services are available to surviving Participant of the immediate family for one year after the Participant's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Participant in Hospice.

- **Human Organ and Tissue Transplants**
  - *Pre-certification Requirement for Transplant Evaluation*: expenses incurred in connection with the evaluation of a Plan Participant for any human organ or tissue transplant will be covered, but only after Referral and Precertification through the Claims Administrator has occurred. The Plan Participant or his Physician should contact the Claims Administrator for Precertification of an evaluation prior to the Referral to a transplant Physician. The Claims Administrator will assign a Case Manager to work with the Plan Participant closely through the transplant process.
  - *Pre-certification Requirement for Transplant Procedure*: After the evaluation by a Plan-designated transplant Physician has occurred, the Plan Participant or the transplant Physician should contact the Case Manager. Medical information about the Plan Participant's condition and the proposed transplant protocol will be requested for review. The Case Manager will coordinate the review of the medical information for Medical Necessity and coverage determination. The Case Manager will communicate the determination to the Plan Participant and transplant Physician.
  - *Covered Services*
    - Covered Transplant Procedures: any of the following adult or pediatric human organ and tissue transplant procedures determined to be Medically Necessary:
      - Heart;
      - Liver;
      - Bone marrow (related or unrelated);
      - Lung;
      - Kidney;
      - Pancreas;
      - Cornea;
      - Multivisceral/intestine;
      - Simultaneous pancreas/kidney; and
      - Simultaneous heart/lung.
    - Transplant Services: any services directly related to a Covered Transplant Procedure including, but not limited to, Inpatient and Outpatient Hospital services, Physician services for diagnosis, treatment, and Surgery for a Covered Transplant Procedure, diagnostic services, and procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, as well as surgical, storage and transportation costs incurred and directly related to the successful acquisition of an organ or

tissue used in an eligible and covered organ transplant. Transplant Services also include, but are not limited to, Durable Medical Equipment rental outside of the Hospital, prescription drugs including immunosuppressives, surgical supplies and dressings, and home health care.

- Organ and/or Tissue Procurement: Charges for procurement expenses for a donor organ or tissue are covered.
- Transportation/Lodging: For benefits to be available, the Participant must live more than 75 miles from the hospital where the transplant will be performed. The following will be covered:
  - The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Participant receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Participant must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Lodging for purposes of this Plan does not include private residences.

Benefits shall be payable up to one year from the date of the transplant while the covered Participant is receiving services at the Transplant facility. Benefits for transportation and lodging are limited to a combined maximum of $10,000 per transplant.

o *Specific Exclusions for Organ/Tissue Transplants*: there are no benefits for:

- services and supplies of any Provider located outside of the United States of America, except for procurement services (subject to the amounts shown in the Maximums section), which will be limited to those nations which share the same protocols, standards, and registry with the U.S.A.;
- services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied or received unless otherwise covered as a clinical trial;
- implant of an artificial or mechanical heart or part thereof – this does not include replacement of a heart valve;
- services for non-human organ transplants;
- all other exclusions, limitations, or conditions set forth in this Plan, unless otherwise provided in this Human Organs and Tissue Transplants section;
- services or supplies, including rehabilitation services, which are provide in a non-continuous chronology related to an actual transplantations performed within the effective eligibility of the Plan Participant under this Plan;
- charges for organ transplant surgery, other than those provided in this Human Organs and Tissue Transplants section; and
- transplants that are not medically recognized or that are experimental.

- **Inhalation Therapy**: for the treatment of a condition by the administration of medicines, watervapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Inpatient Services**: Inpatient services include charges from a Hospital Birthing Center, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services; Ancillary (related) services; and Professional services from a Physician while an Inpatient.
    - Room, Board, and General Nursing Services:
        - A room with two or more beds.
        - A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available or the Hospital has only private room available.
        - A room in a special care unit approved by the Claims Administrator, on behalf of the Employer. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.
    - Ancillary (Related Services):
        - Operating, delivery and treatment rooms and equipment.
        - Prescribed Drugs.
        - Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
        - Medical and surgical dressings, supplies, casts and splints.
        - Diagnostic Services.
        - Therapy Services.
    - Professional Services:
        - Medical care visits limited to one visit per day by any one Physician.
        - Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
        - Concurrent care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
        - Consultation which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or

cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.

- Surgery and the administration of general anesthesia.
- Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

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

- **Maternity Services**: maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services as well as services of a Certified Nurse-Midwife. These services are used for normal or complicated pregnancy, miscarriage, and ordinary routine nursery care for a healthy newborn. Coverage includes that of a dependent daughter pregnancy.

  If the Participant is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to an In-Network Provider to have Covered Services paid at the In-Network level. If the Participant is pregnant on her Effective Date, benefits for obstetrical care will be paid at the In-Network level if the Participant is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period. The Participant must complete a Continuation of Care Request Form and submit to the Claims Administrator.

  Note: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Deductible, Coinsurance and/or Copayment.

  If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

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

  Covered Services include at-home post-delivery care visits at your residence by a Physician or Nurse performed no later than 48 hours following you and your newborn

child's discharge from the Hospital. Coverage for this visit includes, but is not limited to, parent education, assistance and training in breast or bottle feeding, and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. At your discretion, this visit may occur at the Physician's office.

In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders: phenylketonuria; hypothyroidism; galactosemia; homocystinuria; maple syrup urine disease; hemoglobinopathies, including sickle cell anemia; congenital adrenal hyperplasia; biotinidase deficiency; cystic fibrosis; hearing impairment.

Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to: tandem mass spectrometry (MS/MS); high volume radioimmunoassay; hemoglobin electrophoresis; isoelectric focusing; bacterial inhibition assays; Immunoreactive trypsin (IRT); and DNA testing.

- **Medical Supplies**: supplies are considered as a medical benefit if the supplies, equipment or appliances are not received through the Pharmacy benefit. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose are covered under the medical benefit. Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

  Covered services may include, but not limited to, allergy serum extracts; chem strips, glucometer, lancets; clinitest; casts; splints; dressings; catheters; colostomy bags; oxygen; and syringes and needles for the treatment of allergies or diabetes.

  Non-covered services include, but are not limited to, adhesive tape, band aids, cotton tipped applicators; arch supports; doughnut cushions; hot packs, ice bags; vitamins; and medijectors.
- **Medicines**: includes medicines dispensed and administered during an inpatient stay. See Prescription Drug Benefits for outpatient prescription drug coverage information.
- **Morbid Obesity Treatment Services**: includes coverage for treatment of Morbid Obesity including medications and surgery. Second surgeries resulting from complications from the initial surgery will also be covered even if the covered Participant no longer meets the definition of Morbidly Obese. Benefit maximums are listed in the Summary of Medical Benefits. In order to qualify for surgical Bariatric treatment the following criteria must be met:
  - must be at least 21 years old;
  - must complete at least 6 months of Physician supervised, clinically appropriate weight reduction efforts documented by Physician records;

- must be able to show that there are no clinical or psychological contraindications to the surgical procedure; and
- must be physically able to handle anesthesia.

No benefits will be payable for a second surgery for the following:

- reversal of the initial surgical procedure; and
- cosmetic procedures including, but not limited to, removal of excess skin (unless medically necessary) or alteration of body contour.

The Plan will not cover services for the surgical treatment of morbid obesity for a Participant younger than 21 years of age unless two (2) Physicians licensed under Indiana Code 25-22.5 (one who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in Indiana) determine that the surgery is necessary to:

- save the life of the Participant; or
- restore the Participant's ability to maintain a major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Each Physician documents in the Participant's medical record the reason for the Physician's determination.

- **Newborn Care**: includes services and supplies for a covered newborn who is sick or injured, including infant formula when needed for the treatment of inborn errors of metabolism while the infant is hospital-confined. Also includes hospital nursery services and routine newborn care provided during the birth confinement or on an outpatient basis for non-hospital births. For more information regarding newborn care, please see the "Maternity Services" section.

  Any dependent child born while the Employee or Employee's spouse is eligible for coverage will be covered from birth for a period of 31 days. If the child is not enrolled within 31 days of the date of birth or placement for adoption, coverage will cease.

  If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Deductible, Coinsurance and/or Copayment.
- **Oncology Services**: medically necessary cancer screenings not otherwise covered under Preventive Health Benefit.
- **Oral Surgery**: includes oral surgery and care for the following procedures:
  - Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part;
  - Oral/surgical correction of accidental injuries as indicated in the "Dental Services" section;

- Treatment of non-dental lesions, such as removal of tumors and biopsies;
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

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

- **Orthotics**: covered services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices may include, but are not limited to, the following:

  - Cervical collars.
  - Ankle foot orthosis.
  - Corsets (back and special surgical).
  - Casts.
  - Orthopedic braces.
  - Splints (extremity).
  - Trusses and supports.
  - Slings.
  - Wristlets.
  - Built-up shoe.
  - Custom made shoe inserts.

  Orthotic appliances may be replaced once per year per Participant when Medically Necessary in the Participant's situation. However, additional replacements will be allowed for Participant's under age 18 due to rapid growth, or for any Participant when an appliance is damaged and cannot be repaired.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-Covered Services include but are not limited to:

  - Orthopedic shoes (except therapeutic shoes for diabetics).
  - Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
  - Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).

- **Outpatient Services**: Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by the Claims Administrator, on behalf of the Employer. Professional charges only include services billed by a Physician or other professional.

  For emergency accident or medical care refer to the Emergency Care and Urgent Care sections.

- **Physician Home Visits and Office Services**: Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care" and "Home Care Services" for other services covered by the Plan. For Emergency Care refer to the "Emergency Care" and "Urgent Care" sections. Services include:
  - **Office visits** for medical care and consultations to examine, diagnose, and treat an Illness or Injury performed in the Physician's office.
  - **Home Visits** for medical care and consultations to examine, diagnose, and treat an Illness or Injury, performed in your home.
  - **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
  - **Retail Health Clinic Care** for limited basic health care services to Participants on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.
  - **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
  - **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.
- **Preadmission Testing**: will be payable for diagnostic lab test and x-ray exams when:
  - performed on an outpatient basis within seven days before a Hospital confinement;
  - related to the condition which causes the confinement; or
  - performed in place of tests while Hospital confined

  Covered Charges for this testing will be payable even if test shows the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.
- **Preventive Care Services ("PHB")**: covered charges are payable for routine preventive services, such as well-baby care, regular periodic health evaluations for adults and children, periodic health screenings, and routine immunizations appropriate for the Participant as required by the ACA and other applicable laws and regulations. Covered services are rated with an "A" or "B" from the United States Preventive Task Force. You can find a list of the covered services on the Saint Joseph Health System

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

- **Prosthetics**: includes artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  - replace all or part of a missing body part and its adjoining tissues; or
  - replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  - aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
  - Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant);
  - breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per calendar year, as required by the Women's Health and Cancer Rights Act. To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses;
  - replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  - Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered;

- colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
- restoration prosthesis (composite facial prosthesis); and
- penile prosthesis in men suffering impotency resulting from disease or injury.

Non-covered Prosthetic appliances include but are not limited to:

- dentures, replacing teeth or structures directly supporting teeth;
- dental appliances;
- such non-rigid appliances as elastic stocking, garter belts, arch supports and corsets;
- artificial heart implants; and
- wigs (except when following cancer treatment).

- **Pulmonary Rehabilitation:** to restore an individual's functional status after an Illness or Injury. Covered Services include but are not limited to, Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.
- **Radiation Therapy**: for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Reconstructive Surgery**: includes reconstructive surgery after a mastectomy, including reconstructive surgery of the breast on which the mastectomy was performed as well as reconstructive surgery of the other breast to produce a symmetrical appearance is also covered in accordance with the Women's Health and Cancer Rights Act of 1998. Coverage includes prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

  Coverage also includes charges for reconstructive surgery to correct deformities caused by congenital or developmental abnormalities, Illness, Injury or an earlier treatment in order to create a more normal appearance.

  Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

- **Second Opinion**: certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

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

Benefits will be provided for a second opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

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

- **Skilled Nursing Facility Care**: room and board and nursing care furnished by a Skilled Nursing Facility (*including an intensive rehabilitation facility and sub-acute hospital facility*) will be payable if and when:
  - the patient is confined as a bed patient in the facility;
  - attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
  - the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

  A Skilled Nursing Facility is a facility that meets all the below qualifications:
  - It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
  - Its services are provided for compensation and under the full-time supervision of a Physician.
  - It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
  - It maintains a complete medical record on each patient.
  - It has an effective utilization review plan.
  - It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
  - It is approved and licensed by Medicare.
- **Sleep Disorders**: services, supplies, testing and medications related to diagnosis and treatment of, for example, obstructive sleep apnea, insomnia, narcolepsy, and parasomnias. Sleep Studies are covered regardless of location. Sleep apnea monitor will be covered under the DME benefit.
- **Smoking Cessation**: includes programs, counseling and medications are covered under the Preventive Health Benefit as required by the Affordable Care Act.
- **Sterilization**: includes voluntary sterilization procedures. Sterilizations for women will be covered under the Preventive Care benefit. Excludes reverse sterilization procedures.
- **Sub-Acute Facilities**: at a sub-acute rehabilitation facility or unit, or in a skilled nursing unit, the following services must be available: medical care, physical therapy,

occupational therapy, speech-language therapy, therapeutic recreation, psychological services, and 24-hour nursing care and other services as needed.

- **Surgical Services**: coverage for surgical services when provided as part of a Physician Home Visit and Office Services, Inpatient Services, or Outpatient Services includes, but not limited to:
  - Performance of generally accepted operative and other invasive procedures;
  - The correction of fractures and dislocations;
  - Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
  - Usual and related pre-operative and post-operative care;
  - Other procedures as approved by the Administrator, on behalf of the Employer.

  The surgical fee includes normal post-operative care.

  Covered Surgical Services include, but are not limited to:
  - Operative and cutting procedures;
  - Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
  - Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

  If two (2) or more surgical procedures are performed during the same operative session, the maximum benefit is as follows:
  - if all procedures are performed through the same incision or in the same natural body orifice; the amount for the procedure with the highest Maximum Eligible Charge;
  - if the procedures are performed in remote operative fields and through separate incisions; the amount for the procedure with the highest Maximum Eligible Charge plus 50% of the Maximum Eligible Charge for each other procedure;
  - if bilateral procedures are performed in separate operative fields, they are treated as one (1) procedure; the Plan will pay 1-1/2 times the Maximum Eligible Charge for the unilateral procedure; and
  - if an assistant surgeon is required, the reimbursement for the assistant surgeon's Covered Charge will not exceed 20% of either the surgeon's contracted rate for In-Network Physicians, or the Usual and Customary allowance for an Out-of-Network physician.
- **Telemedicine Services:** coverage includes telemedicine services delivered by a Provider by use of interactive audio, video, the internet or other electronic media. These services are provided by Teledoc.
- **Temporomandibular Joint Dysfunction (TMJ):** surgical and nonsurgical treatment of TMJ, myofascial pain dysfunction syndrome and/or orthognathic treatment. Coverage excludes orthodontia or prosthetic devices prescribed by a Physician or Dentist.

- **Therapy, Short-Term**: includes the following rehabilitation therapy services provided on an outpatient basis:
  - *Physical Therapy*: includes services by a licensed therapist or physician for improvement of bodily function and provided in accordance with physician's order as to type, frequency and duration.
  - *Occupational Therapy*: includes services and supplies when provided by a certified occupational therapist under the direction of a physician that are needed to improve and maintain a patient's ability to function.
  - *Speech Therapy*: includes services of a licensed speech therapist when prescribed by a physician following:
    - surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); or
    - Injury, or Illness (other than a learning or mental disorder).

  Maintenance care is not covered under any category above. Occupational therapy does not include coverage for recreational or social interaction.
- **Urgent Care Services**: include services that can be obtained at an Urgent Care facility. Often an urgent rather than an Emergency medical problem exists. If you experience an accidental Injury or an Illness, the Plan will determine whether your Injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

  An Urgent Care medical problem is an unexpected episode of Illness or an Injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital.
- **Vison Services**: includes services for medical and surgical treatment of Injuries and/or disease affecting the eye. Vision screenings required by Federal Law are covered under the "Preventive Care" benefits. Coverage for the initial pair of eyeglasses, contact lenses or intra-ocular lenses following cataract surgery will be covered.
- **Wigs**: charges associated with the purchase following cancer treatment.

For More Information

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

Expenses Not Covered

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

Alternative/Complementary Medicine

- acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, and electromagnetic therapy.

Comfort/Convenience Items and Services

- personal hygiene, environmental control, or convenience items including but not limited to:
    - air conditioners, humidifiers, air purifiers;
    - personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - charges for non-medical self-care except as otherwise stated;
    - purchase or rental of supplies for common household use, such as water purifiers;
    - allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - infant helmets to treat positional plagiocephaly;
    - safety helmets for Participants with neuromuscular disease;
    - sports helmets.
    - home modifications such as elevators, handrails and ramps, medical alert systems; and
    - non-hospital adjustable beds, orthopedic mattresses, blood pressure instruments, scales, and first aid supplies and other non-prescription drugs or medicines.

Counseling

- services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein;
- pastoral counseling (except as provided as part of Bereavement Counseling);
- marital and pre-marital counseling; and
- financial counseling.

Custodial Care/Home Services/Nursing

- custodial care, convalescent care or rest cures (as defined above in the Definition section);
- self-help training and other forms of non-medical care self-care, except as otherwise provided herein;

- manipulation therapy services rendered in the home as part of Home Health Care Services;
- home management and compensatory training, meal preparation, safety procedures, and adaptive equipment instructions used to support activities of daily living unless otherwise provided herein;
- care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution;
- for Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are covered only when provided through the Home Care Services benefit as specifically stated in the Eligible Expenses section; and
- domiciliary care provided in a residential institution, treatment center, supervised living or halfway house, or school because a Participant's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Dental/Oral

- dental treatment, regardless of origin or cause, except as specified elsewhere in Eligible Expenses. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:
  - extraction, restoration and replacement of teeth;
  - medical or surgical treatments of dental conditions;
  - services to improve dental clinical outcomes.
- treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as an Eligible Expense;
- dental implants and dental braces;
- dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
  - transplant preparation;
  - initiation of immunosuppressives;
  - direct treatment of acute traumatic injury, cancer or cleft palate; and
- treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

Foot Care/Podiatry

- routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:

- cleaning and soaking the feet;
- applying skin creams in order to maintain skin tone;
- other services that are performed when there is not a localized illness, injury or symptom involving the foot; and

- surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

Hearing Services

- hearing aids or examinations for prescribing or fitting them, however, cochlear implants are covered.

Hospital Services

- any hospital stay that is not for the diagnosis or treatment of an Illness or Injury;
- charges for any resident or intern of a hospital;
- room and board charges unless the treatment provided meets the Claim Administrators Medical Necessity criteria for Inpatient admission for your condition;
- care received in an emergency room which is not Emergency Care, except as specified in this Summary Plan Document. This includes, but is not limited to suture removal in an emergency room; and
- non-emergency hospital admission on a Friday or Saturday unless surgery is performed within 24 hours of admission.

Medical Supplies/Appliances

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

Never Events

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

Non-compliance

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

Physical Appearance

- weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity;
- health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for

developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas;

- reconstructive services except as specifically stated in the Eligible Expenses section;
- procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by the Claims Administrator, on behalf of the Employer, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Participant was covered by another carrier/self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions;
- treatment of telangiectatic dermal veins (spider veins) by any method;
- sclerotherapy for treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to access the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy;
- surgical treatment of gynecomastia;
- treatment of hyperhidrosis (excessive sweating); and
- expenses related to the care and treatment of hair loss including alopecia, wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician. However, wigs are covered after cancer treatment.

Reproduction/Sexual

- for elective abortions and/or fetal reduction surgery unless the pregnancy is a result of rape or incest or if continuing the pregnancy is life-threatening to the mother;
- for any services or supplies provided to a person not covered under the Plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);
- services to reverse voluntarily induced sterility; and
- charges for services and supplies for diagnostic testing and treatment of infertility, including, but not limited to, artificial insemination, gamete intra fallopian transfer (GIFT), and in vitro fertilization, except as specifically provided.

Services Provided by another Plan

- services and supplies that are provided as benefits by any governmental unit, unless otherwise required by law or regulation;
- for any condition, disease, defect, ailment, or Injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

Travel-Related Expenses

- for mileage, lodging and meals costs, and other Participant travel related expenses, except as authorized by the Claims Administrator or specifically stated as an Eligible Expense; and
- expenses for care or treatment outside of the United States, if travel was for the sole purpose of obtaining medical services.

Vision Services

- routine vision screenings/exams not required by federal law;
- for prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as an Eligible Expense. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition;
- vision orthoptic training; and
- expenses for radial keratotomy, keratectomy, or any other surgery to correct nearsightedness, farsightedness, or refractive errors.

Other Services

- services received from an individual or entity that is not licensed by law to provide covered services. Examples may include masseurs or masseuses (massage therapists) and physical therapist technicians;
- services rendered by an unlicensed provider;
- human growth hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Administrator, on behalf of the Employer, through Prior Authorization;
- for Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over-the-counter products that the Plan must cover as a "Preventive Care" benefit under federal law with a Prescription;
- nutritional and/or dietary supplements, except as provided in this Summary Plan Document or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter,

which by law do not require either a written Prescription or dispensing by a licensed Pharmacist;

- examinations related to research screenings;
- standby charges of a Physician;
- for any Illness or Injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared;
- for a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident;
- for care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, unless otherwise required by law or regulation;
- for court ordered testing or care unless Medically Necessary;
- wilderness camps;
- experimental or investigational services or supplies (as defined above in the Definitions);
- services or supplies that are not medically necessary for diagnosing or treating your condition, as determined by the Plan;
- any charges in excess of the maximum amount payable under the Plan for a particular service or supply;
- services or supplies for which the patient does not have to pay, or for which no charges would be made if this coverage did not exist;
- charges that a school system is required by law to provide;
- services or care provided or billed by a school, Custodial Care center for the developmentally disabled, halfway house, or outward bound programs, even if psychotherapy is included;
- for any for which you are responsible under the terms of this Summary Plan Document to pay a Copayment, Coinsurance or Deductible, and the Copayment , Coinsurance or Deductible is waived by an Out-of-Network Provider;
- services not recommended and approved by a physician or treatment, services, or supplies when the participant is not under the regular care of a physician that is appropriate for the Injury or Illness;
- maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement;
- services prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self;
- complications directly related to a service or treatment that is a non-covered service under the Plan because it was determined by the Claims Administrator, on behalf of the Employer, to be Experimental/Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the

Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service;

- charges incurred for which the Plan has no legal obligation to pay;
- care, treatment or supplies for which a charge was incurred before a person was covered under the Plan or after coverage ceased under this Plan;
- professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service;
- charges for missed or canceled appointments;
- charges to completion of claim forms or charges for medical records or reports unless otherwise required by law;
- charges for telephone consultations or consultations via electronic mail or internet/web site, except as listed as an Eligible Expense;
- for membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results;
- physician or other practitioners' charges for consulting with Participant by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Participant, except as otherwise described in this Summary Plan Document;
- surcharges for furnishing and/or receiving medical records and reports;
- charges for doing research with Providers not directly responsible for your care;
- charges that are not documented in Provider records;
- charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician; and
- physical exams and immunizations required for enrollment in any insurance program, as condition of employment, for licensing, or for other purposes.

Precertification

Precertification of certain medical procedures is a condition to the Plan covering certain types of medical services, treatment, pharmaceuticals, and equipment. The following services must be precertified:

- All Inpatient Admissions (including, but not limited to long-term acute, sub-acute, and rehabilitation admissions)
- Skilled Nursing Facility Admissions and Stays
- Inpatient for Mental Health/Substance Abuse
- Residential Treatment (RES) for Mental Health/Substance Abuse
- Intensive Outpatient Program (IOP) for Mental Health/Substance Abuse
- Partial Hospitalization Program (PHP) for Mental Health/Substance Abuse
- Transplant Evaluations and Procedures
- Home Health Care
- Hospice Care
- Oncology Services (Chemotherapy and Radiation)
- Durable Medical Equipment (DME) (*any purchase over $750 and all rentals*)
- Prosthetics (*any purchase over $750 and all rentals*)
- Specialty Medications
- Applied Behavioral Analysis (ABA Therapy)
- Implantation of Cardiac Defibrillators/Pacemakers
- Dialysis
- Occupational Therapy *(no Precertification required for the Evaluation and first 12 treatments)*
- Physical Therapy *(no Precertification required for the Evaluation and first 12 treatments)*
- Speech Therapy *(no Precertification required for the Evaluation and first 12 treatments)*
- Bariatric and Morbid Obesity Services
- MRI, PET, MRA Scans
- Enteral Feeding
- Genetic Testing
- Orthognathic Surgery
- Cosmetic Surgery *(including, but not limited to, abdominoplasty, blepharoplasty, mammoplasty, septoplasty, sclerotherapy, skin lesion removal, and rhinoplasty)*
- Pain Management Services *(including, but not limited to, epidural steroid injections,– when injections are greater than 3 in a 12-month period)*

Note: For a maternity stay that is longer than 48 hours following a vaginal delivery or longer than 96 hours following a cesarean delivery, the attending Physician will need to obtain Precertification.

Procedure

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

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

- name of the patient and relationship to the covered Employee;
- name, Member ID number and address of the covered Employee;
- name of the Employer;
- name and telephone number of the attending Physician;
- name of the Medical Care Facility, proposed date of admission, and proposed length of stay;
- diagnosis and/or type of surgery; and
- proposed rendering of listed medical services

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

Penalty for Noncompliance with Precertification

If the Plan Participant does not follow precertification procedures and receive prior authorization from the Plan for the services, treatment, pharmaceuticals, and equipment as listed above or anywhere else in this Agreement, each failure will result in a 30% penalty per claim. ***Note:*** For services provided by an Encircle provider, if precertification is required for the services and an approved referral is not obtained, only one 30% penalty will apply.

Utilization Review

Utilization review is a program designed to help insure that all covered Participants receive necessary and appropriate health care while avoiding unnecessary expenses. This review may include a review and/or audit of Claims, including claim form(s), invoices, and any other relevant billing and healthcare records, both prospectively and retrospectively, especially for high cost claims, to ensure applicable charges were actually performed, appropriate and otherwise meet the eligibility and coverage requirements as defined by the Plan.

Case Management

In cases where the Plan Participant's condition is expected to be chronic or complex or a Plan Participant needs assistance navigating the health care system during their health event, case management services are available. The use of case management is a voluntary program to

the Plan Participant; however these services will generally provide a greater benefit to the Plan Participant by participating in the program.

The case manager will review the medical care provided to Plan Participants and may recommend alternative, cost-efficient programs of treatment. Such programs will be implemented only with the consent of the Plan Participant, his physician, and the Plan Supervisor and may, in appropriate cases, provide for payment of benefits that would not otherwise be covered by the Plan, if payment of such benefits is expected to accelerate recovery or reduce overall expenses. A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

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

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

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

SECTION IV: YOUR PRESCRIPTION DRUG BENEFITS

How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug program. Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of an Illness or injury. Covered drugs must be:

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

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network.

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

Using a Network Retail Pharmacy

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

Out-of-Network Retail Pharmacy

If you use an out-of-network retail pharmacy you will have to pay full cost of the medication. For reimbursement, see below.

Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately.

To fill a prescription through the mail-service program, you must complete an order form and include your co-payment (using a credit card, check, or money order). With your first order, you also must include the original prescription order written by your doctor and a completed patient profile form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you will not need a new prescription from your doctor if the prescription is still valid.

Direct Member Reimbursement

CVS/Caremark Participating Pharmacy

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

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

Out-of-Network Pharmacy

If you purchase a drug from an Out-of-Network pharmacy, you will have to pay full cost of the medication. For reimbursement of prescriptions received from an Out-of-Network pharmacy, please submit your claim form to SIHO Insurance Services. You must include the original receipt for reimbursement, which will include the following information:

- Patient Name
- Date of Fill
- Total Charge
- Prescription Number
- Quantity
- Medicine NDC Number
- Days Supply
- Pharmacy Name
- Pharmacy Address

You will be reimbursed the amount you paid to the pharmacy subject to the terms set forth in the plan document. There is no coverage for Mail-order drugs received at an Out-of-Network pharmacy.

Copayments

A copayment may apply to each covered pharmacy drug charge and is shown in the Summary of Pharmacy Benefits. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply. Copayments accrue toward the Out-of-Pocket maximum.

Coverage Categories

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

Prescription Formulary Drug Tiers

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

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

Tier 3: Non-Preferred or Non-Formulary Brand Name Drugs: Any brand drug for which a generic product is available may be designated as a non-preferred product. Please see the "Prescription Drug Benefit" chart for coverage amounts.

Prior Authorization and Limits

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

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

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

Step Therapy Program

The Step Therapy Program encourages members to use generic medications that are generally recognized as safe and effective, but are also lower-cost. Under this program, in order to receive coverage, you may need to first try a proven, cost effective medication before progressing to a more costly treatment.

Specialty Medications

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

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

For information on ordering specialty medications, dispensing limitations, and your required cost for these drugs, contact the Claims Administrator.

Covered Prescription Drugs and Supplies

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

- Hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order.
- Insulin, disposable insulin pens, insulin cartridges, and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits).
- Prescription prenatal vitamins.
- Immunizations as required by the Affordable Care Act.
- Specialty Medication with an approved prior authorization.
- Compound prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) medication.
- Contraceptives: all FDA-approved contraceptive methods for all individuals with reproductive capacity are covered as required by the Affordable Care Act.
- Smoking-cessation programs, counseling and medication are covered under the Preventive Health Benefit as required by the Affordable Care Act.
- Human Growth Hormones with an approved prior authorization.
- Drugs used for the purpose of treating HIV/AIDS, unless considered experimental or investigational.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Treatment of Onychomycosis (toenail fungus).
- Nutritional and dietary supplements that require a prescription, including Vitamin B-12.
- Weight Loss Medication for treatment of Morbid Obesity – Prior Authorization is required.

Expenses Not Covered

Note: The following exclusions are not exhaustive.

The following drugs and supplies, among others, are not covered under the Plan:

Administration: any charge for the administration of a covered Prescription Drug. Some exceptions may apply.

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

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

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

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

FDA: any drug not approved by the FDA.

Infertility: a charge for fertility medication.

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

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

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

Medical exclusions: a charge excluded under Medical Plan Exclusions.

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

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

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

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

Supplements: over-the-counter (OTC) appetite suppressants, nutritional and dietary supplements.

Quantity Limits: drugs in quantities which exceed the limits established by the Plan.

Summary of Pharmacy Benefits

PPO Plan

PRESCRIPTION DRUG BENEFITS		
Prescription Benefits Manager (PBM) – CVS/Caremark		
Prescription Amounts apply to the Medical Out-of-Pocket Maximums.		
Amounts listed are what member pays	**IN-NETWORK**	**OUT-OF-NETWORK**
Retail (up to a *30-day supply*)		
Generic	$10 copayment	50% no deductible (minimum $40 per prescription order)
Brand Name Formulary	$30 copayment	50% no deductible (minimum $40 per prescription order)
Brand Name Non-Formulary	$50 copayment	50% no deductible (minimum $40 per prescription order)
Specialty Medication* - (up to a *30-day supply*)		
Generic	$10 copayment	Not Covered
Brand Name Formulary	$30 copayment	Not Covered
Brand Name Non-Formulary	$50 copayment	Not Covered
Mail Order (up to a *90-day supply*)		
Generic	$15 copayment	Not Covered
Brand Name Formulary	$45 copayment	Not Covered
Brand Name Non- Formulary	$60 copayment	Not Covered
Specialty Medication* (up to a *90-day supply*)		
Generic	$15 copayment	Not Covered
Brand Name Formulary	$45 copayment	Not Covered
Brand Name Non-Formulary	$60 copayment	Not Covered
*Specialty Medications (*injectable and otherwise*) other than insulin, hemopoetics and anticoagulants are covered under the pharmacy benefit if received through the Phmarcy. **Precertification is required**. To obtain prior authorization for these medications, call (800) 553-6027.		
Orally Administered Cancer Chemotherapy	$0 copayment	$0 copayment
Asthma Supplies	$0 copayment	$0 copayment

SECTION V: ADMINISTRATIVE INFORMATION

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

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

Plan Sponsor and Administrator

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

Plan Administrator

School City of Mishawaka

1402 S. Main Street

Mishawaka, IN 46544

Tel: (574) 254-4500

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

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

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Benefit Year

The Benefit Year is January 1 through December 31.

Plan Year

The Plan Year is November 1 through October 31.

Plan Effective Date

November 1, 2017

Plan Number

501

Type of Plan

This Plan is called a “welfare plan”, which includes medical and prescription drug coverage.

Identification Numbers

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

EIN: 35-6002649

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The Plan Sponsor and employees both contribute to the Plan. Assets of the Plan are used for the exclusive purpose of providing benefits to Plan participants and their beneficiaries. Any premium contributions will remain part of the general assets of the Plan Sponsor and benefits will be paid solely from those general assets.

Claims Administrators

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

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every

attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Medical/Utilization Review

Claims Administrator

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

Agent for Service of Legal Process

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

School City of Mishawaka
1402 S. Main Street
Mishawaka, IN 46544

Future of the Plan

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

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

SECTION VI: PLAN ADMINISTRATION

Plan Administrator

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

Duties of Plan Administrator

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

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

Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Indemnity

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

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

Fiduciary

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

Fiduciary Duties

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

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

Named Fiduciary

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

Claims Administrator is Not Fiduciary

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

Amending and Terminating Plan

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

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

SECTION VII: PROCEDURES FOR OBTAINING OR DETERMINING BENEFITS

Claim Filing

If an Enrollee receives a bill directly from a provider, is required to pay for services at the time they are provided, or assigns his or her right to reimbursement to a provider with the consent of the Claims Administrator, the Clean Claim may be submitted to the Claims Administrator for payment. Clean Claim means a claim submitted by the Enrollee or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If the Claims Administrator has not received information it needs to process a claim, the Claims Administrator will request additional information from the party that submitted the Claim. In those cases, the Claims Administrator cannot complete the processing of the Claim until the additional information requested has been received.

In order to be eligible for payment, the Claim must be submitted with receipts within 12 months from the date the services were rendered or, in the case of an In-Network Provider, within the timeframe for submitting claims set forth in the provider agreement in effect between the In-Network Provider and the Claims Administrator. If the Claims Administrator approves the Claim, the Claims Administrator will reimburse the Enrollee or provider, as appropriate, for Covered Benefits less any applicable Copayments, Deductible, Coinsurance, penalty, and any amounts that the Claims Administrator has already paid to the Enrollee or the provider prior to receiving the Claim. The Claim should describe the occurrence, character, and extent of the Medical Care provided by the provider.

Out-of-Network Providers

Out-of-Network Providers must submit claims to the Claims Administrator within 12 months of the date services were provided to be eligible for payment. Notwithstanding anything herein to the contrary, Enrollees may not assign any claims or other rights to receive Benefits hereunder to any Out-of-Network Provider without the prior approval of the Claims Administrator. In the absence of such prior approval, the Claims Administrator reserves the right to pay claims or other benefits directly to the Enrollee, and such payment shall fully discharge the Claims Administrator's obligation under this Agreement with respect to such Claims or other Benefits. In such a case, the Enrollee is responsible for all payments that may be due to the Out-of-Network Provider.

Claim Form

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

Claim Determination

Pre-Service Claims

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

- This 15-day period may be extended for an additional 10 days if the Claims Administrator determines that an extension is necessary due to matters beyond the Health Plan's control and notifies the claimant of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.
- If an extension is necessary because the claimant has not submitted information necessary to decide the Claim, the Claims Administrator will provide the claimant with a notice of extension which will specifically describe the additional information required. If the extension is necessary because the Claim does not properly identify the individual requesting a benefit, specify the medical condition or symptom, and the specific treatment, service, or product for which approval is requested, the Claims Administrator will provide the notice of extension and an explanation of the proper procedures to be followed in filing a Claim. Any notice of extension may be oral, unless the claimant requests a notice in writing. The claimant will have at least 45 days to provide any requested information.

Post-Service Claims

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

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

Urgent Care Claims

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

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

Concurrent Care Claims

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

Grievances

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

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

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

Once a Grievance has been initiated by an Enrollee, the Claims Administrator will respond within 3 business days to acknowledge its receipt of the Grievance. Such response will be in writing, unless the Grievance was received orally, in which case the response may be oral. Grievances will be resolved within 20 business days after they are filed if all information needed to complete a review is available. If additional information is needed and the Grievance does

not involve Precertification matters, the Claim Administrator may notify you before the 19th business day of its election to take an additional 10 business days to receive information and address the Grievance.

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

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

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

Appeal Procedures

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

General

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

  SIHO Appeals Coordinator
  P.O. Box 1787
  Columbus, IN 47202
- All written notices requesting an appeal will be forwarded to an appeals coordinator.
- All verbal requests must be documented by the Claims Administrator who is assisting the claimant. Upon request, the notice will be forwarded to the appeals coordinator.
- An acknowledgement notice will be sent to the claimant within 3 business days of receipt of the written or verbal appeal request.

Claimant's Rights on Appeal

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

Appeals Hearing Committee

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

Notification of Resolution of Appeal

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

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

Expedited Appeals

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

Notice of Decision on Appeal

If the Claims Administrator denies the appeal, the request will then be heard by the Health Trust Committee which is comprised of a representative from School City of Mishawaka, Select and R&R Benefits. This committee will review the information relating to the appeal and the Claims Administrator's reasons for denying the appeal. If the Health Trust Committee upholds the decision of the appeal, you will be notified by letter stating the committee agreed with the denial. If the Health Trust Committee disagrees with the decision of the Claims Administrator's appeal committee, you will be notified by letter and the claim will be reprocessed.

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

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

- a statement describing the claimant's right to bring a civil suit under federal law; and
- the name, address and telephone number of the appeals coordinator whom the claimant may contact for more information.

External Review of Appeals Process

- If the claimant is dissatisfied with the Appeal Hearing Committee's resolution, and the matter involves (i) an adverse determination of appropriateness, (ii) an adverse determination of Medical Necessity, (iii) a determination that the proposed service is Experimental or Investigational, or (iv) a rescission of coverage by the Claim Administrator, he or she may file a written request to initiate an External Review Appeal. This request must be filed no later than 120 days after the claimant is notified of the resolution of the Appeal Hearing Committee's decision. External Review Appeal is not available for matters other than those specified in this paragraph.
- The claimant may not file more than one (1) External Review Appeal request on the same appeal.
- Upon receipt of the request for External Review Appeal, the appeals coordinator will select an independent review organization that is certified to perform external review in the State of Indiana.
- The independent review organization will assign a medical review professional who is board certified in the applicable specialty for resolution of the appeal.
- The independent review organization and the medical review professional conducting the external review may not have a material professional, familial, or financial, or other affiliation with the Claims Administrator; any officer, director, or management employee of the Claims Administrator; the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician. However, the medical review professional may have an affiliation under which the medical review professional provides health care services to Enrollees of the Claims Administrator and may have an affiliation that is limited to staff privileges at the health facility if the affiliation is disclosed to the claimant and to the Claims Administrator before commencing the review and neither the claimant nor the Claims Administrator objects to the affiliation.
- A claimant who files an appeal under this final alternative is not subject to retaliation for exercising his or her right to an appeal by an independent review organization. The claimant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. The claimant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the independent review organization by providing any requested medical information or authorizing the release of necessary medical information.
- The Claims Administrator shall cooperate with the independent review organization by promptly providing any information requested by the independent review organization.

- The independent review organization shall make a determination to uphold or reverse the Claims Administrator's appeal resolution based on information gathered from the claimant, the Claims Administrator, the treating physician, or any additional information that the independent review organization considers necessary and appropriate. For standard appeals, the determination shall be made within 15 business days from the filing date of the request for external review. For expedited appeals, the determination shall be made within 72 hours after the external review request is filed.
- When making the determination of the resolution of the appeal, the independent review organization shall apply the standards of decision making that are based on objective clinical evidence and the terms of the appellant's benefit contract.
- The independent review organization shall notify the Claims Administrator and the claimant of the determination made under this section within 72 hours after making the determination. For expedited appeals, the notification will occur within 24 hours of the determination. The result of the determination is binding on the Claims Administrator.
- If at any time during the external review process the claimant submits information to the Claims Administrator that is relevant to the Claims Administrator's previous appeal resolution and was not considered by the Claims Administrator during the appeals hearing phase, the Claims Administrator shall reconsider the previous resolution under the appeals hearing process. The independent review organization shall cease the external review process until the reconsideration by the Claims Administrator is completed.
- If additional information from the claimant results in the Claims Administrator's reconsideration of the appeal at the hearing level, the Claims Administrator will notify the claimant of its decision within 15 days after the information is received. If the appeal is related to an Urgent Care Claim, the Claims Administrator will make a determination within 72 hours of receipt of the additional information.
- If the reconsideration determination made by the Claims Administrator's is adverse to the claimant, the claimant may request that the independent review organization resume the external review.

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

Coordination of Benefits (COB)

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

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

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

- The difference between the cost of a private hospital room and the cost of a semi-private hospital room is ***not*** considered an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice.

- When benefits are reduced under a primary plan because a Participant does not comply with the plan provisions related to: second surgical opinions; precertification of admissions or services; and preferred provider arrangements, the amount of the reduction will ***not*** be considered an Allowable Expense.

- If a plan is advised by a Participant that all plans covering the Participant are high-deductible health plans, and the Participant intends to contribute to a health savings account established in accordance with §223 of the Internal Revenue Code of 1986 ("IRC"), the primary high-deductible health plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible as described in §223 of the IRC. An expense or a portion of an expense that is not covered by any of the plans is ***not*** an Allowable Expense.

- Any expense that a provider, by law, or in accordance with a contractual agreement, is prohibited from charging a Participant is ***not*** an Allowable Expense.

Determining the Allowable Expense when this Plan is not primary

- If the Participant is covered by two (2) or more plans that both provide benefits or services on the basis of negotiated fees or contracted amounts, this Plan's payment arrangement shall be the Allowable Expense for this Plan, unless otherwise indicated below in Coordination with Medicare section.

- If a Participant's primary plan calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology, and this Plan provides its benefits or services on the basis of negotiated fees or contracted amounts, this Plan's payment arrangement shall be the Allowable Expense for this Plan, unless otherwise indicated below in Coordination with Medicare section.

- If a Participant is covered by two (2) or more plans that both calculate their benefit payments on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology, this Plan will utilize the primary plan's calculated amount as the Allowable Expense.

- If the Participant's primary plan calculates its benefits or services on the basis of negotiated fees or contracted amounts, and this Plan calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology, this Plan will utilize the primary plan's payment arrangement as the Allowable Expense.

Standard Coordination of Benefits

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

Your medical benefits are coordinated with benefits from:

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

How Standard Coordination Works

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

Order of Benefit Determination Rules

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

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

parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

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

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

Coordination with Medicare

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

If Medicare is determined to be the primary payer, this Plan will utilize the Medicare allowable amount and base its payment upon benefits that have been paid by Medicare. If the Plan Participant is eligible for Medicare and has not enrolled in Medicare Part B, the Claims Administrator will calculate benefits as if they had enrolled.

For the purposes of the calculation of benefits, if the Participant has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

The Plan also coordinates with Medicare as follows.

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

Coordination with Auto Insurance Plans

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

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

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

For Maximum Benefit

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

Subrogation and Reimbursement

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

Right of Recovery

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

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

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

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

Right to Subrogation

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

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

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer an illness, injury, or damages, or who is legally responsible for the illness, injury, or damages; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
    - underinsured or uninsured motorist insurance;
    - medical provisions of no-fault or traditional insurance (auto, homeowners, or otherwise);
    - Workers' Compensation coverage; or
    - any other insurance carrier or third party administrator.

Pay and Pursue

If the Plan receives claims for expenses that were either the result of the alleged negligence of another person, or which arise out of any claim or cause of action which may accrue against

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

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

When This Provision Applies To You

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

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

You or your covered dependent agrees to sign any documents requested by the Plan including but not limited to a reimbursement and/or subrogation agreement, or accident questionnaire, as

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

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

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

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

SECTION VIII: YOUR HIPAA/COBRA RIGHTS

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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

Protected Health Information and its Disclosure

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

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

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

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

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

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

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

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

The following employees and contractors for School City of Mishawaka and its affiliated and related entities are designated and authorized to receive Protected Health Information from the Plan in order to perform their duties with respect to the Plan:

- Human Resources Benefits Specialist
- Broker for School City of Mishawaka

Certificate of Creditable Coverage

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

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

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

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

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

Continuing Health Care Coverage through COBRA

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

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

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

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 60 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 60 days, you will have to wait until the next open enrollment period to enroll your child.

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

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

COBRA Qualifying Events and Length of Coverage

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

18-Month Continuation

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

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

- retirement; or
- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

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

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

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

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

36-Month Continuation

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

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

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

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

COBRA Notifications

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

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

Cost of COBRA Coverage

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

COBRA Continuation Coverage Payments

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

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

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

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

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

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

How Benefit Extensions Impact COBRA

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

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

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

When COBRA Coverage Ends

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

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

SECTION IX: GENERAL PROVISIONS

No Obligation to Continue Employment

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

Payment of Benefits

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

Payment of Benefits to Others

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

Non-Alienation of Benefits

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

Expenses

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

Fraud

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

Typographical or Administrative Error

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

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

Severability

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

Incontestability

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

Limitation of Action

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

Governing Law

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

Conformity with Statutes and Regulations

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

Non-discrimination

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

Discrimination is Against the Law

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

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

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

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

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

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

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

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

Language Assistance Services

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

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

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

Burmese:

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

ဖုန်းနံပါတ် 800.443.2980 (TTY: 800.743.3333) သို့ ခေါ်ဆိုပါ။

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

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

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

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

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

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

Arabic:

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

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

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

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

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

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

ADOPTION OF THE PLAN

The School City of Mishawaka Employee Health Benefit Plan, as stated herein, is hereby adopted as of 01/01/2018. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this 2nd day of FEBRUARY, 2018.

BY: _____

Plan TITLE: CFO & DIRECTOR OF BUSINESS