PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION

FOR THE

CITY OF FORT WAYNE
EMPLOYEE BENEFIT PLAN

Amended and Restated Effective January 1, 2024

PREFACE

This Plan Document and Summary Plan Description for the City of Fort Wayne Employee Benefit Plan, hereinafter called the "Plan," defines the benefits that will be paid to or on behalf of a Covered Person during the continuance of this Plan in the event he or she Incurs Covered Expenses as defined herein. The Plan as described herein is intended to comply with Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (the "Code"), and is to be interpreted in a manner consistent with the requirements of Code Sections 105 and 106. The Plan is subject to all the terms, provisions and limitations stated herein, effective as of January 1, 2020.

The City of Fort Wayne believes that the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the contact information set forth below. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

GENERAL INFORMATION

Plan Name:	City of Fort Wayne Employee Benefit Plan
Employer Identification Number (EIN):	35-6001029 - Civil City 35-6001255 - City Utilities
Group Number:	6650
Type of Plan:	Major Medical Benefits and Prescription Drug Benefits
Plan Effective Date:	The Plan was originally effective January 1, 1998 The Plan is being restated effective January 1, 2020
Plan Year:	The calendar year
Source of Funding:	Contributions to the Plan are funded by Employer contributions and Employee or Retiree contributions
Plan Administrator:	City of Fort Wayne 200 East Berry Fort Wayne, IN 46802
Claims Administrator:	Automated Group Administration, Inc. 7605 Westfield Drive Fort Wayne, IN 46825 Phone Number: (260) 489-6447
Agent for Service of Legal Process:	Garry Morr City of Fort Wayne 200 East Berry Fort Wayne, IN 46802
COBRA Coordinator:	Laura Helmkamp City of Fort Wayne 200 East Berry Fort Wayne, IN 46802 Phone Number: (260) 427-2634 Fax Number: (260) 427-5890
Trustee:	Fifth Third Bank 38 Fountain Square Cincinnati, OH 45263

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SECTION 1
SCHEDULE OF BENEFITS

MAJOR MEDICAL BENEFITS
The Plan provides Major Medical Benefits under two separate medical plan options:

- $1,200 Deductible Traditional EPO Plan – Grandfathered ($1,200 Deductible Plan)
- $3,400 Deductible HSA EPO Plan – Grandfathered ($3,400 Deductible Plan)

The Major Medical Benefits provided under each medical plan option are outlined in the applicable Schedule of Medical Benefits in this Section. For more information regarding the Major Medical Benefits under the Plan, see Sections 4 through 7 of the Plan.

PRESCRIPTION DRUG BENEFITS
The Plan provides Prescription Drug Benefits under each medical plan option, which are outlined in the applicable Schedule of Medical Benefits in this Section. For more information regarding the Prescription Drug Benefits under the Plan, see Section 8 of the Plan. Each Covered Person enrolled in Major Medical Benefits receives Prescription Drug Benefits as provided in the Plan.

DENTAL BENEFITS
The Plan provides Dental Benefits in addition to Major Medical Benefits and Prescription Drug Benefits, which are outlined in the Schedule of Dental Benefits in this Section. For more information regarding the Dental Benefits under the Plan, see Section 9 of the Plan. Each Covered Employee enrolled in Major Medical Benefits receives Dental Benefits as provided in the Plan. However, a Covered Employee may choose to enroll in Dental Benefits only (without Major Medical Benefits) if the Employee has medical coverage outside the Plan, or a Covered Employee may choose to waive Dental Benefits. Dental Benefits are also offered to Eligible Retirees.

[*The Schedule of Benefits will begin on the following page*]

$1,200 DEDUCTIBLE PLAN SCHEDULE OF BENEFITS

$1,200 DEDUCTIBLE PLAN HOSPITAL SERVICES	Exclusive EPO Hospitals	PPO Hospitals	No EPO Hospital Available	Non-PPO Hospitals
PLAN YEAR DEDUCTIBLE				
- Each Covered Person	$1,200	$2,200	$1,200	$4,200
- Each Family	$3,600	$6,600	$3,600	$12,600
A Covered Expense applied toward the Deductible for all Hospital and Provider categories is also accumulated toward the Deductible for the other Hospital and Provider categories. All Covered Expenses are subject to the Deductible unless otherwise indicated.				
BENEFIT PERCENTAGE (except as indicated otherwise)	80%	70%	70%	50%
Applies after the Deductible (excluding Covered Expenses subject to Co-Payments) until the Out-of-Pocket Maximum Limit has been satisfied.				
OUT-OF-POCKET MAXIMUM LIMIT (after satisfaction of Deductible and exclusive of Co-Payments)				
- Each Covered Person	$2,500	$5,500	$2,500	$14,000
- Each Family	$5,000	$11,000	$5,000	$28,000
- Thereafter during the Plan Year, benefits are paid at Benefit Percentage	100%	100%	100%	100%
Out-of-pocket expenses paid by the Covered Person other than Deductibles and Co-Payments are accumulated toward the Out-of-Pocket Maximum Limit in all Provider categories. Unless otherwise indicated, all Covered Expenses paid by the Covered Person accumulate toward the Out-of-Pocket Maximum Limit.				
COVERED SERVICES				
- Mental Illness, Nervous Disorders, Psychiatric, Psychoanalytic and Related Conditions	80%	70%	70%	50%
- Substance Abuse, Chemical Dependency and Related Conditions	80%	70%	70%	50%
- Home Health Care	80%	70%	70%	50%
- Convalescent/Skilled Nursing Facility, subject to a maximum 30 days for each Convalescent Period	80%	70%	70%	50%
- Hospital Benefits (Inpatient and Outpatient)	80%	70%	70%	50%
- Emergency Room Visit (visits for chest pain are not subject to Deductible)	80%	70%	70%	50%
- Maternity Expense Benefits	80%	70%	70%	50%
- Routine Nursery Care of Newborn Includes initial medical history, exam, and circumcision	80%	70%	70%	50%
Benefits payable only while the Dependent is properly enrolled under the Plan and subject to Deductible and Benefit Percentage for coverage provided to the Dependent				
- Hospital Pre-Admission Testing – Not Subject to Deductible Tests for a condition requiring hospitalization within 7 days of tests	100%	100%	100%	100%

$1,200 DEDUCTIBLE PLAN

PHYSICIAN AND ALL OTHER NON-HOSPITAL SERVICES, INCLUDING AMBULATORY SURGICAL CENTERS	PPO Providers	No PPO Provider Available	Non-PPO Providers
PLAN YEAR DEDUCTIBLE			
- Each Covered Person	$1,200	$1,200	$4,200
- Each Family	$3,600	$3,600	$12,600
A Covered Expense applied toward the Deductible for all Hospital and Provider categories is also accumulated toward the Deductible for the other Hospital and Provider categories. All Covered Expenses are subject to the Deductible unless otherwise indicated.			
BENEFIT PERCENTAGE (except as indicated otherwise)	80%	70%	50%
Applies after the Deductible (excluding Covered Expenses subject to Co-Payments) until the Out-of-Pocket Maximum Limit has been satisfied.			
OUT-OF-POCKET MAXIMUM (after satisfaction of Deductible and exclusive of Co-Payments)			
- Each Covered Person	$2,500	$2,500	$14,000
- Each Family	$5,000	$5,000	$28,000
- Thereafter during the Plan Year, benefits are paid at Benefit Percentage	100%	100%	100%
Out-of-pocket expenses paid by the Covered Person other than Deductibles and Co-Payments are accumulated toward the Out-of-Pocket Maximum Limit in all Provider categories. Unless otherwise indicated, all Covered Expenses paid by the Covered Person accumulate toward the Out-of-Pocket Maximum Limit.			
COVERED EXPENSES			
- Elective Second Surgical Opinion – Not Subject to Deductible	100%	100%	100%
- Physician Office Visits:			
- Allergy Injections – Deductible only applies to Non-PPO Providers	100%	100%	50%
- Allergy Serum – Deductible only applies to Non-PPO Providers	$30 Co-Pay, then 100%	$30 Co-Pay, then 100%	50%
- Contraceptives – Deductible only applies to Non-PPO Providers (includes injectables, IUD, Patch and Norplant)	$30 Co-Pay, then 100%	$30 Co-Pay, then 100%	50%
- Counseling Services - Mental Illness, Nervous Disorders, Psychiatric, Psychoanalytic and Related Conditions	$30 Co-Pay, then 100%	$30 Co-Pay, then 100%	50%
- Other Services** – Deductible only applies to Non-PPO Providers	$30 Co-Pay, then 100%	$30 Co-Pay, then 100%	50%
- Urgent Care Centers** – Not Subject to Deductible	$35 Co-Pay, then 100%	$35 Co-Pay, then 100%	$35 Co-Pay, then 100%

**Limited to the charge for the basic PPO office visit only; additional charges are considered under Major Medical Expense Benefits subject to Deductible and Benefit Percentage.

- Wellness Benefits (subject to conditions below):			
- First $2,000 in Benefits, per visit	$30 Co-Pay, then 100%	$30 Co-Pay, then 100%	50%
- After $2,000 in Benefits	80%	70%	50%

Covered Expenses for Wellness Benefits include:
- Routine Physical Examinations
- Preventive Immunizations
- Routine Prostate Examinations (Physician Fees and Laboratory Charges)
- Routine Pap Test (Physician Fees and Laboratory Charges)
- Routine Mammograms (one for women ages 35-39; one per calendar year for women age 40 and over; one per calendar year for women with prior personal or family history of cancer)

- Health Club Membership/Weight Loss Program, up to $400 per year (participation requirements apply)

- Colonoscopy (payable at 100% in-network only, once every five years for those 40 years and older with a medical condition or family history, or once every 10 years for those 45 years and older as a screening tool)

- Surgical Treatment or Services for Morbid Obesity (including complications), subject to a maximum lifetime benefit of $25,000 and the following criteria: - BMI is 40 or higher (Extreme Obesity), or - BMI is 30 or higher and serious weight related health problems, such as diabetes, high blood pressure, or severe sleep apnea exist, and - Non-surgical treatment supervised by a Physician has been unsuccessful	80%	70%	50%
- Allergy Testing	80%	70%	50%
- Diabetic Training and Education Benefits, subject to a maximum lifetime benefit of four sessions for Type II diabetics and six sessions combined for Type II diabetics and insulin dependent diabetics	80%	70%	50%
- Mental Illness, Nervous Disorders, Psychiatric, Psychoanalytic, and Related Conditions	80%	70%	50%
- Substance Abuse, Chemical, Dependency and Related Conditions	80%	70%	50%
- Temporomandibular Joint (TMJ) Dysfunction Syndrome Benefits	80%	70%	50%
- Diabetic Supplies – Not Subject to Deductible for PPO Providers (includes diabetic supplies and insulin pumps)	$30 Co-Pay, then 100%	70%	50%
- Smoking Cessation Counseling Program – Not Subject to Deductible (includes nicotine replacement products)	80%	70%	50%

$1,200 DEDUCTIBLE PLAN – ADDITIONAL SERVICES	TERMS
MASSAGE AND MANIPULATION TREATMENTS	
- Subject to Deductible	Yes
- Maximum Plan Year Visits	25
- Benefit Percentage	80%

Covered Expenses paid by the Covered Person **do not accumulate** toward the Out-of-Pocket Maximum Limit.

AMBULANCE (Ground or Air Ambulance Services)

- Subject to Deductible ..... Yes
- Benefit Percentage 80%

HUMAN ORGAN OR TISSUE TRANSPLANT SERVICES EXPENSE BENEFITS ..... Included

(Charges considered under Major Medical Expense Benefits)

- Maximum Plan Year Benefit for all transplants involving common organ — Unlimited*
- Human to Human Transplants Only

Charges for the removal, preserving, storage and transportation costs of the donated organ or tissue to the extent not covered by the donor's medical plan are considered Covered Expenses and any benefits are accumulated toward the Out-of-Pocket Maximum.

PHOTOTHERAPY EXPENSE ..... Included

Charges for Outpatient Phototherapy Services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the home services are provided through the Exclusive Preferred Provider of the Daavlin Distributing Company by calling Automated Group Administration (AGA) at 1-800-888-6472, benefits for Covered Expenses will be paid:

- Subject to Deductible ..... No
- Benefit Percentage 100%

DIALYSIS EXPENSE ..... Included

Charges for Outpatient Dialysis Services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the services are provided by the Exclusive Preferred Dialysis Provider, as identified by calling Automated Group Administration (AGA) at 1-800-888-6472, benefits for Covered Expenses will be paid:

- Subject to Deductible ..... Yes
- Benefit Percentage 100%

LABORATORY EXPENSE - Lab Card ..... Included

Charges for Outpatient laboratory services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the services are provided through the vendor indicated on your Group Identification Card/Lab Card, benefits for Covered Expenses will be paid:

- Subject to Deductible ..... No
- Benefit Percentage 100%

DIRECT IMAGING EXPENSE ..... Included

Charges for Imaging Services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the services are provided through the Exclusive Preferred Provider, Direct Imaging LLC by calling (260) 212-1901, benefits for Covered Expenses will be paid:

- Subject to Deductible ..... No
- Benefit Percentage 100%

$1,200 DEDUCTIBLE PLAN – ADDITIONAL SERVICES	TERMS

SPECIALTY CARDIAC EXPENSE (Heart) ..... Included

Charges for cardiac services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the services are provided through the specialty cardiac network indicated on your Group Employee Benefit ID Card, benefits for Covered Expenses will be paid:

- Subject to Deductible..... No
- Benefit Percentage..... 100%

HEALTHY TRACK (Diabetic Supplies)..... Included

Charges for a diabetic meter, test strips and lancets, when provided through the Exclusive Preferred Provider, by calling (866) 751-2723, benefits for Covered Expenses will be paid:

- Subject to Deductible No
- Benefit Percentage 100%

COVID-19 TESTING..... Included

Charges for COVID-19 diagnostic testing (and related items and services), as further outlined in Section 5, are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage, except that any such charges that are incurred on or after March 18, 2020, and for the duration of the public health emergency as declared by the Secretary of Health and Human Services (HHS) will be paid:

- Subject to Deductible..... No
- Benefit Percentage..... 100%

PREGNANCY PRE-CERTIFICATION..... **Required**

Pre-Certification - Required for all Pregnancies. Call within 30 days following the diagnosis of a pregnancy and again within 24 hours after delivery of a Newborn. Call the Pre-Certification Organization at the telephone number shown on your Group Employee Benefit ID Card.

Benefits will be reduced by $400 if the procedures and guidelines are not followed.

However, in accordance with the Newborns' and Mothers' Health Protection Act, at least a 48 hour stay following a vaginal delivery of a Newborn (96 hours for cesarean section) will be approved without benefit reduction for not following the pre-certification procedures.

INPATIENT HOSPITAL ADMISSION PRE-CERTIFICATION ..... **Required**

For all hospitalizations, call at least five business days before a non-emergency hospitalization. Call within 48 hours following an emergency hospitalization. Call the Pre-Certification Organization at the telephone number shown on your Group Employee Benefit ID Card.

Benefits will be reduced by $400 If the procedures and guidelines are not followed.

OUT-PATIENT PROCEDURES PRE-CERTIFICATION ..... **Required**

Call 48 hours prior to an out-patient procedure, Outpatient Procedures include; Outpatient Surgery, Physical, Occupational and Speech Therapies, Wound Care, Home Health Care, Hospice, Cardiac Rehabilitation, Skilled Nursing Facility, GAMMA Knife and Durable Medical Equipment over $500. Call the Pre-Certification Organization at the telephone number shown on your Group Employee Benefit ID Card.

Benefits will be reduced by $400 if the procedures and guidelines are not followed.

$1,200 DEDUCTIBLE PLAN – ADDITIONAL SERVICES	TERMS
PRESCRIPTION DRUG BENEFITS	
- Benefits for prescription drugs available by using your Drug Card are paid only when the prescription is filled using the Drug Card through a pharmacy contracted with the vender indicated on your Card.	
- Retail Prescription Drug Card provided by the vendor indicated on your Card	
- Co-pay	
- Generic Drug	$15[1]
- Formulary when Generic is not available	$40
- Non-Formulary when Generic is not available	$60
- Formulary or Non-Formulary when Generic is available	$15[2]
- Diabetic Supplies, Insulin, Amylin Analog and Incretin Mimetic Agents	$15
- Smoking Cessation Rx	Included
- Lifetime Maximum	180 days
- Oral Contraceptives	Included
- Impotence Rx	Included
- Viagra/Cialis limited to six (6) tablets per month	
- Benefit Percentage	100%
- Maximum day supply for each prescription or refill	34 days

[1] When a Generic Drug is filled using the Medtipster Generic Drug Program, the Generic Co-pay is waived.

[2] Plus the difference between the Generic and the Brand price. However, when the Physician mandates "Dispense as written" on the prescription, the co-pay for a Brand Drug (Generic is not available) is used.

- Mail Order Prescription Maintenance Drugs through the vendor indicated on your Card	
- Co-pay	
- Generic Drug	$30
- Formulary	$80
- Non-Formulary	$120
- Diabetic Supplies, Insulin, Amylin Analog and Incretin Mimetic Agents	$30
- Oral Contraceptives	Included
- Impotence Rx	Included
- Viagra/Cialis limited to six (6) tablets per month	
- Smoking Cessation Rx	Not included
- Benefit Percentage	100%
- Maximum day supply for each prescription or refill	90 days

$3,400 DEDUCTIBLE PLAN SCHEDULE OF BENEFITS

$3,400 DEDUCTIBLE PLAN HOSPITAL SERVICES	Exclusive EPO Hospitals	PPO Hospitals	No EPO Hospital Available	Non-PPO Hospitals
PLAN YEAR DEDUCTIBLE				
- Each Covered Person	$3,400	$4,400	$3,400	$7,000
- Each Family	$6,800	$8,800	$6,800	$14,000
A Covered Expense applied toward the Deductible for all Hospital and Provider categories is also accumulated toward the Deductible for the other Hospital and Provider categories. All Covered Expenses are subject to the Deductible unless otherwise indicated.				
BENEFIT PERCENTAGE (except as indicated otherwise)	100%	90%	100%	50%
Applies after the Deductible (excluding Covered Expenses subject to Co-Payments) until the Out-of-Pocket Maximum Limit has been satisfied.				
OUT-OF-POCKET MAXIMUM LIMIT (after satisfaction of Deductible and exclusive of Co-Payments)				
- Each Covered Person	$0	$3,000	$0	$14,000
- Each Family	$0	$6,000	$0	$28,000
- Thereafter during the Plan Year, benefits are paid at Benefit Percentage	100%	100%	100%	100%
Out-of-pocket expenses paid by the Covered Person other than Deductibles and Co-Payments are accumulated toward the Out-of-Pocket Maximum Limit in all Provider categories. Unless otherwise indicated, all Covered Expenses paid by the Covered Person accumulate toward the Out-of-Pocket Maximum Limit.				
COVERED SERVICES				
- Mental Illness, Nervous Disorders, Psychiatric, Psychoanalytic and Related Conditions	100%	90%	100%	50%
- Substance Abuse, Chemical Dependency and Related Conditions	100%	90%	100%	50%
- Hospital Benefits (Inpatient and Outpatient)	100%	90%	100%	50%
- Home Health Care	100%	90%	100%	50%
- Convalescent Nursing Facility, subject to a maximum 30 days for each Convalescent Period	100%	90%	100%	50%
- Emergency Room Visit	$150 Co-Pay, then 100%	$150 Co-Pay, then 90%	$150 Co-Pay, then 100%	50%
- Maternity Expense Benefits	100%	90%	100%	50%
- Routine Nursery Care of Newborn Includes initial medical history, exam, and circumcision Benefits payable only while the Dependent is properly enrolled under the Plan and subject to Deductible and Benefit Percentage for coverage provided to the Dependent	100%	90%	100%	50%
- Hospital Pre-Admission Testing Tests for a condition requiring hospitalization within 7 days of tests	100%	90%	100%	50%

$3,400 DEDUCTIBLE PLAN

PHYSICIAN AND ALL OTHER NON-HOSPITAL SERVICES, INCLUDING AMBULATORY SURGICAL CENTERS	PPO Providers	No PPO Provider Available	Non-PPO Providers
PLAN YEAR DEDUCTIBLE			
- Each Covered Person	$3,400	$3,400	$7,000
- Each Family	$6,800	$6,800	$14,000
A Covered Expense applied toward the Deductible for all Hospital and Provider categories is also accumulated toward the Deductible for the other Hospital and Provider categories. All Covered Expenses are subject to the Deductible unless otherwise indicated.			
BENEFIT PERCENTAGE (except as indicated otherwise)	100%	100%	50%
Applies after the Deductible (excluding Covered Expenses subject to Co-Payments) until the Out-of-Pocket Maximum Limit has been satisfied.			
OUT-OF-POCKET MAXIMUM LIMIT (after satisfaction of Deductible and exclusive of Co-Payments)			
- Each Covered Person	$0	$0	$14,000
- Each Family	$0	$0	$28,000
- Thereafter during the Plan Year, benefits are paid at Benefit Percentage	100%	100%	100%
Out-of-pocket expenses paid by the Covered Person other than Deductibles and Co-Payments are accumulated toward the Out-of-Pocket Maximum Limit in all Provider categories. Unless otherwise indicated, all Covered Expenses paid by the Covered Person accumulate toward the Out-of-Pocket Maximum Limit.			
COVERED EXPENSES			
- Elective Second Surgical Opinion	100%	100%	100%
- Physician Office Visits:			
- Allergy Injections	100%	100%	50%
- Allergy Serum	100%	100%	50%
- Contraceptives (includes injectables, IUD, Patch and Norplant)	100%	100%	50%
- Counseling Services - Mental Illness, Nervous Disorders, Psychiatric, Psychoanalytic and Related Conditions	100%	100%	50%
- Other Services	100%	100%	50%
- Urgent Care Centers	100%	100%	50%

- Wellness Benefits (subject to conditions below):			
- First $2,000 in Benefits	100%	100%	50%
- After $2,000 in Benefits – Deductible applies	100%	100%	50%

Covered Expenses for Wellness Benefits include:
- Routine Physical Examinations
- Preventive Immunizations
- Routine Prostate Examinations (Physician Fees and Laboratory Charges)
- Routine Pap Test (Physician Fees and Laboratory Charges)
- Routine Mammograms (one for women ages 35-39; one per calendar year for women age 40 and over; one per calendar year for women with prior personal or family history of cancer)

- Health Club Membership/Weight Loss Program, up to $400 per year (participation requirements apply)

- Colonoscopy (payable at 100% in-network only, once every five years for those 40 years and older with a medical condition or family history, or once every 10 years for those 45 years and older as a screening tool)

- Surgical treatment or Services for Morbid Obesity (including complications), subject to a maximum lifetime benefit of $25,000 and the following criteria: - BMI is 40 or higher (Extreme Obesity), or - BMI is 30 or higher and serious weight related health problems, such as diabetes, high blood pressure, or severe sleep apnea exist, and - Non-surgical treatment supervised by a Physician has been unsuccessful	100%	100%	50%
- Allergy Testing	100%	100%	50%
- Diabetic Training and Education Benefits, subject to a maximum lifetime benefit of four sessions for Type II diabetics and six sessions combined for Type II diabetics and insulin dependent diabetics	100%	100%	50%
- Mental Illness, Nervous Disorders, Psychiatric, Psychoanalytic, and Related Conditions	100%	100%	50%
- Substance Abuse, Chemical, Dependency and Related Conditions	100%	100%	50%
- Temporomandibular Joint (TMJ) Dysfunction Syndrome Benefits	100%	100%	50%
- Diabetic Supplies (includes diabetic supplies and insulin pumps)	100%	100%	50%
- Smoking Cessation Counseling Program – Not Subject to Deductible (includes nicotine replacement products)	100%	100%	100%

$3,400 DEDUCTIBLE PLAN – ADDITIONAL SERVICES	TERMS
MASSAGE AND MANIPULATION TREATMENTS	
- Subject to Deductible	Yes
- Maximum Plan Year Visits	25
- Benefit Percentage	100%

Covered Expenses paid by the Covered Person **do not accumulate** toward the Out-of-Pocket Maximum.

AMBULANCE (Ground or Air Ambulance Services)

- Subject to Deductible ..... Yes
- Benefit Percentage 100%

HUMAN ORGAN OR TISSUE TRANSPLANT SERVICES EXPENSE BENEFITS ..... Included

(Charges considered under Major Medical Expense Benefits)

- Maximum Plan Year Benefit for all transplants involving common organ — Unlimited
- Human to Human Transplants Only

Charges for the removal, preserving, storage and transportation costs of the donated organ or tissue to the extent that covered by the donor's medical plan are considered Covered Expenses and any benefits are accumulated toward the Out-of-Pocket Maximum.

PHOTOTHERAPY EXPENSE ..... Included

Charges for Outpatient Phototherapy Services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the home services are provided through the Exclusive Preferred Provider of the Daavlin Distributing Company by calling Automated Group Administration (AGA) at 1-800-888-6472, benefits for Covered Expenses will be paid:

- Subject to Deductible ..... Yes
- Benefit Percentage 100%

DIALYSIS EXPENSE ..... Included

Charges for Outpatient Dialysis Services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the services are provided by the Exclusive Preferred Dialysis Provider, as identified by calling Automated Group Administration (AGA) at 1-800-888-6472, benefits for Covered Expenses will be paid:

- Subject to Deductible ..... Yes
- Benefit Percentage 100%

LABORATORY EXPENSE - Lab Card ..... Included

Charges for Outpatient laboratory services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the services are provided through the vendor indicated on your Group Identification Card/Lab Card, benefits for Covered Expenses will be paid:

- Subject to Deductible ..... Yes
- Benefit Percentage 100%

DIRECT IMAGING EXPENSE ..... Included

Charges for Imaging Services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the services are provided through the Exclusive Preferred Provider, Direct Imaging LLC by calling (260) 212-1901, benefits for Covered Expenses will be paid:

- Subject to Deductible ..... Yes
- Benefit Percentage 100%

$3,400 DEDUCTIBLE PLAN – ADDITIONAL SERVICES	TERMS

SPECIALTY CARDIAC EXPENSE (Heart) ..... Included

Charges for cardiac services are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage. When the services are provided through the specialty cardiac network indicated on your Group Employee Benefit ID Card, benefits for Covered Expenses will be paid:

- Subject to Deductible ..... Yes
- Benefit Percentage 100%

HEALTHY TRACK (Diabetic Supplies) Included

Charges for a diabetic meter, test strips and lancets, when provided through the Exclusive Preferred Provider, by calling (866) 751-2723, benefits for Covered Expenses will be paid:

- Subject to Deductible No
- Benefit Percentage 100%

COVID-19 TESTING ..... Included

Charges for COVID-19 diagnostic testing (and related items and services), as further outlined in Section 5, are considered under Major Medical Expense Benefits subject to the Deductible and Benefit Percentage, except that any such charges that are incurred on or after March 18, 2020, and for the duration of the public health emergency as declared by the Secretary of Health and Human Services (HHS) will be paid:

- Subject to Deductible ..... No
- Benefit Percentage 100%

PREGNANCY PRE-CERTIFICATION ..... **Required**

Pre-Certification - Required for all Pregnancies. Call within 30 days following the diagnosis of a pregnancy and again within 24 hours after delivery of a Newborn. Call the Pre-Certification Organization at the telephone number shown on your Group Employee Benefit ID Card.

Benefits will be reduced by $400 if the procedures and guidelines are not followed.

However, in accordance with the Newborns' and Mothers' Health Protection Act, at least a 48 hour stay following a vaginal delivery of a Newborn (96 hours for cesarean section) will be approved without benefit reduction for not following the pre-certification procedures.

INPATIENT HOSPITAL ADMISSION PRE-CERTIFICATION ..... **Required**

For all hospitalizations, call at least five (5) business days before a non-emergency hospitalization. Call within 48 hours following an emergency hospitalization. Call the Pre-Certification Organization at the telephone number shown on your Group Employee Benefit ID Card.

Benefits will be reduced by $400 If the procedures and guidelines are not followed.

OUT-PATIENT PROCEDURES PRE-CERTIFICATION ..... **Required**

Call 48 hours prior to an out-patient procedure, Outpatient Procedures include; Outpatient Surgery, Physical, Occupational and Speech Therapies, Wound Care, Home Health Care, Hospice, Cardiac Rehabilitation, Skilled Nursing Facility, GAMMA Knife and Durable Medical Equipment over $500. Call the Pre-Certification Organization at the telephone number shown on your Group Employee Benefit ID Card.

Benefits will be reduced by $400 if the procedures and guidelines are not followed.

$3,400 DEDUCTIBLE PLAN – ADDITIONAL SERVICES	TERMS
PRESCRIPTION DRUG BENEFITS	Included
- Benefits for prescription drugs available by using your Drug Card are paid only when the prescription is filled using the Drug Card through a pharmacy contracted with the vender indicated on your Card.	
- Subject to Deductible	Yes
- Retail Prescription Drug Card provided by the vendor indicated on your Card	
- Co-pay	
- Generic Drug	$0
- Formulary when Generic is not available	$40
- Non-Formulary when Generic is not available	$60
- Formulary or Non-Formulary when Generic is available	$15[1]
- Diabetic Supplies, Insulin, Amylin Analog and Incretin Mimetic Agents	$0
- Smoking Cessation Rx	Included
- Lifetime Maximum	180 days
- Oral Contraceptives	Included
- Impotence Rx	Included
- Viagra/Cialis limited to six (6) tablets per month	
- Benefit Percentage	100%
- Maximum day supply for each prescription or refill	34 days

[1] Plus the difference between the Generic and the Brand price. However, when the Physician mandates "Dispense as written" on the prescription, the co-pay for a Brand Drug (Generic is not available) is used.

- Mail Order Prescription Maintenance Drugs through the vendor indicated on your Card	
- Co-pay	
- Generic Drug	$0
- Formulary	$80
- Non-Formulary	$120
- Diabetic Supplies, Insulin, Amylin Analog and Incretin Mimetic Agents	$0
- Oral Contraceptives	Included
- Impotence Rx	Included
- Viagra/Cialis limited to six (6) tablets per month	
- Smoking Cessation Rx	Not included
- Benefit Percentage	100%
- Maximum day supply for each prescription or refill	90 days

DENTAL SCHEDULE OF BENEFITS

DENTAL BENEFITS	DENTAL PROVIDER
- **Plan Year Deductible**	
- Each Covered Person	$50
- Each Family	$150
- Levels Subject to Deductible	2 and 3
- **Maximum Plan Year Benefit**	
- Levels 2 and 3 Combined	
- Each Covered Person	$1,200
- **Maximum Lifetime Benefit**	
- Level 4	
- Each Covered Person	Not covered
- **Dental Benefit Percentage**	
- Level 1	100%
- Level 2	90%
- Level 3	60%
- Level 4	N/A

SECTION 2

DEFINITIONS

This Definition Section contains information as pertains specifically to this Plan.

Masculine pronouns used in the Plan shall include both the masculine and feminine gender unless the context indicates otherwise. Words used in the Plan in the singular or plural shall also be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply. When used in the Plan "you" and "your" refer to the Eligible Employee or Eligible Retiree who elected coverage under the Plan. Where the context permits, such term may refer to any other Covered Person.

ACTIVELY AT WORK
The active expenditure of time and energy in the service of the Employer; except that an Employee will be considered Actively at Work on each day of a regular paid vacation or on a regular non-working day on which he or she is not disabled provided he or she was Actively at Work on the last preceding regular working day.

AMBULATORY SURGICAL CENTER
A specialized institution or facility, either free standing or as part of a Hospital, which:

- Is established, equipped, and operated in accordance with applicable laws of the jurisdiction in which it is located primarily for the purpose of performing surgical procedures;

- Is operated under the supervision of a Physician who devotes full-time to such supervision and permits a surgical procedure to be performed only by a Physician who at the time of the surgical procedure is privileged to perform such procedure in at least one Hospital in the area;

- Requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure;

- Provides the full-time services of one or more graduate nurses for patient care in operating rooms and post anesthesia recovery rooms. Also there shall be one Registered Nurse for each post anesthesia recovery room;

- Maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require Hospital confinement after the surgical procedures; and

- Maintains medical records for each patient; such records shall contain a diagnosis, medical history, operative report, and post-operative report.

An office maintained by a Physician for the practice of medicine or dentistry, or for the purpose of performing terminations of pregnancy, shall not be considered to be an Ambulatory Surgical Center.

AUTHORIZED REPRESENTATIVE
A person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. Minor Dependents must have the signature of a parent or legal guardian in order to appoint a third party as an Authorized Representative. If a Covered Person chooses to use an Authorized Representative, the Covered Person must submit a written letter to the Plan stating the following: The name of the Authorized Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant the Authorized Representative access to the Covered Person's Protected Health Information. This letter must be signed by the Covered Person to be considered official.

BENEFIT PERCENTAGE
That portion of Covered Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. The Benefit Percentage is the basis used to determine any out-of-pocket expenses in excess of the Deductible, which are to be paid by the Participant.

CLAIMS ADMINISTRATOR
An organization contracted by the Plan Administrator to perform certain administrative functions on behalf of the Plan Administrator with respect to the benefits provided under the Plan. Such functions may include the issuance of benefit summaries, basic record keeping and reporting, and the processing of claims. The Claims Administrator for the Plan is indicated on the first page of this Plan.

CLOSE RELATIVE
The Covered Person's spouse, parent, brother, sister, child, mother-in-law, or father-in-law.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CODE
The Internal Revenue Code of 1986, as amended.

CO-INSURANCE
The percentage of Covered Expenses payable by the Covered Person, when the Plan states its coverage on the Schedule of Benefits as a Benefit Percentage (e.g., if the Benefit Percentage payable by the Plan is 90% of a Covered Expense, the Co-Insurance payable by the Covered Person is the remaining 10%).

COLLECTIVE BARGAINING AGREEMENT
Any of the following agreements that cover certain Employees and former Employees of the Employer:

- The agreement by and between the Employer and the Indiana Fraternal Order of Police Labor Council, Inc., effective January 1, 2020, and as may be amended thereafter;

- The agreement by and between the Employer and the Fort Wayne Patrolmen's Benevolent Association, Inc., effective January 1, 2019, and as may be amended thereafter; and

- The agreement by and between the Employer and the Fort Wayne Professional Fire Fighters Union, Local 124, Inc., Professional Fire Fighters Union of Indiana, International Association of Fire Fighters, AFL-CIO, CLC, effective for 2019-2020, and as may be amended thereafter.

CONGENITAL BIRTH DEFECT
A medical condition that existed at birth.

CONVALESCENT NURSING FACILITY
An institution or part thereof constituted and operated pursuant to law which meets all of the following conditions:

- It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Illness or Injury, professional nursing services rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Physician or Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;

- Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;

- 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, mental retardates, custodial or educational care, or care of mental disorders; and

- It is approved as a provider of services under Medicare.

This term shall also apply to an institution which otherwise meets the required conditions, referring to itself as a Skilled Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

CONVALESCENT PERIOD
A period of time commencing with the date of confinement by a Covered Person in a Convalescent Nursing Facility. Such confinement must meet all of the following conditions:

- The confinement must commence within 14 days of the Covered Person's discharge from a Hospital;

- The prior Hospital confinement must have been for a period of not less than three consecutive days; and

- Both the Hospital and convalescent confinements must have been for the care and treatment of the same Illness or Injury.

A Convalescent Period will terminate when the Covered Person has been free of confinement in any and all institutions providing Hospital or nursing care for a period of 90 consecutive days. A new Convalescent Period shall not commence until a previous Convalescent Period has been terminated.

The attending Physician must supply medical records for the Covered Person and certify that the proper treatment of the Illness or Injury would require continued confinement as an Inpatient in a Hospital in the absence of the services and supplies provided in a Convalescent Nursing Facility.

CO-PAYMENT (OR CO-PAY)
A specified dollar amount which the Covered Person is required to pay for certain health services provided under the Plan. The Covered Person is responsible for the payment of any Co-Payment directly to the provider of the health services at the time of service. Co-Payments are excluded from the Out-of-Pocket Maximum Limit and continue to be required for applicable Covered Services after the Out-of-Pocket Maximum Limit is met.

COSMETIC PROCEDURES
Those medical or surgical procedures which are primarily used to improve, alter or enhance physical appearance whether or not for psychological or emotional reasons, but which do not correct or materially improve a physiological function, and regardless of whether Medically Necessary.

COVERED DEPENDENT
A Dependent of a Covered Employee or Covered Retiree (or the surviving Dependent of a deceased Employee or Retiree) who meets the requirements for coverage as specified in the Plan while such Dependent remains properly enrolled for coverage in accordance with the provisions of the Plan.

COVERED EMPLOYEE
An Employee of the Employer meeting the requirements for coverage as specified in the Plan while such Employee remains properly enrolled for coverage in accordance with the provisions of the Plan.

COVERED EXPENSE
The portion of a charge Incurred by a Covered Person for a health or medical treatment, service, or supply that is payable by the Plan, subject to the Deductible and Benefit Percentage in accordance with the terms and conditions of the Plan. In order to be a Covered Expense, the expense must:

- Be Medically Necessary;
- Incurred on the recommendation of a Physician while this Plan is in force for the Covered Person;
- Not in excess of Reasonable and Customary Charges;
- Not excluded under the terms of this Plan; and
- Not in excess of any amounts paid under this Plan.

COVERED PERSON
Any person who has met the eligibility requirements of this Plan as a Participant or as an eligible Dependent of such Participant and whose coverage has become effective.

CUSTODIAL CARE
Health care services or other related services (such as assistance in activities of daily living), which do not seek to cure, or which are provided during periods when the medical condition of the patient is not changing and which does not require continued administration by medical personnel.

DEDUCTIBLE
A specified dollar amount of Covered Expenses not payable under the Plan which must be Incurred by a Covered Person during a Plan Year before any other Covered Expenses Incurred during the Plan Year can be considered for payment according to the applicable Benefit Percentage. The Deductible does not include Co-Payments. All Covered Expenses are subject to the Deductible unless otherwise indicated.

Covered Expenses are payable under the Plan with respect to a Covered Person once he or she has met the Deductible stated in the Schedule of Benefits applicable to "Each Covered Person," regardless of whether the Covered Person is enrolled in single coverage or family coverage.

Covered Expenses are payable under the Plan with respect to all Covered Persons in the same family coverage once the aggregate Covered Expenses of all Covered Persons enrolled in such family coverage has met the Deductible stated in the Schedule of Benefits applicable to "Each Family," regardless of whether any individual within the family coverage has satisfied the Deductible.

DEPENDENT
The Participant's spouse or child. When permitted by the Plan, a Dependent also includes the deceased Participant's surviving spouse or child.

"Spouse" means the legally recognized marital partner of the Participant under federal law. The spouse must be a U.S. citizen or a resident of the U.S.

"Child" means the Participant's natural child, legally adopted child or child placed for adoption, stepchild, or child placed under the legal guardianship of the Participant until the end of the month in which the child turns age 26. A child also includes a child for whom the Participant is required to provide medical care or insurance under the terms of a Qualified Medical Child Support Court Order.

In addition, a child age 26 or older who is incapable of self-sustaining employment because of a long-term physical or mental incapacity will remain a Dependent while the incapacity and inability to be employed continue, provided:

- The child is primarily dependent on the Participant for support;
- Proof of the incapacity is furnished to the Plan Administrator within 31 days after the date coverage would otherwise terminate; and
- Proof of continued incapacity, which may include a medical examination at the Plan's expense, is furnished upon request.

The Plan may request additional proof not more than annually after the two year period following the child's attainment of age 26.

The spouse or child of an Employee who dies while the Employee is an active Employee or Eligible Retiree is eligible to continue Dependent benefits under this Plan pursuant to the terms of Section 3 of the Plan.

DURABLE MEDICAL EQUIPMENT
Medical equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an Injury or Illness, and is appropriate for use in the home.

ELIGIBLE EMPLOYEE
Any "regular full-time employee," which is defined as an Employee who is hired into a position of indefinite duration and who normally works 30 hours or more per week. An Eligible Employee also includes all Employees listed as unclassified in the Salary Ordinance.

The following categories of Employees are not Eligible Employees under the Plan:

1. Regular part-time employees (positions of indefinite duration and less than 30 hours per week).
2. Temporary/seasonal employees (positions of limited duration at full-time or part-time hours for a period of no more than six months in duration).
3. Intern employees (positions for academic credit or educational opportunity, regardless of duration and whether full-time or part-time hours). Intern employees can either be in a paid or unpaid status during their employment.
4. Any person serving as a director of the Employer, unless such person is otherwise eligible for coverage under the Plan as an Eligible Employee.
5. Any person who by written agreement is not eligible for benefits.

Notwithstanding the above, if any Employee is employed in an excluded category, but is determined to work an average of 30 hours or more per week (and is not seasonal), such Employee will be treated as an Eligible Employee consistent with the Employer's policy for offering coverage to its full-time employees under the Patient Protection and Affordable Care Act.

ELIGIBLE RETIREE
Any Retiree who meets one of the following:

- The Retiree terminated employment with the Employer on or after January 1, 1999 as a non-safety Employee (i) with 20 years of Employer service or (ii) under disability with a minimum of

five years of consecutive Employer service. Indiana Public Retirement System ("INPRS") service with other government entities will not be counted for retiree health benefits eligibility; or

- The Retiree is covered by and qualifies for retiree health benefits pursuant to a Collective Bargaining Agreement.

EMERGENCY CARE
Care for a serious medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (not a medical professional) who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

EMPLOYEE
A common law employee of the Employer. An Employee does not include the following individuals:

1. Any individual designated in good faith by the Employer as an independent contractor, regardless of whether the Internal Revenue Service or a court of law later determines such individual to be a common law employee for tax purposes.

2. Any individual who is a nonresident alien and who receives no earned income (within the meaning of Code Section 911(d)(2)) from the Employer which constitutes income from sources within the United States within the meaning of Code Section 861(a)(3).

3. Any self-employed individual described in Code Section 401(c).

EMPLOYER
The City of Fort Wayne.

EXPERIMENTAL OR INVESTIGATIONAL
Any treatment, procedure, facility, equipment, drug, service, or supply that:

- Is not accepted as standard medical treatment for the condition being treated; or

- Requires but has not received federal or other governmental agency approval at the time of service.

The final determination will be made by a medical policy committee of the Employer consistent with the opinion of at least two independent Physicians. Each Physician will be Board Certified in the specialty for the condition being considered and will not be involved in providing (or associated with the Physician who will provide) the proposed medical treatment plan.

FMLA
The Family and Medical Leave Act of 1993, as amended.

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

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

HOME HEALTH CARE AGENCY
A service or agency providing home health care and possessing a valid certificate of approval issued in accordance with Title XVIII of the Social Security Act, that is licensed as such under all applicable local, state and federal laws or regulations.

HOME HEALTH CARE PLAN
A program for care and treatment of a Covered Person that has been established and approved in writing by the Covered Person's attending Physician which states that the proper treatment of the Injury or Illness requires confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided by the Home Health Care Agency.

HOSPICE
A health care program approved by the Plan Administrator providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for a Covered Person suffering from a condition having a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE BENEFIT PERIOD
A specified amount of time during which the Covered Person undergoes treatment under a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal Illness or Injury, and the Covered Person is approved for a Hospice program by the Plan Administrator. The period shall end the earliest of six months from such date or at the death of the Covered Person. Subject to the consent of the Plan Administrator, the period may be extended if the attending Physician certifies that the Covered Person is still terminally ill.

HOSPITAL
An institution which meets all of the following requirements:

- It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
- It is established, licensed, and operated as a hospital in accordance with the laws of the jurisdiction in which it is located;
- It maintains on its premises all the facilities necessary to provide for the diagnosis and the medical and major surgical treatment of an Illness or an Injury;
- Treatment is provided for compensation by or under the supervision of Physicians, with continuous 24 hour nursing services by Registered Nurses;
- It maintains a complete medical record on each person served;
- It is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals (JCAH);
- It is approved as a provider of services under Medicare; and
- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of mental disorders.

ILLNESS
A disorder of the body or mind, a disease, or pregnancy. All Illnesses which are due to the same cause or to a related cause or causes will be deemed to be one Illness.

INCURRED, INCURRED EXPENSE, OR EXPENSES INCURRED
The charge for a medical treatment, service or supply rendered to a Covered Person. Such charge will be considered to have been Incurred on the date the treatment or service was provided or the supply purchased.

INJURY
A bodily condition which results directly from an accident and independently of all other causes. This definition does not include any intentionally self-inflicted injury, unless the direct result of a covered Injury or Illness (such as depression).

INPATIENT
The classification of a Covered Person while such Covered Person remains admitted to a Hospital as a registered bed patient for medical care, and charges are made for Room and Board as a result of such treatment.

INTENSIVE CARE UNIT
A section, ward, or wing within a Hospital which is separated from other facilities and:

- Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
- Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
- Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

MASSAGE AND MANIPULATION TREATMENT
Treatment for the detection or correction of structural imbalance, distortion or subluxation in the human body, by manual or mechanical means, for the purpose of removing nerve interference or the effects thereof.

MEDICALLY NECESSARY/MEDICAL NECESSITY
Health care treatments, services or supplies which are appropriate and consistent with the diagnosis and treatment of a medical condition and which, in accordance with generally accepted medical standards, could not have been omitted or performed by a less expensive procedure or in a less expensive setting or substituted by a less expensive service or supply without adversely affecting the patient's condition or the quality of medical care rendered.

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

MORBID OBESITY
A condition in which the Covered Person has:

- A body mass index (BMI) of 40 or higher (Extreme Obesity); or
- A body mass index (BMI) of 30 or higher and serious weight related health problems, such as diabetes, high blood pressure, or severe sleep apnea.

For either BMI category above, the Covered Person also must have received non-surgical treatment supervised by a Physician that was unsuccessful.

NEWBORN
An infant child from the date of birth until the initial Hospital discharge.

OCCUPATIONAL THERAPY
As distinct from Physical Therapy, training to restore or develop work-related skills.

OPEN ENROLLMENT PERIOD
An annual enrollment period typically held during the fourth quarter during which the Employer permits Eligible Employees to make or change an election for benefits under the Plan for himself and/or his Dependents with respect to the following Plan Year.

ORTHOTIC APPLIANCE
An external device designed specifically for the Covered Person and intended to correct a defective function of the human body.

OUT-OF-POCKET MAXIMUM LIMIT
The amount of out-of-pocket expenses that a Covered Person may Incur after satisfaction of the Deductible and exclusive of Co-Payments, after which the Plan will pay 100% of Covered Expenses for the remainder of the Plan Year, subject to any maximums stated in the Schedule of Benefits. Unless otherwise indicated in the applicable Schedule of Medical Benefits, all Covered Expenses paid by the Covered Person accumulate toward the Out-of-Pocket Maximum Limit.

OUTPATIENT
The classification of a Covered Person while such Covered Person is receiving medical care, treatment, services or supplies at home, in an Emergency Room, Urgent Care Facility, Ambulatory Surgical Center, Physician's office, Outpatient Psychiatric Facility, Outpatient Alcoholism Treatment Facility or a Hospital if not admitted as an Inpatient.

OUTPATIENT ALCOHOLISM TREATMENT FACILITY
An institution which:

- Provides a program for the diagnosis, evaluation, and effective treatment of alcoholism;
- Provides detoxification services needed with such treatment program;
- Provides infirmary-level medical services or arranges with a Hospital in the area for any other medical services that may he required;
- Is at all times supervised by a staff of Physicians;
- Provides at all times skilled nursing care by Licensed Practical Nurses or Registered Nurses who are directed by a full-time Registered Nurse;
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs;
- Maintains a complete medical record on each person served; and
- Meets all required licensing standards.

OUTPATIENT PSYCHIATRIC FACILITY
An administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PARTICIPANT
An Eligible Employee or Eligible Retiree who is covered by this Plan.

PHYSICAL THERAPY
As distinct from Occupational Therapy, training required to restore independence in performing activities of daily living such as dressing oneself, eating, writing or walking.

PHYSICIAN
Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), or a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified nurse anesthetist (CNRA). The term Physician may also include, at the Plan Administrator's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

PLAN
The City of Fort Wayne Employee Benefit Plan, as described herein.

PLAN ADMINISTRATOR
The Employer.

PLAN YEAR
The 12 month period commencing each January 1 and ending December 31.

PPO PROVIDER
A Physician or facility who, at the time of providing or authorizing services to the Covered Person has entered into a contract (or on whose behalf a contract has been entered into) with the Plan to accept Plan negotiated reimbursement for professional services provided to Covered Persons.

PREFERRED PROVIDER ORGANIZATION (PPO)
The network which the Plan Administrator has designated to provide medical services at contracted fees for the Covered Person.

PSYCHIATRIC CARE OR PSYCHOANALYTIC CARE
Diagnostic measures or treatment for a mental illness or disorder, a nervous disorder, alcoholism, or drug abuse.

PSYCHOLOGIST
An individual holding the degree of Ph.D. in the science of the mind and behavior and who is acting within the scope of his license to treat an Illness or Injury.

REASONABLE AND CUSTOMARY
That portion of a charge, as determined by the Plan Administrator, made by a Physician or other provider of services, supplies, medications, or equipment which does not exceed the lesser of:

- The general level of charges made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or

- The level of negotiated charges acceptable to the Preferred Provider Organization (PPO) as full payment in the geographical area covered by the PPO Providers.

RECONSTRUCTIVE SURGERY
Surgical procedures performed on abnormal structures of the body when a physical impairment exists due to Illness or Injury and surgery is expected to restore or improve function.

REGISTERED NURSE
An individual, who has received specialized nursing training, is authorized to use the designation "R.N.," and who is duly licensed under all applicable local, state and federal laws and regulations.

RETIREE
An Employee who, after meeting the qualifications of age and years of service, begins receiving pension benefits under any one of the Employer's pension plans.

ROOM AND BOARD
The Expenses Incurred by an Inpatient which are made by a Hospital as a condition of occupancy. Such charges include normal nursing services provided to Inpatients not in an Intensive Care Unit but does not include the professional services of Physicians.

ROUTINE NURSERY CARE
Medical treatment, services or supplies rendered to a Newborn solely for the purposes of health maintenance and not for the treatment of an illness or Injury, but shall not include circumcision.

ROUTINE WELL-BABY CARE
Medical treatment, services or supplies rendered to a child, other than a Newborn, solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

SEMI-PRIVATE
A class of accommodations in a Hospital in which two patients' beds are available per room

SPECIAL ENROLLMENT PERIOD
A period during which an Eligible Employee who declined coverage under the Plan for himself and/or his Dependents when first eligible becomes eligible to enroll for coverage under the Plan in advance of the next Open Enrollment Period.

URGENT CARE CENTER
A free-standing facility, by whatever actual name it may be called, which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A Physician, a Registered Nurse, and a Registered X-ray Technician must be in attendance at all times that the clinic is open. An Urgent Care Center does not include an Emergency Room.

WAITING PERIOD
For periods prior to January 1, 2021, the Waiting Period for all Employees who are not Division Heads is the first 30 days of employment as an Eligible Employee, and no Waiting Period applies to Employees who are Division Heads. Effective January 1, 2021, the Waiting Period for all Employees is the first 30 days of employment as an Eligible Employee.

SECTION 3
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY OF COVERAGE
Coverage provided under the Plan for Eligible Employees, Eligible Retirees, and their Dependents will be in accordance with the Eligibility, Effective Date, and Termination provisions stated in this Section. The terms governing participation by active Employees and their Dependents are outlined first. The terms governing participation by Eligible Retirees and their Dependents (including the terms applicable to surviving Dependents) are outlined second.

ACTIVE EMPLOYEE AND DEPENDENT COVERAGE

EMPLOYEE ELIGIBILITY
An Employee who satisfies the definition of an Eligible Employee is eligible for coverage on the 1st day following the date that he or she has met the Waiting Period.

DEPENDENT ELIGIBILITY
Dependents are eligible on the later of the date of the Employee's eligibility or the date the Dependent becomes eligible under this Plan. If both spouses are eligible for coverage as Employees:

- One spouse may enroll as an Employee and the other may be enrolled as the Dependent of the Employee; or
- Both spouses may enroll as Employees; and
- Their children may be covered as Dependents under either Participant's coverage, but not both.

The following special rules apply to Dependent coverage of children:

- A Newborn child of a covered Employee will be covered from the moment of birth for Injury or Illness, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent of the Employee within 30 days of the child's date of birth. This provision will not apply, nor in any way affect, the normal maternity provisions applicable to the mother.

- If a child is acquired, other than at the time of his or her birth, due to a court order, decree, or marriage, that child will be considered a Dependent from the date of such court order, decree, or marriage, provided that the child is properly enrolled as a Dependent of the Employee within 30 days of the court order, decree of marriage.

- A child under a Qualified Medical Child Support Order (QMCSO) will be covered as a Dependent pursuant to the terms of QMCSO, provided the child otherwise qualifies for Dependent coverage. A QMCSO is defined as a medical support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or beneficiary is eligible under the Plan. A child who is identified in such an order is designated an "alternate recipient" and has the same status and rights as any other child covered under the Plan. Alternate recipient is defined as any child of a Participant who is recognized under a medical child support order as having a right to be enrolled under the Plan. The Plan Administrator must perform the following duties in conjunction with the QMCSO:

  1. Notify the Participant and alternate recipient(s) that an order has been received.

2. Inform the Participant and alternate recipient(s) of the Plan's procedures used in determining if the order is qualified as a QMCSO. Such procedures must be in writing and provide for prompt notification of all interested parties, including the Claims Administrator.

3. Determine, within a reasonable amount of time (or within the time limit set forth in a national medical support notice), if the order is a QMCSO and notify all interested parties, including the Claims Administrator.

The following special rules apply to Dependent coverage of spouses:

- A spouse of a covered Employee will be considered a Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent of the Employee within 30 days of the date of marriage.

- If a spouse is eligible to enroll in his or her own employer's group health plan, the spouse must enroll in such coverage (for at least "employee-only" coverage) in order to be eligible under this Plan, in which case this Plan's coverage is secondary to the spouse's coverage under the other employer's plan. Notwithstanding the preceding sentence, a spouse is eligible for primary coverage in this Plan if one of the following circumstances apply:

  1. Both the Employee and the spouse work for the Employer;

  2. The spouse is not currently employed;

  3. The spouse is employed but either: (i) the spouse is not eligible for health coverage through his or her employer because the employer does not sponsor a health plan or because the spouse works in a non-benefits-eligible position or (ii) the employer does not pay at least 50% of the employee-only premium;

  4. The spouse is self-employed and is not eligible for group health coverage through such employment;

  5. The spouse is retired and is not covered as a retiree under any employer-sponsored health plan; or

  6. The spouse is retired and eligible for Medicare.

SPECIAL ENROLLMENT PERIOD

An Employee is entitled to a Special Enrollment Period of 30 days that begins on the following dates:

- If the Employee declined coverage under the Plan for the Employee or a Dependent because the Employee and/or Dependent had coverage under another group health plan, the date such coverage under the other plan terminated as a result of the loss of eligibility for coverage under the plan when COBRA continuation coverage is not elected, or the expiration of COBRA continuation coverage.

  A Special Enrollment Period also begins when the Employee or Dependent becomes responsible for paying the full premium for the other coverage, where the premium was subsidized by an employer or other party. However a Special Enrollment Period does not begin when coverage

terminated as a result of non-payment of a required premium by or on behalf of a person or termination of COBRA coverage except at the end of the person's eligibility.

- The date the Employee acquires a Dependent as the result of marriage, birth, adoption or placement of a child in the home of the Employee prior to adoption of the child by the Employee.

- The date the Employee or an Employee's dependent has lost eligibility under Medicaid or the Children's Health Insurance Program (CHIP) or becomes eligible for a Medicaid or CHIP premium subsidy. In this circumstance only, the 30 day period is extended to 60 days.

- The date stipulated by a Qualified Medical Child Support Order (QMCSO), including a National Medical Support Notice (NMSN). A copy of the Plan Procedures for a QMCSO may be obtained from the Plan Administrator upon request or receipt of a Medical Support Order.

During a Special Enrollment Period, the Employee may enroll himself for coverage under the Plan. Subject to coverage of the Employee under the Plan, the Covered Employee may also enroll any Dependent of the Employee under the Plan.

OPEN ENROLLMENT PERIOD

The Employer provides an Open Enrollment Period each year to allow Eligible Employees to make or change their coverage elections for the following Plan Year. Coverage elections made during an Open Enrollment Period are effective on the following January 1.

EFFECTIVE DATES OF EMPLOYEE COVERAGE

Coverage under the Plan for an Employee will become effective on the date determined in accordance with the following:

- If the Employee is not required to make a contribution for his or her coverage, coverage will automatically become effective on the date of eligibility.

- If the Employee is required to make a contribution for his or her coverage and the Employee has enrolled within 30 calendar days after the date of eligibility, coverage will become effective on the date of eligibility.

- If the Employee is required to make a contribution for coverage and the Employee fails to enroll within 30 calendar days after the date the Employee first became eligible, coverage will become effective at the beginning of the first Plan Year if the Employee properly enrolls during the Open Enrollment Period, unless the Employee is entitled to a Special Enrollment Period.

- If the Employee properly enrolls in coverage during a Special Enrollment Period, coverage will become effective on the first day of the Special Enrollment Period.

An Employee's coverage under the Plan will commence at 12:01 a.m. Standard Time on the date such coverage is to be effective.

To the extent permitted by HIPAA, if an Employee is not Actively At Work on the date coverage would otherwise be effective, coverage will begin on the day he or she returns to active work status.

EFFECTIVE DATES OF DEPENDENT COVERAGE

Coverage under the Plan will become effective with respect to a Dependent of an Employee on the date determined in accordance with the following:

- If the Employee is not required to make a contribution for coverage of the Dependent, the coverage will automatically become effective on the date of eligibility of the Dependent.

- If the Employee is required to make a contribution for coverage of the Dependent and the Employee has enrolled the Dependent within 30 calendar days after the date of eligibility of the Dependent, coverage for the Dependent will become effective on the date of eligibility of the Dependent.

- If the Employee is required to make a contribution for coverage of the Dependent and the Employee fails to enroll the Dependent within 30 calendar days after the date of eligibility of the Dependent, coverage will become effective at the beginning of the first Plan Year if the Employee properly enrolls the Dependent (and the Employee, if not already enrolled) during the Open Enrollment Period, unless the Employee or Dependent is entitled to a Special Enrollment Period.

- If the Employee properly enrolls his or her Dependent in coverage during a Special Enrollment Period, coverage for the Dependent (and the Employee, if not already enrolled) will become effective on the first day of the Special Enrollment Period.

A Dependent's coverage under the Plan will commence at 12:01 a.m. Standard Time on the date such coverage is to be effective.

If Dependent Coverage is effective retroactively, all terms, conditions and limitations of the Plan are applicable and must be complied with at the time a charge is Incurred.

TERMINATION OF EMPLOYEE COVERAGE
Coverage under this Plan for an Employee will end on the earliest of:

- The last day of the month in which the Employee ceases to be an Eligible Employee. However, Employee coverage will not terminate in the following circumstances:

    - During an FMLA approved leave of absence, provided that coverage under this provision shall run concurrently with any extended coverage in the following two paragraphs;

    - During a period not to exceed three months from the last day of the month in which the Employee ceases to be an Eligible Employee, when the Employee continues to receive compensation; or

    - During a period not to exceed one month from the last day of the month in which the Employee ceases to be an Eligible Employee, when the Employee does not receive compensation.

  Notwithstanding the above, an Employee may continue to be eligible for coverage under the Plan pursuant to the Plan's retiree provisions or continuation coverage under COBRA or USERRA.

- The date the Employee fails to make any required contribution for coverage.

- The date the Plan is terminated, or with respect to any particular benefit, the date of termination of such benefit.

- The date the Employee dies.

TERMINATION OF DEPENDENT COVERAGE
Coverage under this Plan for a Dependent of an Eligible Employee will end on the earliest of:

- The last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan.

- The date on which coverage for the Employee is terminated.

- The date the Employee fails to make any required contribution for coverage with respect to the Dependent.

- The date the Plan is terminated, or with respect to any particular benefit, the date of termination of such benefit.

- The date the Employee dies.

Notwithstanding the above, a Dependent may continue to be eligible for coverage under the Plan pursuant to the Plan's retiree provisions or continuation coverage under COBRA or USERRA.

A Dependent's coverage will also end on the date the Covered Person has voluntarily cancelled coverage with respect to the Dependent, although he or she may still be an eligible Dependent, for example, in connection with an Open Enrollment Period.

REINSTATEMENT AFTER TERMINATION OF COVERAGE

An Employee who terminates coverage under the Plan as a result of a loss of eligibility may be reinstated in coverage upon once again becoming an Eligible Employee. Except as provided in this section, an Employee's reinstatement of coverage will be subject to the applicable Waiting Period, and the Employee must make written request for coverage within 30 days after the date he or she again becomes an Eligible Employee.

An Employee whose coverage under the Plan was terminated as the result of a reduction of hours, a layoff, or an unpaid leave of absence that does not qualify under the FMLA will be eligible for automatic reinstatement of coverage under the Plan upon once again becoming an Eligible Employee, and will not be subject to a Waiting Period, provided the Employee timely elects and pays the premium for COBRA coverage for himself or herself and any Dependents who have coverage in effect on the termination date and through the reinstatement date. The reinstated coverage will be identical to the coverage in effect on the date of termination. The effective date of the reinstated coverage will be 12:01 a.m. on the date of Employee again becomes an Eligible Employee.

No benefits will be paid for charges Incurred after the date of termination of coverage and before the effective date of the reinstated coverage (unless COBRA was properly elected).

Covered Expenses Incurred prior to the termination of coverage which were applied toward the Deductible or any limit and any benefits which were accumulated toward a maximum, will be carried forward to the effective date of reinstated coverage occurring in the same Plan Year.

ELIGIBLE RETIREE AND DEPENDENT/SURVIVOR COVERAGE

RETIREE ELIGIBILITY AND EFFECTIVE DATE

A Retiree who satisfies the definition of an Eligible Retiree is eligible for coverage on the 1st day of retirement. Coverage is effective as of the 1st day of retirement, provided the Eligible Retiree makes an election for retiree coverage within 30 days of retirement.

Notwithstanding, if an Eligible Retiree continues his or her career with another employer and is covered under the other employer's health coverage, the Retiree may decline coverage under this Plan and re-enroll in coverage under this Plan within 30 days of the loss of coverage under the other plan when that employment ends. In this circumstance, the Retiree must return to the medical plan option in which he or she was previously enrolled or, if no longer available, the option that most resembles that option.

A Retiree who is enrolled in his or her spouse's employer health plan as a dependent may continue coverage under this Plan as secondary coverage. Under this arrangement, the costs not covered by the

spouse's plan may be paid from this Plan in accordance with the Coordination of Benefits provision of this Plan.

An Eligible Retiree's coverage under the Plan will commence at 12:01 a.m. Standard Time on the date such coverage is to be effective.

DEPENDENT ELIGIBILITY AND EFFECTIVE DATE

An Eligible Retiree may cover any Dependent who is an eligible Dependent as defined in the Plan at the time of retirement. Coverage is effective at the same time as it becomes effective for the Eligible Retiree. No other individuals may be covered as Dependents at any later time. For purposes of retiree coverage under this Plan, the spouse coordination provisions for working spouses of active Employees do not apply. Therefore, a spouse of an Eligible Retiree may receive coverage under this Plan as primary coverage, even if the spouse is eligible for other employer-sponsored coverage.

A Dependent's coverage under the Plan will commence at 12:01 a.m. Standard Time on the date such coverage is to be effective.

SURVIVOR ELIGIBILITY

Upon the death of an Eligible Retiree or an active Employee, coverage will remain in effect for Dependents under the Plan as follows:

- Upon the death of an active Covered Employee:
    - If the Covered Employee's coverage is governed by a Collective Bargaining Agreement, his or her Covered Dependents are eligible for survivor coverage under this Plan pursuant to the terms of the applicable Collective Bargaining Agreement.
    - If the Covered Employee's coverage is not governed by a Collective Bargaining Agreement, his or her Covered Dependents are eligible for continuation coverage under the COBRA provisions of this Plan.
- Upon the death of an Eligible Retiree:
    - If the Eligible Retiree's coverage is governed by a Collective Bargaining Agreement, his or her Covered Dependents are eligible for survivor coverage under this Plan pursuant to the terms of the applicable Collective Bargaining Agreement.
    - If an Eligible Retiree's coverage is not governed by a Collective Bargaining Agreement, his or her surviving spouse and surviving children may continue coverage under this Plan until the spouse is eligible for Medicare. In the event the Eligible Retiree does not have a surviving spouse or such spouse is (or becomes) eligible for Medicare, the Eligible Employee's surviving children are eligible for continuation coverage under the COBRA provisions of this Plan.

TERMS OF RETIREE COVERAGE

The coverage provided under this Plan to Eligible Retirees and their Dependents (as well as surviving Dependents) will be the same coverage that applies to active Employees, subject to the following:

- The cost of coverage shall be determined by the terms of the applicable Collective Bargaining Agreement. If an Eligible Retiree's coverage is not governed by a Collective Bargaining Agreement, the cost of coverage shall be the same rate paid by Covered Employees.
- The cost of coverage must be paid on an after-tax basis. To the extent applicable, Eligible Retirees will receive a monthly invoice that must be paid timely to maintain coverage.

- An Eligible Retiree may not enroll new Dependents (although an Eligible Retiree may elect to terminate coverage for existing Dependents at any time).

- If the medical plan option in which the Eligible Retiree is enrolled becomes unavailable, the Eligible Retiree may enroll in the Plan option that most resembles the previous option in effect.

TERMINATION OF RETIREE COVERAGE
Coverage under this Plan for an Eligible Retiree will end on the earliest of:

- The date on which the Eligible Retiree is eligible for Medicare (except in cases where the Plan is required to pay primary to Medicare).

- The date the Eligible Retiree fails to make any required contribution for coverage.

- The date the Plan is terminated, or with respect to any particular benefit, the date of termination of such benefit.

- The date the Eligible Retiree dies.

TERMINATION OF DEPENDENT COVERAGE
Coverage under this Plan for a Dependent of an Eligible Retiree will end on the earliest of:

- The day on which the Dependent is eligible for Medicare (except in cases where the Plan is required to pay primary to Medicare).

- The last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan.

- The date on which coverage for the Eligible Retiree is terminated, except that Dependent coverage may continue if coverage terminates for the Eligible Retiree as a result of Medicare eligibility.

- The date the Eligible Retiree fails to make any required contribution for coverage with respect to the Dependent.

- The date the Plan is terminated, or with respect to any particular benefit, the date of termination of such benefit.

- The date the Eligible Retiree dies, except that Dependent coverage may continue for those Dependents who are eligible for survivor coverage under the Plan.

A Dependent's coverage will also end on the date the Covered Person has voluntarily cancelled coverage with respect to the Dependent, although he or she may still be an eligible Dependent.

COORDINATION OF RETIREE COVERAGE WITH COBRA CONTINUATION PROVISIONS
Coverage under the Plan for Eligible Retirees and their Dependents will coordinate with COBRA continuation coverage as follows:

- Upon retirement, each Eligible Retiree and his or her Covered Dependents will have an opportunity to elect COBRA continuation coverage for a period of up to eighteen (18) months pursuant to Section 11 of the Plan in lieu of retiree coverage under this Plan. An election to continue coverage under this Plan will be deemed to have waived COBRA continuation coverage that would otherwise be available in connection with the Eligible Retiree's retirement.

- Upon the death of an active Covered Employee or Eligible Retiree, each Covered Dependent will have an opportunity to elect COBRA continuation coverage for a period of up to thirty-six (36) months pursuant to Section 11 of the Plan in lieu of survivor coverage under this Plan. An election to continue coverage under this Plan (if eligible) will be deemed to have waived COBRA continuation coverage that would otherwise be available in connection with the Covered Employee's or Eligible Retiree's death.

- A Covered Dependent who ceases to be an eligible Dependent (e.g., the divorce of a spouse or a child attaining age 26) while on retiree or survivor coverage will be eligible to elect COBRA continuation coverage for a period of up to thirty-six (36) months pursuant to Section 11 of the Plan at such termination of coverage.

- A loss of coverage due to a spouse becoming entitled to Medicare is not a COBRA qualifying event and does not give rise to a COBRA election. However, if the spouse's Medicare entitlement occurs within the 36-month period following the Employee's death or the Retiree's death or entitlement to Medicare, any Dependent children who lose coverage due to the spouse's Medicare entitlement will be eligible to elect COBRA continuation coverage for the remainder of the 36-month period measured from the Employee's or Retiree's loss of coverage.

SECTION 4
MAJOR MEDICAL EXPENSE BENEFITS

BENEFITS ARE SUBJECT TO ANY DEDUCTIBLE, CO-INSURANCE, AND CO-PAYMENT AS SHOWN IN THE SCHEDULE OF BENEFITS

DEDUCTIBLE

Benefits will be paid if the Covered Person Incurs Covered Expenses as a result of Injury or Illness. Most charges are subject to the Plan Year Deductible. Co-Payments do not apply toward the Deductible.

When the Family Deductible is met, as shown in the Schedule of Benefits, no further Plan Year Deductible amount will be required for any member of that family unit during that Plan Year. Under the $1,200 Deductible Traditional EPO Plan only, Covered Expenses Incurred in the last three months of the Plan Year which are used to satisfy the Deductible will also be applied to the Deductible for the subsequent Plan Year. However, the maximum amount of Covered Expenses used to satisfy Deductibles for all Covered Persons in a family during a Plan Year will not exceed the Deductible Per Family shown on the Schedule of Benefits.

CO-PAYMENT

Certain expenses may be subject to a Co-Payment instead of a Deductible. Co-Payments do not apply toward the Plan's Out-of-Pocket Maximum Limit.

CO-INSURANCE & OUT-OF-POCKET MAXIMUM LIMIT

The Plan will pay benefits at the Benefit Percentage shown in the Schedule of Benefits. The remaining amount due is the Co-Insurance. Once a Covered Person or family unit satisfies the Deductible and Out-of-Pocket Maximum Limit in a Plan Year, the Plan will pay 100% of Covered Expenses for the remainder of the Plan Year, and no further Co-Insurance will be due. However, Covered Expenses will continue to be subject to applicable Co-Payments and any maximums stated in the Schedule of Benefits. The Out-of-Pocket Maximum Limit does not apply to:

1. Co-Payments;

2. Deductibles (Deductibles must be met before Co-Insurance is applied, which applies until the Out-of-Pocket Maximum Limit is met);

3. Penalties imposed as a result of a Covered Person's failure to follow pre-certification requirements; and

4. Non-Covered Services.

PPO PROVIDERS

Selected providers of medical treatments, services and supplies may be identified on the Schedule of Benefits as PPO Providers. The Benefit Percentages and Deductibles shown on the Schedule of Benefits are applicable independently to Covered Expenses for treatments, services and supplies provided by PPO Providers, if any, compared to Covered Expenses for treatments, services and supplies delivered by providers who are non-PPO Providers. However, out-of-pocket expenses paid to non-PPO Providers will accumulate toward the Deductible and Out-of-Pocket Maximums applicable to PPO Providers, and vice versa.

SECTION 5
COVERED MEDICAL EXPENSES

COVERED MEDICAL EXPENSES
In order to be covered under the Plan, charges must be:

- Incurred by a Covered Person while coverage under the Plan is in effect with respect to the Covered Person;
- Medically Necessary for the diagnosis or treatment of an Illness or injury;
- Administered or ordered by a Physician;
- Not excluded or in excess of a limit indicated on the Schedule of Benefits or otherwise stipulated under the Plan; and
- Not in excess of the Reasonable and Customary charge for the treatment, service or supply.

Covered Expenses are subject to any exclusion or limitation under the Plan. An expense will not be covered under more than one provision of the Plan.

COVERED EXPENSES INCLUDE THE FOLLOWING:

A. Charges made by a Hospital for:

1. Room and Board or confinement in an Intensive Care Unit; however, charges for Routine Nursery Care for a healthy Newborn Dependent child will not be covered except to the extent, if any, such is indicated on the Schedule of Benefits. Charges made by a Hospital having only private rooms will be considered a Covered Expense in an amount equal to the amount indicated by the Hospital as their most common Semi-Private rate; or if such rate is not available, the Covered Expense is equal to 90% of the Hospital's lowest private room rate.

2. Necessary services and supplies other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use, physical therapy treatments, hemodialysis, and X-ray and linear therapy; however, charges incurred for such miscellaneous services and supplies by a healthy Newborn Dependent child will not be covered except to the extent, if any, such is indicated on the Schedule of Benefits.

B. Charges made by a Convalescent Nursing Facility under a program of care approved by the Plan Administrator for the following services and supplies furnished by the Convalescent Nursing Facility during any one Convalescent Period. Only charges incurred in connection with convalescence from the Illness or Injury for which the Covered Person is confined will be eligible for benefits. These expenses include:

1. Room and board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily room and board charge allowed equal to the amount indicated by the Hospital as their most common Semi-Private rate; or if such rates is not available, the Covered Expense is equal to 90% of the Hospital's lowest private room rate.

2. Medical services customarily provided by the Convalescent Nursing Facility, with the exception of private duty or special nursing services and Physician's fees;

3. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.

C. Charges made under a Hospice program approved by the Plan Administrator for:

1. Nursing care by a Registered Nurse, a Licensed Practical Nurse, a vocational nurse or a public health nurse who is under the direct supervision of a Registered Nurse;

2. Physical therapy and speech therapy when rendered by a licensed therapist;

3. Medical supplies, including drugs and biologicals and the use of medical appliances;

4. Physician's services;

5. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

D. Charges for the services of a legally qualified Physician for medical care and/or surgical treatments including office and home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care, and surgical opinion consultations. However, fees for Massage and Manipulation Treatments shall be limited as indicated on the Schedule of Benefits.

E. Fees of a Registered Nurse or Licensed Practical Nurse for private duty nursing.

F. Charges for treatment or services rendered by a licensed physical therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

G. Fees of a legally qualified Physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Illness or Injury, other than a functional disorder, or due to surgery performed on account of an Illness or Injury. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

H. Charges for professional ground ambulance service to the nearest Hospital where care or treatment can be provided. If the Hospital lacks resources to provide needed care or treatment, Covered Expenses will include charges for one subsequent professional ground service to the nearest Hospital where such resources are available. Except as indicated on the Schedule of Benefits, charges for air ambulance services are not Covered.

I. Charges for drugs that can only be obtained by written prescription from a licensed Physician. When the prescription drug is available through a prescription drug purchasing program, the charge is a Covered Expense only when obtained through such program.

J. Charges for X-rays, microscopic tests, and laboratory tests.

K. Charges for chemotherapy or radiation therapy or treatment.

L. Charges for Cosmetic Procedures and Reconstructive Surgery when such surgery resulted from:

1. An Injury;

2. A Congenital Birth Defect; or

3. Surgical removal of breast tissue as a result of Illness.

If a Covered Person is receiving benefits under the Plan as a result of a mastectomy and elects breast Reconstructive Surgery, charges for the following procedures will be considered Covered Expenses:

1. Reconstruction of the breast after mastectomy;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications at all stages of the mastectomy and reconstruction, including lymphedemas.

M. Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.

N. Charges for oxygen and other gases and their administration.

O. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

P. Charges for the cost and administration of an anesthetic.

Q. Charges for dressings, sutures, casts, splints, trusses, crutches, braces, or other necessary medical supplies, with the exception of dental braces or corrective shoes.

R. Subject to the prior written approval by the Plan Administrator, charges for the rental of a wheelchair, hospital bed or other Durable Medical Equipment required for temporary therapeutic use or, at the option of the Plan Administrator, the purchase of such equipment.

S. Charges for an initial artificial limb, eye or larynx, or the initial Orthotic Appliance. The charge for the repair or replacement of an artificial limb will be considered a Covered Expense when:

1. The expense for the repair or replacement of the artificial limb was incurred as a result of the maturation of a Dependent child; or

2. The expense for the repair or replacement of the artificial limb was incurred by a Covered Person at least five years after the last Covered Expense under the Plan for the artificial limb.

T. Charges for voluntary sterilization.

U. Charges made by an Ambulatory Surgical Center or Minor Emergency Medical Clinic if treatment has been rendered.

V. Charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan approved by the Plan Administrator. Such expenses include:

1. Part-lime or Intermittent nursing care by a Registered Nurse or by a Licensed Practical Nurse, a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

2. Home health aides; and

3. Medical supplies, drugs, and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital but only to the extent that they would have been covered under the Plan if the Covered Person had remained in the Hospital.

Specifically excluded from coverage under the Home Health Care Plan are the following:

1. Services and supplies not included in the Home Health Care Plan;
4. Services of a person who ordinarily resides in the home of the Covered Person, or is a Close Relative of the Covered Person;
5. Transportation services; and
6. Meals.

W. Maternity Expense Benefits as follows:

1. If birth of a Newborn occurs while coverage of the Covered Person is in effect, benefits for charges incurred by the Covered Person as a result of the pregnancy will be paid under Major Medical Expense Benefits the same as for an Illness.

2. No Maternity Expense Benefits will be paid for Expenses Incurred by a Covered Person if the delivery of the Newborn occurs after her coverage has terminated.

X. Charges for COVID-19 diagnostic testing and related items and services, as follows:

Covered Diagnostic Tests

1. FDA-approved in vitro diagnostic products for the diagnosis of COVID-19;

2. Tests where the developer has requested (or intends to request) emergency use authorization under the Food, Drug, and Cosmetic Act;

3. Tests that are developed in and authorized by a state that has notified the Department of Health and Human Services (HHS) of its intention to review tests to diagnose COVID-19;

4. Serological tests that are used to detect antibodies against the virus causing COVID-19, and which are intended for use in diagnosis of the disease or of having a current or past infection; and

5. Other tests that the Department of HHS approves through guidance.

Related Items and Services

6. The office visit (including by telehealth), urgent care center visit, and emergency room visit to evaluate the individual to determine the need for a diagnostic test;

7. The furnishing or administration of certain tests (such as an influenza test or a blood test) that the provider determines should be performed to determine if diagnostic testing for COVID-19 is necessary; and

8. The furnishing or administration of the diagnostic test for COVID-19 (whether provided in traditional or non-traditional care settings, including drive-through screening and testing locations).

For those expenses outlined above that are incurred on or after March 18, 2020, and for the duration of the public health emergency as declared by the Secretary of HHS, the Plan will provide full coverage to Covered Persons, and will not impose any cost-sharing requirements,

prior authorization requirements, or other medical management requirements, whether provided by PPO Providers or out-of-network providers.

ADDITIONAL REQUIREMENTS RELATED TO COVERAGE

SECOND SURGICAL OPINION

If a Physician recommends that a Covered Person have a surgical operation, the Covered Person may be required to obtain a second surgical opinion under the Hospital Admissions and Pregnancy Pre-Certification provision (see below) or may at his discretion seek a second surgical opinion from another Physician. The Physician rendering the second opinion must be qualified to render such a service, either through conference, specialist training, education or similar criteria and must not be affiliated in any way with the other Physician. The cost of the second surgical opinion will be paid as shown on the Schedule of Benefits.

WEEKEND HOSPITAL ADMISSIONS

Charges for Room and Board Incurred in connection with a Hospital admittance of a Covered Person from 8:00 a.m. Friday to 12:00 p.m. Sunday are usually not Covered Expenses. They will be Covered Expenses only when the attending Physician states in writing that such admittance was an emergency Hospital admittance and was Medically Necessary.

PREGNANCY AND HOSPITAL ADMISSIONS PRE-CERTIFICATION

Pregnancy and Hospital Admissions Pre-Certification is a program designed to help insure that Covered Persons receive only Medically Necessary care. Information concerning each pregnancy and each emergency or non-emergency Hospital admission of a Covered Person must be provided to the Hospital Pre-Certification Organization shown on the Schedule of Benefits. However, pre-certification of the care as Medically Necessary does not guarantee benefits will be paid. Expenses associated with a pre-certified Hospital confinement will be considered under Major Medical Expense Benefits subject to other Plan conditions, exclusions and limitations.

The following procedures, to the extent deemed appropriate by the Hospital Pre-Certification Organization, will be used to avoid unnecessary Hospital admissions and to control Expenses Incurred by the Covered Person while an Inpatient.

A. Hospital Admission and Pregnancy Review. The Hospital Pre-Certification Organization must be notified, by or on behalf of the Covered Person within the following periods.

1. Pregnancy - within 30 days following the diagnosis of a pregnancy and again within 24 hours after delivery of a Newborn. If the mother is not a Covered Person but the Newborn is eligible to be covered, the Hospital Pre-Certification Organization must be notified within 24 hours after delivery of the Newborn.

2. Emergency Hospitalization – within 48 hours following the hospital admission.

3. Non-emergency Hospitalization - at least five business days before the hospitalization.

The Hospital confinement shall be confirmed by the Hospital Pre-Certification Organization after the Physician treating the Covered Person has established to the satisfaction of the Hospital Pre-Certification Organization that such confinement is Medically Necessary.

B. Second Surgical Opinion. Prior to the performance of a non-emergency surgical procedure while the Covered Person is an Inpatient, a second surgical opinion may be required by the Hospital Pre-Certification Organization to verify such procedure is Medically Necessary. If the second surgical opinion does not confirm the medical necessity of the surgery, a third surgical opinion may be required by the Hospital Pre-Certification Organization.

If the second surgical opinion confirms the medical necessity of the surgery, or if such second

surgical opinion does not confirm, but a third surgical opinion does, the expense of such surgery will be considered under the Major Medical Expense Benefits provision of the Plan, subject to all conditions, exclusions and limitations of the Plan.

The Physicians rendering the second and third surgical opinions must be approved by the Hospital Pre-Certification Organization as qualified to render such a service, either through conference, specialist training or education, or similar criteria, and must not be affiliated in any way with each other or the Physician who will perform the actual surgery.

If the surgery is Medically Necessary on an emergency basis, a second or third surgical opinion is not required. The cost of providing the second or third surgical opinions under this Hospital Admissions Pre-Certification provision shall be considered an expense of the Plan and not an expense payable in any part by the Covered Person.

C. Ongoing Hospitalization. During a hospitalization, the Hospital Pre-Certification Organization will contact the attending Physician and/or facility to help ensure that the Covered Person receives Medically Necessary care and treatment.

D. Hospital Discharge Planning. The Hospital Pre-Certification Organization shall consult with the Physician treating the Covered Person to coordinate the timely discharge of the Covered Person or movement to other facilities providing appropriate levels of care.

E. Large Case Management. The Hospital Pre-Certification Organization may refer a Covered Person who is identified as having a major illness or injury, chronic disease, or other condition which can be expected to result in high costs to Large Case Management (LCM). LCM works intensively with the Covered Person, their family members and Physicians, to coordinate quality health care.

The cost of providing the services of the Hospital Pre-Certification Organization and Large Case Management under this Hospital Admissions Pre-Certification provision shall be considered an expense of the Plan and not an expense payable in any part by the Covered Person.

Benefits for the Hospital confinement will be reduced as indicated on the Schedule of Benefits if the Hospital admission of the Covered Person is not reported to the Hospital Pre-Certification Organization in accordance with the written procedures and guidelines provided by the Plan Administrator to the Covered Employee. Benefits will also be reduced or denied as follows:

- No benefits will be paid for treatments, services or supplies that cannot be confirmed as Medically Necessary;
- No benefits will be paid for charges Incurred while a Hospital Inpatient beyond the time established as Medically Necessary by the Hospital Pre-Certification Organization; and
- No benefits will be paid when the Covered Person does not obtain a second or third opinion when asked to do so by the Hospital Pre-Certification Organization.

SECTION 6
HUMAN ORGAN OR TISSUE TRANSPLANT SERVICES EXPENSE BENEFITS

The Plan will pay benefits for Expenses Incurred by the Covered Person for organ and tissue transplant services during a Transplant Benefit Period commencing while the Covered Person is covered by the Plan when the Covered Person is the recipient of a human to human organ or tissue transplant.

The Plan will only pay the benefits for transplant services if the Covered Person, at least five days prior to the scheduled transplant surgery, notifies the Plan Administrator and provides two opinions to the satisfaction of the Plan Administrator that the transplant is Medically Necessary. The opinions must be given:

A. By a board certified specialist in the appropriate field of surgery; and

B. In writing. The specialist must certify that alternate procedures, services or courses of treatment would not be effective in the treatment of the Covered Person's condition and that the Covered Person would have a reasonable expectation of recovery from the transplant surgery.

No benefits will be paid for Experimental Procedures or Experimental Treatments.

A Transplant Benefit Period is the period commencing five days before the date of a covered organ or tissue transplant and ending 18 months after the transplant. Two or more Transplant Benefit Periods will be treated as follows:

A. If the transplants are due to unrelated causes, they will be treated as separate periods.

B. If the transplants are due to related causes, they will be treated as separate periods if:

   1. In the case of an Employee, they are separated by him or her being engaged in Full-Time Employment continuously for at least one week; or

   2. In the case of a Dependent, they are separated by at least three consecutive months.

Expenses Incurred while the Plan is in force with respect to a Covered Person during a Transplant Benefit Period as the result of the Covered Person being the recipient of a covered organ or tissue will be considered under this provision if such expenses are due to an Illness or Injury otherwise covered by the Plan.

If the transplant is not completed as scheduled due to the Covered Person's medical condition, benefits will be paid for item A. above only if the donated organ or tissue cannot be used for transplant in another person or for another purpose.

SECTION 7
MEDICAL PLAN EXCLUSIONS

No benefit will be paid, except to the extent specifically indicated on the Schedule of Benefits, for the following charges, or for expenses or complications related, directly or indirectly, to the following charges or conditions:

A. Charges Incurred prior to the Covered Person's effective date of coverage under the Plan, or after such coverage is terminated.

B. Charges not related to the treatment of an Illness or Injury.

C. Conditions or charges Incurred which resulted from war or any act of war, whether declared or

undeclared, or caused during service in the armed forces of any country.

D. Conditions or charges Incurred which resulted from or occurred:

1. While the Covered Person is engaged in an illegal occupation;
2. While the Covered Person is committing or attempting to commit a felonious act or aggravated assault;
3. While the Covered Person is participating in a riot or civil insurrection; or
4. As the result of court ordered treatment regardless of whether or not the Covered Person is found guilty of any wrongdoing, This exclusion is applicable whether or not the Covered Person is charged or convicted of the activity or offense.

E. Conditions or charges Incurred as the result of an Injury which occurred while the Covered Person was under the influence of illegal drugs or when the Covered Person was operating a motor vehicle while under the influence of alcohol. A person will be considered under the influence of alcohol if the level of their blood alcohol at the time the Injury occurred exceeded the legal limit for operating a motor vehicle in the jurisdiction where the Injury occurred. A person will be considered under the influence of an illegal drug if use of the drug by the Covered Person is established by a laboratory test.

F. Conditions or charges Incurred which resulted from an intentionally self-inflicted Illness or Injury regardless of whether sane or insane, unless the direct result of a covered Injury or Illness (such as depression). The intent of the Covered Person will be judged by the normal actions of prudent persons not intending to harm themselves.

G. Charges Incurred as the result of an Injury sustained while participating in a sanctioned or non-sanctioned speed or endurance contest; motorcycle, boat, or auto racing or stunt driving; aerobatics, trapeze or high-wire demonstration or contest; hang gliding; scuba diving except when the Covered Person is certified by a nationally recognized scuba training organization or under the instruction of one of their instructors; sky diving; or riding a three wheel all-terrain vehicle.

H. Conditions or charges resulting from or Incurred in the course of employment, whether such employment is with the Employer, another employer, or self-employment regardless of whether or not the Covered person is covered by workers compensation insurance.

I. Charges Incurred while the Covered Person is not under the direct care of a Physician.

J. Charges Incurred in connection with services and supplies which are not Medically Necessary for the treatment of an Illness or Injury, or are in excess of the Reasonable and Customary charge, or are not recommended and approved by a Physician.

K. Charges Incurred as the result of, or a complication of, a non-covered condition, treatment, service, drug or supply.

L. Charges Incurred for psychiatric or psychoanalytic care or in connection with treatment of a functional, mental or nervous disorder, alcoholism, chemical dependency or drug abuse except to the extent indicated on the Schedule of Benefits.

M. Charges Incurred for which the Covered Person is not, in the absence of the coverage under the Plan, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of the coverage under the Plan.

N. Charges Incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue, alveolar processes or extractions (simple or surgical); however, benefits will be payable for a

charge incurred for treatment required because of Injury to natural sound teeth. Coverage must be in effect on the date of treatment. Treatment because of Injury shall not in any event be deemed to include a charge for treatment for the repair or replacement of a denture.

O. Services, supplies, procedures or treatments not recognized by the appropriate medical association in the United States as generally accepted and Medically Necessary for the diagnosis and/or treatment of an Illness or Injury; or a charge for procedures, surgical or otherwise, which are specifically recognized by the appropriate medical association in the United States as having no medical value.

P. Charges Incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with Custodial Care, rest cures, education or training, Occupational Therapy, or expenses actually Incurred by other persons.

Q. Charges Incurred in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure. However, such expense will be considered a Covered Expense only to the extent of the least expensive service, supply or procedure which will correct the condition.

R. Charges for Cosmetic Procedures, except as specifically included as Covered Expense.

S. Charges Incurred related to weight loss, except as specifically covered under the Schedule of Benefits with respect to Morbid Obesity.

T. Charges Incurred to the extent such charges are paid or reimbursable through a program sponsored by the United States Government; or the treatment, service, or supply is available to the Covered Person at no cost or reduced cost through a Hospital or other facility owned or operated by the United States Government or an Agency thereof.

U. Charges for Physician's fees for any treatment which is not rendered by or in the physical presence of a Physician.

V. Charges for a service rendered by a Physician, nurse, or licensed therapist if such Physician, nurse, or licensed therapist is a Close Relative of the Covered Person, or resides in the same household as the Covered Person.

W. Charges for Room and Board Incurred in connection with a Hospital admittance from 8:00 a.m. Friday to 12:00 p.m. Sunday unless the attending Physician states in writing that such admittance was an emergency Hospital admittance and was Medically Necessary.

X. Charges Incurred outside the United States for medical treatment, services, drugs or supplies if the Covered Person traveled to a foreign location for the primary purpose of obtaining medical treatment, services, drugs or supplies.

Y. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility or reverse sterilization, artificial insemination, or in-vitro fertilization.

Z. Charges Incurred for routine medical examinations or routine health check-ups, nutritional supplements, vitamins, or immunizations not necessary for the treatment of an Illness or Injury, except as indicated under the Wellness Benefits on the Schedule of Benefits.

AA. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not

connected with an Illness or Injury.

BB. Charges for medical treatment, services, drugs or supplies for a tissue or organ transplant, or complications thereof, except as indicated under the Organ or Tissue Transplant Services Expense Benefit.

CC. Charges for Experimental Procedures or Experimental Treatments; or drugs, treatments or procedures disclosed to the Covered Person as part of a research study.

DD. Charges for Routine Nursery Care or Routine Well-Baby Care, including the usual, ordinary, and routine care of a Newborn except to the extent indicated on the Schedule of Benefits with respect to Maternity Services and Wellness Benefits (as applied to the child as a Dependent).

EE. Charges related to sex transformations or sexual dysfunctions or inadequacies.

FF. Charges for laser eye surgery, such as LASIK or radial keratotomy, to correct defective vision.

GG. Charge related to an abortion except:

1. A spontaneous miscarriage;

2. An abortion when the life of the Covered Person is threatened by the pregnancy; or

3. An abortion when the pregnancy resulted from rape or incest.

Notwithstanding any provision of this Plan to the contrary, charges related to complications of an abortion, whether or not charges for the abortion are covered, will be covered subject to all other applicable exclusions and limitations.

To the extent other benefits are generally provided for a type of Injury, the other benefits otherwise payable for charges Incurred as a result of the Injury will be paid if the Injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

SECTION 8
PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits will be paid under the Plan when the Covered Person incurs charges for:

A. Drugs and medicines which can be obtained only with a Physician's prescription; and

B. Injectable insulin.

The cost of Prescription Drug Benefits is determined by the applicable Schedule of Medical Benefits for the medical plan option in which a Covered Person is enrolled.

Prescription Drug Benefits are subject to the Medical Plan Exclusions provision. In addition, except to the extent indicated on the applicable Schedule of Medical Benefits, no payment will be made for any charge for:

A. A quantity of drugs or medicines received for each filling of a prescription in excess of the amount indicated on the Schedule of Benefits; taken as ordered by the Physician;

B. A refill of any prescription in excess of the number ordered by the Physician, or a prescription or refill dispensed more than one year after the date of the Physician's prescription order;

C. Injectable drugs except insulin;

D. Drugs labeled "Caution - Limited by Federal Law to Investigational Use" or experimental drugs even if a charge is made for such drugs;

E. Drugs or medicines which may be legally obtained without a Physician's prescription, except injectable insulin;

F. The administration of drugs or insulin;

G. Drugs or medicines delivered or administered to the Covered Person by the Physician.

H. Immunizing agents; biological sera; blood or blood plasma;

I. Any devices used in therapy including hypodermic needles, syringes, support garments, and other non-medical items regardless of their intended use;

J. Drugs or medicines to be taken by or administered to the Covered Person while a patient in a:

1. Hospital;
2. Rest home;
3. Sanitarium;
4. Skilled nursing facility;
5. Convalescent Hospital;
6. Nursing home; or
7. Similar place.

K. Drugs the Covered Person is eligible to receive free of charge under local, state or federal programs.

L. Contraceptives other than oral contraceptives.

SECTION 9
DENTAL BENEFITS

No coverage is provided under this Dental Benefits provision unless such is indicated on the Schedule of Benefits.

DENTAL BENEFIT PERCENTAGE AND PLAN YEAR DEDUCTIBLE

Upon receipt of proof of loss, Dental Benefits will he paid at the Dental Benefit Percentage, differentiated by Level of dental treatments, services and supplies, as shown on the Schedule of Benefits, for Covered Expenses Incurred in a Plan Year, unless otherwise stated in the Plan, which are in excess of the Plan Year Deductible Per Covered Person. With respect to each Covered Person, benefits payable under the Plan, regardless of whether coverage under the Plan is continuous or not, shall be subject to a maximum shown on the Schedule of Benefits.

The Plan Year Deductible is applicable only once to Covered Expenses Incurred in each Plan Year. However, the amount of Covered Expenses used to satisfy Plan Year Deductibles for all Covered persons in a family during a Plan Year will not exceed the Plan Year Deductible Per Family shown on the Schedule of Benefits.

COVERED EXPENSE

Covered Expenses under this Dental Benefits provision are charges for dental treatments, services and supplies furnished by a legally qualified dentist acting within the lawful scope of his license. Dental treatments, services and supplies are classified in Levels as follows:

A. Level 1:

1. Two (2) dental examinations per Plan Year;
2. Four (4) bitewing X-rays per Plan Year;
3. One full mouth X-ray in a period of three (3) continuous Plan Years;
4. Two (2) prophylaxis treatments, including scaling and polishing, per Plan Year;
5. One (1) full mouth fluoride treatment per Plan year for Covered Persons under age 15 years;
6. Space maintainers for deciduous teeth for Covered Persons under age 13 years; and
7. Sealants for Covered Persons under age 14 years.

B. Level 2:

1. Amalgam, synthetic or plastic filings;
2. Adjunctive oral cancer screening per Plan Year;
3. Extractions (including impacted teeth), cysts and neoplasms;
4. Root canals and pulpal therapy;
5. Emergency palliative treatments;
6. Drugs administered by the attending dentist;
7. Prescription drugs;
8. One (1) relining or rebrasing of dentures per Plan Year;
9. Repair or recementing of crowns, inlays, onlays, bridgework, fillings or dentures; and
10. Non-surgical treatment for diseases of the gums and mouth tissues.

C. Level 3:

1. Inlays, gold filings and crowns;
2. Dentures and precision attachments thereto;
3. Fixed bridgework;
4. Surgical treatments for diseases of the gums and mouth tissues; and
5. Implants.

Each procedure is included in only one Level.

INCURRED DATE
The charge for a dental treatment, service or supply is considered to be incurred on the day:

1. The treatment or service is performed; or
2. The supply is delivered to the Covered Person.

If a treatment or service is provided during more than one day, the charge will be allocated to each day on a reasonable basis.

EXCLUDED CHARGES
Dental Benefits are subject to the Plan Exclusions and Limitations provision; additionally no benefit will be paid, except to the extent benefits are otherwise indicated on the Schedule of Benefits, for a:

A. Charges Incurred by the Covered Person for dental treatment, service or supply received from a dental or medical department maintained by:

   1. An employer of the Covered Person;
   2. A mutual benefit association;
   3. A labor union; or
   4. A health and welfare fund.

B. Charges for a Cosmetic Procedure unless the charge is:

   1. Incurred while the person is a Covered Person; and
   2. Required as a result of and within twenty-four (24) months subsequent to the date of an Injury.

C. Charges for a facing on a crown, or a pontic, posterior to the second bicuspid.

D. Charges for a dental treatment, service or supply provided by a Close Relative of the Covered Person.

E. Charges for more than two (2) dental examinations, including prophylaxis and X-rays which are a part of those examinations, in a Plan Year.

F. Charges related to dental sealants for:

   1. Covered Persons under age 6 years or older than 14 years;
   2. Application to areas with cavities; or
   3. Primary teeth.

G. Charges for partial or full removal of dentures or fixed bridgework or for adding one or more teeth to such dentures or bridgework, or for a crown or gold restoration. This exclusion applies only if such procedure involves the replacement of or change in a denture, bridgework, crown or gold restoration which was installed in the five (5) years prior to an extraction, replacement or change.

H. Charges for an adjustment to or relining of partial or full removable dentures if like service was performed in the two (2) years prior to the adjustment or relining.

I. Charges for the replacement of lost or stolen dental appliances, dentures or bridgework.

J. Charges for telephone consultations, dental appointments which are not kept or completing claim forms.

K. Charges for a dental treatment, service or supply not provided by a dentist except:

1. A dental treatment, service or supply provided by a licensed dental hygienist under the supervision of a dentist; or
2. An X-ray ordered by a dentist.

L. Charges for an orthodontic treatment, except as shown on the Schedule of Benefits.

M. Charges for treatment of temporomandibular joint syndrome.

If benefits for Covered Expenses are paid under other terms of the Plan, the amount of Dental Benefits to be paid will be reduced by the amount of the benefits paid under the other terms of the Plan.

PRE-DETERMINATION OF BENEFITS

When a dental problem can be solved in more than one way, an amount will be paid equal to that which, in the judgment of the Plan Administrator, will provide adequate dental care at the lowest cost to the Covered Person. To determine its liability, the Plan Administrator will be guided by standards of the dental profession.

Covered Persons considering dental work are required to send or have the dentist send to the Plan Administrator, in advance, a resume of the plan of treatment being considered if the course of treatment is expected to involve total dental charges of $200 or more. The Plan Administrator will then, as soon as possible, advise the Covered Person and/or the dentist of the benefits available.

IF PRE-DETERMINATION OF BENEFITS IS NOT REQUESTED, THE PLAN ADMINISTRATOR RESERVES THE RIGHT TO PAY THE CLAIM ON THE BASIS OF THE AMOUNT OF BENEFITS WHICH WOULD HAVE BEEN PAID HAD PRE-DETERMINATION BEEN REQUESTED.

SECTION 10
COORDINATION OF BENEFITS

This Coordination of Benefits provision applies when the Covered Person entitled to medical benefits for Covered Expenses under the Plan is also covered by another plan or plans of health care benefits. This provision applies whether or not a claim is filed under the other plan or plans. If required by the Plan Administrator, authorization shall be given to the Plan Administrator by the Covered Employee or other appropriate person to obtain information concerning benefits or services available from the other plan or plans, or to recover overpayments.

DEFINITIONS

A. "Plan" as used in this provision will be expanded to include the Plan and any other plan providing benefits or services for medical or dental treatment when such benefits or services are provided by:

    1. Group insurance or any other arrangement of coverage for persons in a group whether on an insured, partially insured or uninsured basis;
    2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
    3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
    4. Any coverage for students (excluding coverage for student athletes) which is sponsored by, or provided through, a school or other educational institution;
    5. Any coverage under a Governmental program, and any coverage required or provided by any statute;
    6. Group automobile insurance;
    7. Individual automobile insurance coverage on an automobile leased or owned by the Employer; or
    8. Individual automobile insurance coverage based up on the principles of "No-Fault" coverage.

    The term "Plan" in this provision will be construed separately herein with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

B. "Claim Determination Period" means a Plan Year or that portion of a Plan Year during which the Covered Person for whom a claim is made has been covered under the Plan.

COORDINATION PROCEDURES

Notwithstanding other provisions of the Plan, benefits that would otherwise be payable under the Plan will be reduced so that the sum of the benefits payable for Covered Expenses Incurred during any Claim Determination Period under (i) all plans required to pay before the Plan; and (ii) the Plan will not exceed the Covered Expenses under the Plan.

PAYMENTS

Each plan will make its benefit payment according to where it falls in the following order:

A. A plan which contains no provision for coordination of benefits pays before all other plans.

B. A health care plan sponsored by, or provided through, a school or other educational institution pays before any other plans with a provision for coordination of benefits.

C. Except when prohibited by law, Medicare Benefits and benefits provided under a government program will be paid prior to benefits under the Plan.

D. A plan which provides coverage to the claimant by virtue of current employment pays before a plan which provides coverage to the claimant by virtue of past or inactive employment. Within each category of plans, the following rules apply:

1. The plan which covers the claimant as an employee (or named insured) pays before a plan which covers the claimant as a dependent.

2. Dependent Child Covered Under More Than One Plan Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

    a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
        i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
        ii. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
    b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
        i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan;
        ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;
        iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;
        iv. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            1. The plan covering the custodial parent;
            2. The plan covering the custodial parent's spouse;
            3. The plan covering the non-custodial parent; and then
            4. The plan covering the non-custodial parent's spouse.

    c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.
    d. Additionally;

        i. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (e) applies.
        ii. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

e. To the extent the above rules do not establish the order of benefit determination, the benefits of the plan which has covered the claimant for the longer period of time immediately prior to the incurred date of the claim shall be determined first.

If the benefits under any other plan are payable before the benefits under this Plan and the charge for the service has been negotiated under the other plan by a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or other entity, the Covered Expense under this Plan will not exceed the negotiated charge.

The Plan Administrator has the right:

A. To require that the claimant provide the Plan Administrator with information on such other plans so that this provision may be implemented; and
B. To pay the amount due under the Plan to another insurer or other organization if this is necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

COORDINATION WITH MEDICARE

Except when prohibited by law, Medicare Benefits will be paid prior to benefits under the Plan. If any Covered Person eligible for Medicare fails to enroll or maintain Medicare coverage, benefits will be paid under the Plan as though the Covered Person had received Medicare Benefits.

EFFECT OF MEDICARE ON BENEFITS

An Actively at Work Participant and his or her spouse age 65 or older will receive the same benefits under this Plan as shown for persons under age 65.

In the event any Participant or Dependent is eligible for coverage under Medicare due to a disability which qualifies the individual for benefits under Section 226(b) of the Social Security Act, as amended, and the individual is a Dependent of an active Employee of the Employer, or is an Employee, then Medicare will not be the primary payer and this Plan will be the primary payer.

In the event any Participant or Participant's spouse is age 65 or older and covered by Medicare while the Participant is employed by the Employer, then this Plan will be the primary payer and Medicare will be the secondary payer for so long as the coverage and employment relationship giving rise to eligibility for coverage continues.

In the event any Covered Person is afflicted with end-stage renal disease ("ESRD") and becomes eligible for Medicare coverage as the result of ESRD, this Plan will be the primary payer and Medicare will be the secondary payer for the duration of the 30 month period beginning with the first month the Covered Person is entitled to receive Medicare benefits, or if earlier the first month the Covered Person would have been entitled to Medicare benefits if such Covered Person had applied for such benefits.

FACILITY OF PAYMENT

This Plan has the right, at its sole discretion, to pay any amounts it determines to be warranted in order to satisfy the intent of this Section. Amounts so paid will be deemed to be benefits paid under this Plan, and, to the extent of such payments, this Plan will be fully discharged from liability under this Plan.

RIGHT OF RECOVERY

Whenever payments have been made by this Plan in excess of the maximum amount of payment required to satisfy the intent of this Section, this Plan will have the right to recover excess payments from any persons to whom such payments were made; any other insurance companies; or any other organizations

SECTION 11
CONTINUATION OF COVERAGE AND OTHER COVERAGE REQUIREMENTS

I. COBRA GENERAL NOTICE

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this Section 11 or contact the Plan Administrator.

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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events are listed later in this Section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The provisions of this notice that apply to employees include former employees (retirees) unless the context indicates otherwise.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a Dependent.

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the COBRA Coordinator listed on the first page of the Plan.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the COBRA Coordinator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The

disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please contact the COBRA Coordinator for additional information, including the timeframe required for notification.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Human Resources Department of the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the COBRA Coordinator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator and/or COBRA Coordinator.

Plan Contact Information

Contact information for the COBRA Coordinator is located on the first page of this Plan.

II. COBRA PROCEDURES

A. Application of COBRA Provisions at Retirement and Death

1. Upon retirement, an Eligible Retiree and his or her Covered Dependents will be given an opportunity to:

    a. Receive retiree coverage under this Plan, to the extent eligible under Section 3 of the Plan; or

b. Elect COBRA continuation coverage under this Section 11.

An election under subparagraph (a) will be deemed to have waived all rights for COBRA continuation coverage related to the Eligible Retiree's retirement.

2. Upon the death of an active Covered Employee or Eligible Retiree, the Employee's or Retiree's Covered Dependents will be given an opportunity to:

a. Receive survivor coverage under this Plan to the extent eligible under Section 3 of the Plan; or

b. Elect COBRA continuation coverage under this Section 11.

An election under subparagraph (a) will be deemed to have waived all rights for COBRA continuation coverage related to the Covered Employee's or Eligible Retiree's death.

B. **Qualifying Event Involving Divorce or Loss of Dependent Status**

1. Notification to Plan

Qualified beneficiaries who lose coverage (or will lose coverage) because of a divorce or legal separation or because a Dependent no longer qualifies as a Dependent as defined in the Plan, must notify the Plan, in writing, via either facsimile or U.S. Mail, of the qualified beneficiary's desire to extend COBRA coverage after the date of the divorce or loss of dependent status. Such notice must be sent to the COBRA Coordinator, as indicated on the first page of this Plan.

Notice may be made by the Employee/former Employee or any other qualified beneficiary that is a spouse or Dependent of the former Employee. Such notice may be given before the occurrence of the divorce or loss of Dependent status, but must, in all cases, be given no later than sixty (60) days after the date of the divorce or the loss of Dependent status. Oral notice or notice by e-mail is not sufficient under these procedures.

2. Documents Required for Divorce/Separation

With respect to the information which must be given to the Plan Administrator, when divorce or legal separation is the qualifying event, the qualified beneficiary must provide the Plan Administrator with a copy of the Court Decree dissolving the marriage. If the divorce or legal separation has not yet been concluded, the qualified beneficiary must provide the Plan Administrator with any court documents that have been filed (such as a Petition for Dissolution) and indicate the date that the divorce or legal separation is expected to be final.

3. Documents Required for Loss of Dependent Status

With respect to loss of Dependent status, a qualified beneficiary must provide to the Plan Administrator the reason the individual will no longer qualify as a Dependent.

C. **Qualifying Events Involving Termination, Reduction in Hours, Death and Bankruptcy – Notification by Plan**

Qualified beneficiaries who lose coverage because of a termination, reduction in hours, death or bankruptcy will receive a COBRA election form which permits the Employee/former Employee (and Dependents) to elect coverage and indicates the premium for such coverage.

An election form will be sent by U.S. Mail, postage pre-paid, to the last known address of the Employee/former Employee unless the Plan has been notified in writing to the contrary. The last known address will be deemed to the most recent address contained in the Employee/former Employee's personnel file. In the event the Employee/former Employee changes address, it is his or her responsibility to notify the Plan of any change in address and the Plan will not be responsible for notices sent to the wrong address if the more recent address was not provided in the above manner. Notification to an Employee/former Employee who elected spousal coverage will be sent addressed to both individuals. Election forms sent to an Employee/former Employee that has one or more children/Dependents covered will be addressed to the Employee (if the spouse was not covered) or to the Employee and spouse (if spousal coverage was elected), and each will be deemed to include notification to any Dependent children, unless the Plan Administrator has actual knowledge of a different address for a Dependent child before the date the election form is mailed and provided further that any such notification to the Plan Administrator was in writing sent via either U.S. Mail or facsimile.

D. **Errant Notices**

In the event an individual receives a COBRA election form before the date the Plan determines that the individual is not eligible to elect COBRA (either because of an error concerning the individual's eligibility or because the individual was fired for gross misconduct), the Plan will notify the individual of the errant notice within fourteen (14) days of the date that the individual was originally given the COBRA election form.

E. **Early Termination of COBRA**

In the event a qualified beneficiary's COBRA coverage terminates before the duration of COBRA coverage (either 18, 29 or 36 months after the qualifying event), the Plan will notify the qualified beneficiary of the early termination date and the reason for early termination of COBRA coverage.

F. **Postmark Date**

All notifications, payments and other correspondence from a qualified beneficiary (or a possible qualified beneficiary) will be deemed to have been received on the date that the item is postmarked, if sent by U.S. Mail. In the event communication or correspondence is sent via facsimile, the communication or correspondence will be deemed to have been received on the date it is transmitted. All correspondence must be sent to the COBRA Coordinator identified in paragraph A above.

G. **Eleven Month Disability Extension**

COBRA continuees who are determined by Social Security to be disabled within the first 60 days of COBRA continuation coverage (or earlier) may elect to extend the 18th month COBRA period by eleven (11) months, provided the applicable premium is paid. The eleven month extension will only be given if the Plan is notified in writing, via either U.S. Mail or facsimile, of the Social Security determination. This written notification must also contain a copy of the Social Security determination. Qualified beneficiaries are required to request the eleven month extension within 30 days of receiving the Social Security determination and, in any event, must be provided to the Plan before the end of the 18 month COBRA continuation period. Any qualified beneficiary not meeting each of these rules will not be entitled to elect the eleven month extension. Qualified beneficiaries who were originally determined to be disabled but had that determination reversed must notify the Plan within 30 days of notification of the reversal. In the event the qualified beneficiary does not notify the Plan of any such reversal, the qualified beneficiary will be required to repay the Plan for any claims which were Incurred after the date of reversal.

H. **Multiple Qualifying Events**

In the event a qualified beneficiary experiences a second qualifying event during the original 18 or 29 month period, and he or she wishes to apply for an extension of the 18 or 29 months because of a second qualifying event, he or she must notify the Plan via either U.S. Mail or facsimile, of the occurrence of the second qualifying event within 60 days after the event occurs. Any qualified beneficiary who fails to notify the Plan of the occurrence of the second qualifying event will not be entitled to extend coverage past the end of the 18 or 29 month period. COBRA coverage will not extend beyond 36 months from the day of the original qualifying event, regardless of the occurrence of multiple qualifying events. Whether the subsequent qualifying event entitles a qualified beneficiary to extend coverage, under the applicable regulations, will be determined by the Plan.

I. **Payment Requirements**

COBRA payments must be paid monthly in the amount designated on the Election Form. COBRA coverage will terminate if payments are not made as required under this Paragraph I. The first COBRA payment is due within forty-five (45) days after the Election Form is executed. This payment covers the cost of the health care coverage provided from the date of the qualifying event (or loss of coverage, if later) through the date of the election.

After the first payment, all subsequent COBRA payments are due on the first of each month for the applicable month. If no payment is received for a particular month, the qualified beneficiary will be given a grace period of thirty (30) days to pay the premium. When the premium is not paid prior to the end of the grace period, COBRA coverage will terminate at the end of the period for which the last premium was paid.

All payments of COBRA premiums should be made by check, money order or cashier's check. If payment is made by personal check, the qualified beneficiary will be solely responsible for maintaining sufficient funds in his or her account so that the check will clear when presented. If a COBRA payment paid by personal check does not clear when first presented, the Plan will make a second attempt to cash the check if the Plan has at least five (5) working days notice before the end of the thirty (30) day grace period. It is the obligation of the qualified beneficiary to confirm that his or her COBRA personal checks have cleared the bank. The Plan will not be under any obligation to notify the qualified beneficiary if a check does not clear. Additionally, if the Plan is presented with a personal check that does not clear, the Plan will have the option of requiring all subsequent COBRA payments to be made by guaranteed funds (i.e. money order or cashier's check).

III. USERRA Continuation Coverage

A. An Employee who is absent from employment as a result of uniformed service will have the right to elect to continue his coverage under the Plan for himself and any covered Dependents for a period of up to 24 months. Only an Employee or an Authorized Representative of the Employee may elect such coverage and then only if the Employee and Dependents already have Plan coverage before the Employee's absence for uniformed service begins. If an individual is covered under this Plan as a Dependent, he or she will not be entitled to USERRA continued coverage based upon his or her own uniformed service.

B. The Employer will provide reasonable procedures as to notice of an Employee's rights under USERRA. Any Employee returning to work from uniformed service will have the right to reinstatement in this or any other health plan maintained by the Employer without any exclusion or waiting period attributable to service related to break in coverage. Each Employee who wishes to take advantage of USERRA continuation coverage will provide the Employer with advanced notice of any impending uniformed service as a prerequisite to receiving coverage, unless such

notice is precluded by military necessity, impossible or unreasonable under the circumstances, as determined within the discretion of the Plan Administrator.

C. If an Employee fails to report back to work or apply for reemployment within the time period specified under USERRA after completion of uniformed services, the right to continuation coverage will end when the time period for reporting back to work or applying for reemployment expires, even if this period occurs before the end of the 24 month maximum coverage period that would otherwise apply. USERRA continuation coverage may be terminated if the Covered Person fails to pay required premiums, subject to payment requirements and grace periods set out in USERRA.

D. When the period of uniform coverage is less than 31 days, the Plan will not require an Employee to pay more for coverage than he or she would have been required to pay had the Employee not been absent. For periods of greater than 30 days, the Employer may require the Employee to pay 102% of the full premium for the coverage elected. Such amount of full premium will be determined in the same manner as the applicable premium determined under COBRA pursuant to this Section 11.

III. MENTAL HEALTH PARITY ACT OF 1996

A. The Plan will comply with the Mental Health Parity Act of 1996, as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan.

B. As part of such compliance, the financial requirements applicable to covered services for mental health and substance use disorder benefits will be no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all covered services for medical and surgical benefits, as such requirements and limitations are set forth in the Schedule of Benefits. A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of requirement or limit.

C. If the Plan provides coverage for medical or surgical benefits provided by out-of-network providers, the Plan will provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner consistent with this Section.

D. This Section will not apply to any Plan Year in which the Plan meets the cost exemption under the Mental Health Parity Act and the Plan Administrator, in its sole discretion, chooses to apply such exemption.

E. The criteria for Medical Necessity determination made under this Plan with respect to mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential Covered Person, beneficiary, or contracting provider upon request.

IV. GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

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

underwriting purposes or with respect to any individual prior to such individual's enrollment under the Plan in connection with such enrollment.

V. PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The Plan will comply with the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act"), and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the Plan. As a "grandfathered health plan" (within the meaning of the Affordable Care Act), the Plan's compliance includes: extending coverage of adult children to age 26; eliminating lifetime and annual limits on essential health benefits; eliminating pre-existing condition exclusions for Covered Persons; limiting waiting periods to no longer than 90 days; and prohibiting coverage rescissions except in the case of fraud or an intentional misrepresentation of material fact. In the event the Plan is determined to no longer qualify as a grandfathered health plan, at such point, the Plan's compliance will further include: offering the same level of coverage for emergency care provided out-of-network as provided in-network; providing certain preventive care services at no cost to the Participant; limiting out-of-pocket maximums; providing coverage for certain clinical trials; and making available an external review process for Covered Persons whose claims were denied on appeal.

VI. FAMILY AND MEDICAL LEAVE ACT OF 1993

The Employer will comply with the Family and Medical Leave Act of 1993 ("FMLA") with respect to leave requirements for all Employees who are eligible under the FMLA. In the event that the Employer approves an FMLA leave for a Covered Employee, the Covered Employee will be entitled to continue coverage under the Plan for himself or herself and his or her Dependents during the period of FMLA leave, provided that required contributions (if any) are made by or on behalf of the Covered Employee and his or her Dependents.

The coverage continuation provisions of COBRA outlined in Section 11 of the Plan will apply on the earliest of:

1. The date that the Employee informs the Employer of his intent not to return from FMLA leave; or

2. The date that the Employee does not return from FMLA leave and coverage for the Employee or Dependents would be lost were it not for COBRA coverage.

An Employee returning from an approved leave under the FMLA, and who did not continue benefits under this Plan during such leave, may immediately begin participation in the Plan upon returning to Actively at Work status and meeting the definition of an Eligible Employee. Such Employee will not be required to satisfy a new Waiting Period or provide proof of good health.

VII. AMERICANS WITH DISABILITIES ACT

The Plan has not been created, nor is it intended, to violate the Americans With Disabilities Act ("ADA"). Should it be determined that a provision is in violation, the Plan will be amended.

SECTION 12
THIRD PARTY RECOVERY PROVISION

RIGHTS OF SUBROGATION AND REIMBURSEMENT. The Plan will be fully subrogated to any and all rights of recovery and causes of action which a Covered Person may have against a third party who is allegedly responsible for the Covered Person's Injuries. The Plan is granted a specific and first right of reimbursement out of the proceeds of any settlement, judgment, litigation or other recovery by a Covered Person against such third party.

FUNDS TO WHICH SUBROGATION AND REIMBURSEMENT RIGHTS APPLY. In exchange for payment of benefits while the liability of a third party for the Covered Persons Injury is determined, the Plan's subrogation and reimbursement rights apply if the Covered Person receives, or has the right to receive, any sum of money, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan, or legal entity that is legally obligated to make payments as a result of a judgment, settlement, litigation or other recovery, arising out of any act or omission of any third party, (whether a third party or another Covered Person under the Plan): (a) who is allegedly wholly or partially liable for costs or Expenses Incurred by the Covered Person, in connection for which the Plan provided benefits to, or on behalf of, such Covered Person; or (b) whose act or omission allegedly caused Injury or Illness to the Covered Person, in connection for which the Plan provided benefits to, or on behalf of, such Covered Person. The Plan has an equitable lien against such funds, and the right to impose a constructive trust upon such funds, and will be reimbursed there from.

AGREEMENT TO HOLD RECOVERY IN GENERAL ASSETS. If the Plan has paid benefits on behalf of a Covered Person, and the Covered Person recovers monies from a third party as described above through settlement, judgment, or otherwise, the Covered Person agrees to hold such recovery in general assets for the Plan and to reimburse the Plan to the extent of such payments made by the Plan.

DISCLAIMER OF MAKE WHOLE DOCTRINE. The Plan has the right to be paid first and in full from any recovery received by the Covered Person through settlement, judgment, or otherwise, regardless of whether the Covered Person has been "made whole." The Plan's right is a first priority lien. The Plan's right will continue until the Covered Person's obligations hereunder to the Plan are fully discharged, even though the Covered Person does not receive full compensation or recovery for his or her injuries, damages, loss or debt. This right to subrogation pro tanto will exist in all cases and will not be reduced for the Covered Person's comparative fault or contributory negligence.

DISCLAIMER OF COMMON FUND DOCTRINE. The Covered Person will be responsible for all expenses of recovery from such third parties or other persons. The Plan has no duty or obligation to pay or contribute to attorneys' fees and/or expenses incurred in connection with obtaining reimbursement.

OBLIGATIONS OF THE COVERED PERSON. The Covered Person will cooperate fully with the Plan Administrator and will furnish any and all information and assistance requested by the Plan Administrator in order to enforce the rights of the Plan under this Section. If requested, the Covered Person will execute and deliver to the Plan Administrator a subrogation and reimbursement agreement before or after any payment of benefits by the Plan. The Covered Person will not discharge or release any party from any alleged obligation to the Covered Person, will not assign his rights against the third party without the express written consent of the Plan Administrator, and will not take any other action that could impair the Plan's rights to subrogation and reimbursement without the written authorization of the Plan Administrator.

PLAN'S RIGHT TO SUBROGATION. If the Covered Person or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party to obtain a judgment, settlement or other recovery, the Plan Administrator or its designee, upon giving thirty (30) days' written notice to the Covered Person, will have the right to take such action in the name of the Covered Person to recover that amount of benefits paid under the Plan; provided, however, that any such action taken without the consent of the Covered Person will be without prejudice to such Covered Person.

ENFORCEMENT OF PLAN'S RIGHT TO REIMBURSEMENT. If a Covered Person fails or refuses to comply with these provisions by reimbursing the Plan as required herein, the Plan has the right to enforce its equitable lien and/or to impose a constructive trust over any and all funds received by the Covered Person, or as to which the Covered Person has the right to receive. The Plan, through the Plan Administrator, has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this Section, against any and all appropriate parties who may be in possession of the funds described herein.

WITHHOLDING OF PAYMENTS FOR BENEFITS. The Plan may withhold payment of benefits when a party other than the Covered Person or the Plan may be liable for expenses until liability is legally determined. In the event that any payment is made under the Plan for which any party other than the Covered Person or the Plan may be liable, the Plan will be subrogated to all rights of recovery of the Covered Person to the extent of payments by the Plan and will have the right to be reimbursed as set forth in this Section.

FAILURE TO COMPLY. If a Covered Person fails to comply with the requirements of this Section, the Covered Person will not be eligible to receive any benefits, services or payments under the Plan until there is compliance, regardless of whether such benefits are related to the act or omission of a third party or other persons against whom the Covered Person may have a right of recovery.

FUTURE CLAIMS EXCLUDED. Unless specifically agreed to the contrary by the Covered Person and the Plan, if the Covered Person receives any sum of money as described above, the Plan will have no further obligation to pay benefits relating in any way to the Injuries for which the Covered Person receives such sum of money, and Expenses Incurred for services related to such Injuries will be excluded, as set forth in the Schedule of Benefits, to the extent such services would otherwise have been covered under the Plan.

RIGHT TO OFFSET FUTURE BENEFITS. In the event that the Covered Person fails to cooperate with the Plan or fails to comply with the terms of this provision, the Plan may offset or otherwise reduce present or future benefits otherwise payable to the Covered Person or their Dependent under the terms of the Plan. Moreover, in the event that a Covered Person fails to cooperate with the Plan, the Covered Person will be responsible for any and all costs incurred by the Plan in enforcing its rights, including but not limited to attorney's fees.

RECOVERY FROM ANOTHER PLAN UNDER WHICH THE COVERED PERSON IS COVERED
This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

When this happens, the Plan will pay the lesser of:

1. The benefits of this Plan; or

2. 100% of the charges eligible under this Plan for the medical expenses less the amount the Covered Person is eligible to receive for the same charges from the liability insurance, property insurance, casualty insurance or property-casualty insurance.

ASSIGNMENT OF RIGHTS
As a condition to the Plan making payments for any medical charges, the Covered Person must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the Injury or Illness for which such benefits are to be paid. The scope of this assignment is consistent with the amount subject to subrogation and refund set forth above.

SECTION 13
CLAIMS AND APPEALS PROCEDURES

The following Claims and Appeals Procedures apply to Claims for Major Medical Benefits, Prescription Drug Benefits, and Dental Benefits under the Plan. All notifications by the Claims Administrator or by the Plan Administrator to a Claimant for Claim review, denial, approval, and appeal may be done in writing or electronically, unless otherwise designated.

DEFINITIONS

"**Claim**" means a request for a specific medical treatment, for coverage of a treatment which has already been rendered, or a request for payment of benefits for medical services provided. For purposes of these Procedures, any interaction between a Claimant and a preferred or network provider shall not be treated as a Claim if the medical provider exercises no discretion on behalf of the Plan. Similarly, any reply to a request for a pre-certification which does not deny coverage (or limit coverage) for medical services is not considered a "Claim". Additionally, a medical provider's refusal to render services without payment by the Claimant is not considered a Claim subject to these Procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims subject to these Procedures. Notwithstanding the foregoing, any action or inaction by a provider that is not treated as a Claim for those purposes will be treated as a Claim and be reviewed by the appropriate person or entity if a Covered Person files a specific request with the Plan that any action or inaction by the provider be treated as a Claim under the Plan.

"**Claimant**" means any Covered Person filing a claim under the Plan pursuant to these Procedures. A Claimant may include an Authorized Representative.

"**Urgent Care Claim**" is a Claim where the Plan is required to make a determination (about eligibility, medical necessity, etc.) before care can be rendered and a delay could seriously jeopardize a Covered Person's life, health or ability to gain maximum function, or could subject the Covered Person to severe pain that could not be managed without the requested treatment. Notwithstanding the preceding sentence, any Claim designated by the treating Physician as an "Urgent Care Claim" will be treated as such for purposes of these Procedures.

CLAIM FILING REQUIREMENTS

A. **Filing a Claim**

All Claims must be filed with the Claims Administrator identified in the General Information section on the first page of the Plan within six (6) months after the expenses were Incurred. If the Claim involves hospital confinement, the Claim must be filed within six (6) months after termination of such confinement.

B. **Claim Review**

The Claims Administrator shall provide a written response to the Claimant regarding the Claim within a reasonable period of time following receipt of the request, taking into consideration the urgency required by Urgent Care Claims. If a Claim for benefits is wholly or partially denied, any notice of such denial will include the specific reasons for denial, the provisions of the Plan on which the denial is based, and how to apply for a review of the denied Claim. Where appropriate, it shall also include a description of any material which is needed to complete or perfect a Claim and why such material is necessary.

APPEAL PROCEDURES

A. **Filing an Appeal**

In the event a Claim is wholly or partially denied, the Claimant has the right to appeal to the Plan Administrator of the Plan for review of the Claim. All appeals will be decided by the Plan Administrator identified in the General Information section on the first page of the Plan.

All appeals must be filed within six (6) months of the date that the Claim was totally or partially denied. Failure to file an appeal of a Claim will result in the initial determination becoming final and binding on all parties and will be deemed to void any right the Claimant may have to seek judicial review of the original Claim denial.

B. **Appeal Review**

The Plan Administrator shall provide a written response to the Claimant regarding the Claim within a reasonable period of time following receipt of the request, taking into consideration the urgency required by Urgent Care Claims.

Any Claimant making an appeal will have the opportunity to submit written comments, documents or other information in support of the appeal. The appeal review will take into account all new information whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

In the case of an appeal of a Claim denied or partially denied based on medical judgment, the Plan Administrator will consult with a health professional with the appropriate training and expertise, The health care professional who is consulted on appeal will not be the same individual who may have been consulted during the initial determination or subordinate of that individual.

The decision of the Plan Administrator shall be binding on all parties and shall be afforded the maximum deference permitted by law. This administrative appeal process must be completed before any legal action regarding the Claim can be taken. Additionally, if any such judicial proceedings are undertaken, the evidence presented shall be strictly limited to the evidence presented to the Plan Administrator pursuant to these Procedures.

SECTION 14
HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

The Plan complies with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

First, under HIPAA Privacy Regulations, this Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. This Section specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI. This Plan will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in this Section have been adopted and the Plan Sponsor agrees to abide by these terms. The HIPAA Privacy Regulation provision of this Plan took effect April 14, 2003.

Second, under HIPAA Security Regulations, this Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, which is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of this Plan. Modifications made for the HIPAA Security Regulations are effective as of April 21, 2005 and can be identified in this provision by reference to Security Regulations or Electronic PHI.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the HIPAA. Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This Section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agrees to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or employee benefit plans;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

- The Benefits Manager;

- The staff designated by the Benefits Manager;

- The Privacy Officer; and

- The Human Resources Manager.

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, claims administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means the City of Fort Wayne.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Officer is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

SECTION 15
FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. The Plan will pursue all appropriate legal remedies in the event of fraud.

The Plan is obligated to meet the requirements of Section 2712 of the Public Health Service Act, relating to the prohibition on rescissions. As part of such compliance, the Plan will not rescind health coverage, except in the case where a Covered Person (or a person seeking coverage on the Covered Person's behalf) has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact. In such case, the Plan will provide the Covered Person with 30 days advance written notice before coverage is rescinded. A "rescission" is a cancellation or discontinuance of coverage that has retroactive effect. However, the Plan may still cancel or discontinue coverage effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. In addition, nothing in this paragraph prohibits the Plan from cancelling or discontinuing coverage prospectively for any reason provided under the Plan.

Covered Persons must:

- File accurate claims. If someone else - such as your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it.

- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the Expenses Incurred and the services rendered.

- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately.

- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or

- Asks a Covered Person to sign a blank claim form; or

- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

SECTION 16
GENERAL PROVISIONS

EFFECTIVE DATE

The effective date of the restated Plan is January 1, 2020 as of 12:01 a.m. Eastern Standard Time. Eligibility for, and the amount of benefits, if any, payable with respect to Participants of the Employer or their Dependents prior to the effective date will be determined in accordance with any applicable group benefit plan maintained by the Employer at that time. As of the effective date, eligibility for and the amount of benefits, if any, payable with respect to a Participant of the Employer or their Dependents will be determined pursuant to the terms and conditions of this Plan document.

PURPOSE

The City of Fort Wayne, hereinafter referred to as the "Employer," has established and maintains the self-funded employee benefit plan contained herein to provide for the payment or reimbursement of specified medical, prescription drug, and dental Expenses Incurred by its Participants and their Covered Dependents. The name of the Plan is the City of Fort Wayne Employee Benefit Plan. The purpose of this Plan Document and Summary Plan Description is to set forth the provisions of the Plan which provide and/or affect such payment or reimbursement.

PLAN ADMINISTRATOR

The Plan Administrator is the Employer. The Plan Administrator controls and manages the operation and administration of the Plan and has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions. The Plan Administrator has the power to designate other persons to carry out any duty or power which would otherwise be a fiduciary responsibility of the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.

2. To decide disputes which may arise relative to a Covered Person's rights, including the resolution of any appeal of claims denial.

3. To keep and maintain the Plan documents and all other records pertaining to the Plan.

4. To determine eligibility for Plan benefits and to pay claims.

PLAN ADMINISTRATOR COMPENSATION

The Employer will serve as Plan Administrator without compensation. To the extent employees of the Employer perform services on behalf of the Plan, the Employer will pay their compensation, not the Plan. To the extent service providers independent of the Employer are employed to perform services on behalf of the Plan, those expenses may be paid by the Plan.

AMENDMENT OR TERMINATION OF THIS PLAN

Although it is the intention of the Employer to maintain this Plan indefinitely, the Plan may be amended at any time by the Employer, by written resolution of the Office of the Controller of the City of Fort Wayne Any such amendment will state the effective date of the amendment and shall be communicated to all persons participating in this Plan as soon as possible after the amendment is adopted. Any amendment that reduces benefits under the Plan shall not be effective until first communicated to such persons.

If the Plan is amended or terminated, no Employee or Dependent or beneficiary shall be entitled to receive any other benefit described in the Plan and shall not be entitled to receive any different type of coverage or replacement coverage. Upon termination of the Plan, in the event that the assets of the Plan are insufficient to fund claims Incurred, the Plan Administrator shall have the sole and absolute discretion to make any pro rata or other adjustment of benefits, if necessary, so long as said adjustment is made in a non-discriminatory manner.

PLAN ADMINISTRATOR DISCRETIONARY AUTHORITY

The Plan Administrator or its designee will have full discretionary authority and will have all power necessary or convenient to enable the Plan Administrator or its designee to consider claims for benefits pursuant to the "Claims and Appeals Procedures" Section set forth in the Plan and to interpret all plan documents. Benefits will be paid under this Plan only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. All such determinations will be final and binding to all persons affected thereby.

LIABILITY DOES NOT CREATE EMPLOYMENT CONTRACT

This Plan has been established to provide employee benefits only. Said benefits are provided only to the extent specified herein. This Plan is not to be considered as guarantor or other source of indemnification with respect to any Expenses Incurred by a Covered Person. This Plan will not be liable for any injury to any Covered Person which results from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any provider of services in the course of rendering service.

MAINTENANCE OF EMPLOYEE RECORDS

This Plan will maintain records from which may be determined the names, addresses, and effective dates of all employees participating in this Plan. This Plan will, as often as is necessary, require verification as to Dependents entitled to receive benefits under this Plan.

Clerical errors or delay of this Plan in keeping or reporting data relative to coverage will not invalidate benefits that would otherwise be validly provided. Upon discovery of such errors or delay, an equitable adjustment or contribution will be made.

ASSIGNMENT OF PLAN NOT PERMITTED

Except for assignment of benefits to a service provider by Participants, no assignment of this Plan is allowed.

BENEFITS EXEMPT FROM ATTACHMENT

To the full extent permitted by law, all rights and benefits accruing under this Plan are exempt from execution, attachment, garnishment or other legal or equitable process, for debts or liabilities of any Covered Person.

NO WAIVER OR ESTOPPEL

A failure to enforce any provisions of this Plan will not affect any right hereafter to enforce any such provisions, nor will such failure affect any right to enforce any other provisions of this Plan.

IDENTIFICATION CARDS

Each covered Participant will receive an identification card.

CONTRIBUTIONS

The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each Covered Employee and Covered Retiree.

On and after the effective date of termination of the Plan, the obligation of the Employer to make additional contributions to the Plan shall be limited to the amount required to assure payment of benefits under the Plan for Expenses Incurred prior to such date of termination.

FUNDS FOR PAYMENTS OF CLAIMS PAID FROM GENERAL ASSETS

Funds for payment of claims are paid from the Employer's general assets.

CONFORMITY WITH LAW

If any provisions of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations not warranties. No such representations will be used to void coverage or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan.

No failure to enforce any provision of the Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of the Plan.

NOTICE AND PROOF OF CLAIM

Written proof of Covered Expenses must be furnished to the Plan Administrator within one year after the claimed Covered Expenses were Incurred, unless the claimant was legally incapacitated. Failure to furnish written proof of Covered Expenses within that time will neither invalidate nor reduce any claim if it can be shown that it was not reasonably possible to furnish written proof of Covered Expenses within that time, and that written proof of Covered Expenses was furnished as soon as was reasonably possible.

PAYMENT OF BENEFITS

All benefits under this Plan will be paid to the Participant unless he or she has previously authorized payment to the person or institution rendering service, treatment or supplies.

If the Participant dies before all benefits are paid, remaining benefits are paid to any relative of the Participant or to any person or corporation appearing to this Plan to be entitled to payment. The Plan will fully discharge its liability by such payment.

Any Participant may assign benefits to the person or institution rendering service, treatment or supplies. No such assignment will bind this Plan unless it is in writing and received prior to payment of benefits.

If benefits are to be assigned, when a Participant or one of his or her Dependents is admitted to a Hospital, the Participant should show his or her Plan identification card and sign a Hospital form for assignment of benefits. If the Participant does so, the Hospital should send its itemized bill directly to PPO Provider.

EXAMINATION

The Employer will have the right and opportunity, at its own expense, to have a Covered Person examined by a Physician as often as is reasonably necessary while a claim is pending for an Injury or Illness. The Employer will also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intention of the Plan, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to recover such excess payments.

FUTURE OF THE PLAN

The Employer intends to continue the Plan, but reserves the right to terminate it or amend it in any way. If the Plan should be discontinued, all eligible claims outstanding at that time will be paid in full or paid on a prorated basis.

PLAN DOCUMENTS

This Plan Document and Summary Plan Description contains all the provisions of the Plan and governs its legal operations.

SIGNATURE PAGE

FOR THE

CITY OF FORT WAYNE
EMPLOYEE BENEFIT PLAN

APPROVED AND ACCEPTED

IN WITNESS WHEREOF, the City of Fort Wayne has caused the Plan to be executed as of this

_____ day of May 1, 2024, 2024, to be effective as of the

date identified above.

"EMPLOYER"
CITY OF FORT WAYNE

By: Laura Helmkamp
Laura Helmkamp (May 1, 2024 11:27 EDT)
Name/Title

Printed Name: Laura Helmkamp

City of Fort Wayne Restated Employee Benefit Plan and SPD 20240101

Final Audit Report 2024-05-01

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By:	Leslie Byrne (lesliebyrne@mds-mgu.com)
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