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

- Medical Benefits
- Prescription Drug Benefits

INTRODUCTION

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

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

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

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

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

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

TABLE OF CONTENTS

INTRODUCTION i
SECTION I: DEFINITIONS 1
SECTION II: PLAN OVERVIEW 13
- Your Eligibility 13
- Eligible Dependents 13
- Working Spouse Rule 14
- Proof of Dependent Eligibility 14
- Early Retiree Benefits Under Indiana Law 15
  - Enrolling in Early Retiree Coverage 16
  - Benefits for Public Safety Employees Receiving Disability Benefits 17
  - Special Benefit for Medicare-Eligible Retirees 19
- When Coverage Begins 20
  - Look-back Measurement Method for Determining Full-time Employee Status 20
  - For You 21
  - For Your Dependents 21
- Your Cost for Coverage 21
- Enrolling for Coverage 22
  - New Hire Enrollment 22
- Open Enrollment 22
- Effect of Section 125 Tax Regulations on this Plan 23
- Qualifying Change in Status 23
- Special Enrollment Rights 24
- When Coverage Ends 26
- Cancellation of Coverage 27
- Rescission of Coverage 27
- Coverage While Not at Work 27
- If You Are Disabled or FMLA Approved Leave 27
- If You Are Temporarily Laid Off 27
- Leave of Absence 27
- Continuation during Family and Medical Leave 28
- If You Take a Military Leave of Absence 28
- If You Are Permanently Laid Off 28

SECTION III: YOUR MEDICAL BENEFITS 29
- Your Deductible 31
  - PPO Deductible Accumulation: Embedded 31
  - HDHP Deductible Accumulation: Non-Embedded 31
- High Deductible Health Plan with Health Savings Account 32
- Your Copayment (“Copay”) 32
- Your Coinsurance Amount 32
- Your Out-of-Pocket Limit 32
- Summary of Medical Benefits 34
  - PPO Plan 34
  - HDHP Plan 37
- Eligible Expenses 41
- Expenses Not Covered 54
  - Procedure 59
  - Penalty for Non-compliance with Precertification 60
  - Utilization Review 60
- Case Management 60

SECTION IV: YOUR PRESCRIPTION DRUG BENEFITS 62
- How the Plan Works 62
- Using a Network Retail Pharmacy 62
- If You Use an Out-of-Network Retail Pharmacy 62
- Using the Mail-Order Program 62
- Direct Member Reimbursement 63

Coverage Categories ... 63
Prior Authorization ... 63
Specialty Medications ... 63
Covered Prescription Drugs and Supplies ... 63
Prescription Drug Expenses Not Covered ... 64
For More Information ... 65
Summary of Pharmacy Benefits ... 66
PPO Plan ... 66
HDHP Plan ... 66
SECTION V: ADMINISTRATIVE INFORMATION ... 67
Plan Sponsor and Administrator ... 67
Benefit Year ... 68
Plan Year ... 68
Plan Restated Effective Date ... 68
Plan Number ... 68
Type of Plan ... 68
Identification Numbers ... 68
Plan Funding and Type of Administration ... 68
Claims Administrators ... 68
Agent for Service of Legal Process ... 69
Future of the Plan ... 69
SECTION VI: PLAN ADMINISTRATION ... 70
Plan Administrator ... 70
Duties of Plan Administrator ... 70
Plan Administrator Compensation ... 70
Indemnity ... 70
Fiduciary ... 71
Fiduciary Duties ... 71
Named Fiduciary ... 71
Claims Administrator is Not Fiduciary ... 71
Clerical Error ... 71
Amending and Terminating Plan ... 72
SECTION VII: PROCEDURES FOR OBTAINING OR DETERMINING BENEFITS ... 73
Claim Filing ... 73
Out-of-Network Providers ... 73
Claim Form ... 73
Claim Determination ... 73
Pre-Service Claims ... 73
Post-Service Claims ... 74
Urgent Pre-Service Health Claims ... 74
Concurrent Care Claims ... 75
Grievances ... 75
Appeal Procedures ... 76
General ... 76
Claimant's Rights on Appeal ... 76
Appeals Hearing Committee ... 77
Notification of Resolution of Appeal ... 77
Expedited Appeals ... 78
Initial Notice of Decision on Appeal ... 78
Subsequent Appeal Participants ... 78
Subsequent Appeal Process ... 79
Subsequent Notices of Decision on Appeal ... 80
External Review of Appeals Process ... 80
Notification of Decision ... 82
Coordination of Benefits (COB) ... 82
Standard Coordination of Benefits ... 83
How Standard Coordination Works ... 83

Order of Benefit Determination Rules ... 83
Coordination with Medicare ... 85
For Maximum Benefit ... 85
Subrogation and Reimbursement ... 85
Right of Recovery ... 85
Right to Subrogation ... 86
Right to Reimbursement ... 86
Third-Parties ... 86
Pay and Pursue ... 86
When This Provision Applies To You ... 87
SECTION VIII: YOUR OTHER RIGHTS ... 89
Receive Information about Your Plan and Benefits ... 89
Continue Group Health Plan Coverage ... 89
Assistance with Your Questions ... 89
SECTION IX: YOUR HIPAA/COBRA RIGHTS ... 90
Health Insurance Portability and Accountability Act of 1996 (HIPAA) ... 90
Protected Health Information and its Disclosure ... 90
Certificate of Creditable Coverage ... 91
Continuing Health Care Coverage through COBRA ... 92
COBRA Qualifying Events and Length of Coverage ... 92
18-Month Continuation ... 92
18-Month Continuation Plus 11-Month Extension ... 93
36-Month Continuation ... 93
COBRA Notifications ... 94
Cost of COBRA Coverage ... 94
COBRA Continuation Coverage Payments ... 94
How Benefit Extensions Impact COBRA ... 95
When COBRA Coverage Ends ... 95
SECTION X: GENERAL PROVISIONS ... 96
No Obligation to Continue Employment ... 96
Payment of Benefits ... 96
Payment of Benefits to Others ... 96
Non-Alienation of Benefits ... 96
Expenses ... 96
Fraud ... 96
Typographical or Administrative Error ... 96
Severability ... 97
Incontestability ... 97
Limitation of Action ... 97
Governing Law ... 97
Conformity with Statutes and Regulations ... 97
Non-discrimination ... 97
ADOPTION OF THE PLAN ... 100

SECTION I: DEFINITIONS

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

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

- is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- was present at work on the last scheduled working day before:
    - a scheduled vacation;
    - an absence due to a paid holiday, paid jury or witness day, a paid bereavement day, or other form of excused Paid Time Off (PTO);
    - a scheduled day off within the participant's working schedule;
    - an absence excused by the Plan Sponsor; or
    - for purposes of eligibility, if the Participant is absent from work because of a health factor and the absence is excused FMLA protected absence, or the absence is granted as part of an ADA accommodation plan. Paid Time Off (PTO) runs concurrent to FMLA & ADA leave, but if an employee does not have sufficient PTO for FMLA & ADA obligations, unpaid leave may be granted as an excused absence to meet FMLA & ADA standards consistent with Plan Sponsor policy on excused absence.

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

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

Americans With Disabilities Act ("ADA"): a Federal law, as amended, that provides for unpaid leave (Plan Sponsor can affirmatively substitute paid leave if PTO is available) with a planned return date to work as a form of reasonable accommodation with information from the Employee's medical provider if the employee meets eligibility criteria under the ADA. All government employees are eligible for coverage under the ADA if they meet criteria in the law. You should contact the Plan Sponsor with any questions you have regarding eligibility for ADA coverage or how it applies to you.

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

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

Approved Clinical Trial: A phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Experimental or Investigational new drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for services considered "routine patient costs".

A "qualified individual" is a Participant who is eligible to participate in an "Approved Clinical Trial" according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring Physician is a participating provider and has concluded that the participant's participation is appropriate; or (2) the Participant provides medical and scientific information establishing that his/her participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the Plan that is covered for a qualified individual who is not enrolled in an Approved Clinical Trial. Routine patient costs do not include (1) the Experimental or Investigational item, device or service itself; (2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of-network benefits are otherwise provided under the Plan.

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

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

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

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

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

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

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

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

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

Confinement: an inpatient admission to a healthcare facility.

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

Continuing Care Patient means a Participant who, with respect to a provider or facility, are at least one of the following:

- undergoing treatment from the provider or facility for a serious and complex condition, defined as:
  - in the case of an acute Illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
  - in the case of a chronic Illness or condition, a condition that is:
    - life-threatening, degenerative, potentially disabling, or congenital; and
    - requires specialized medical care over a prolonged period of time.
  - undergoing a course of institutional or inpatient care from the provider or facility
  - scheduled to undergo non-elective surgery from the provider or facility, including receipt of post-operative care from such provider or facility with respect to such a surgery.

- pregnant and undergoing a course of treatment for the pregnancy from the provider or facility.
- terminally ill and is receiving treatment for such Illness from the provider or facility.
  - for purposes of this subsection, an individual is considered to be terminally ill if the individual has a medical prognosis that the individual's life expectancy is 6 months or less.

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

Cosmetic Dentistry: dentally unnecessary procedures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Employer: City of Columbus and its affiliates that have Employees under the Plan.

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

Experimental or Investigational Services: Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices which do not conform to the relevant standard(s) of care or fall within the range of accepted standards of medical practice in a given case as determined by a reasonably substantial, qualified, responsible, and relevant segment of the medical community or regulatory oversight agency at the time relevant services were rendered. These services, supplies, and treatment are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein.

Plan Administrator or its designee must make an evaluation of the Experimental/non-Experimental standings of specific treatments, therapies, or technologies. Plan Administrator or its designee shall be guided by a reasonable interpretation of Plan provisions and information provided by other qualified sources who have also reviewed the information provided. Decisions must be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. Plan Administrator or its designee will be guided by the following principles to determine what is defined as “Experimental or Investigational Services”:

- not approved by the FDA, as that term is defined below, to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use, unless it is: (a) designated Humanitarian Use Device (HUD), as defined by 21 CFR 814.3(n) as amended and other relevant laws and regulations, at the time that the HUD is supplied, used, and/or rendered and (b) the HUD is appropriately supplied or rendered according to a validly obtained and approved Humanitarian Device Exception (HDE) by the FDA as defined by 21 CFR 814.2 as amended and other relevant laws and regulations;
- the subject of an ongoing clinical trial that meets the definition of a phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial actually is subject to FDA oversight; or
- not demonstrated through authoritative medical or scientific literature published in the U.S. to be safe and effective for treating or diagnosing the condition or Illness for which its use is proposed.

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

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

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

FDA: the United States Food and Drug Administration.

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

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

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

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

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

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

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

Hospital: a legally licensed facility that:

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

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

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

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

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

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

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

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

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

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

Medical Condition: an Injury or Illness.

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

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

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

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

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

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

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

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

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

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

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

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

Orthoptics/Pleoptics: Orthoptic training is the treatment of defective visual habits, defects of binocular vision, and muscle imbalance (strabismus) by re-education of visual habits, exercise, and visual training. Pleoptic training is system of treating amblyopia (lazy eye) by retraining visual habits using guided exercises. This service is usually prescribed by an ophthalmologist or optometrist or orthoptists (health professional uniquely trained to evaluate and manage childhood and adult eye movement abnormalities).

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

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

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

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

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

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

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

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

Pre-certification: means the process used to determine that Medical Care is Medically Necessary before it is provided to the Participant. The description of Covered Expenses requiring Precertification can be found in the Your Medical Benefits section.

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

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

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

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

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

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

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

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

Retired Employee: is Retired Public Safety Employees as defined in I.C. 5-10-8-2.2 (b),

- Retired Employees as defined in I.C. 5-10-8-1(9)(A), who will have:
  - Reached fifty-five (55) years of age on or before the employee's retirement date but will not be eligible on that date for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*;
  - Completed twenty (20) years of creditable employment with a public employer on or before the employee's retirement date, ten (10) years of which must have been completed immediately preceding the retirement date; and
  - Completed at least fifteen (15) years of participation in the retirement plan of which the employee is a member on or before the employee's retirement date.

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

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

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

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

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

Total Disability (Totally Disabled): means, in the case of an Employee, the complete inability to perform any and every duty of his occupation or employment. In the case of a Dependent, the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

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

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

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

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

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

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

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

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

SECTION II: PLAN OVERVIEW

Your Eligibility

You are eligible for benefits if you are:

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

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

Eligible Dependents

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

- your legal Spouse who is a resident of the same country in which the Employee resides. The term "Spouse" shall mean any individuals who are lawfully married. The Plan Administrator may require documentation proving a legal marital relationship;
- a dependent of a Retired Employee, who continues to meet all other eligibility requirements, and who is eligible to continue coverage under the Plan as defined below;
- your Child under age 26 regardless of financial dependency, residency with you, marital status, or student status; and
- your Child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you. The Plan Administrator may require, at reasonable intervals during the two years following the dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency. The Plan Administrator shall accept plan participants who were considered totally dependent under previous plans offered by Plan Sponsor for a two-year period, before requesting subsequent proof of child's Total Disability and dependency, in order to provide consistency of coverage to employees.

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

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

For purposes of the Plan, your Child means:

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

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

- a person enrolled as an employee under the Plan;
- any person who is in active military services;
- a Foster Child;
- a Legally Separated Spouse;
- a former Spouse;
- a domestic partner; and
- a domestic partner's child(ren).

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

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

Working Spouse Rule

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

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

Proof of Dependent Eligibility

The Plan Sponsor reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for

coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

Early Retiree Benefits Under Indiana Law

If you retire prior to age 65 and satisfy certain requirements under Indiana law, you will be offered the choice between two medical coverage continuation options: (a) COBRA coverage under federal law; and (b) early retiree coverage under Indiana law. The chart below provides a basic comparison of the two options that will apply in most situations.

Option A: COBRA Coverage	**-OR-**	**Option B: Early Retiree Coverage**
Eligibility: Employees eligible upon termination of employment (unless for cause).		Eligibility: Employees eligible for coverage include: • Retired Public Safety Employees as defined in I.C. 5-10-8-2.2 (b), • Retired Employees as defined in I.C. 5-10-8-1(9)(A), who will have: ○ Reached fifty-five (55) years of age on or before the employee's retirement date but will not be eligible on that date for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*; ○ Completed twenty (20) years of creditable employment with a public employer on or before the employee's retirement date, ten (10) years of which must have been completed immediately preceding the retirement date; and ○ Completed at least fifteen (15) years of participation in the retirement plan of which the employee is a member on or before the employee's retirement date.
Cost to Employee: 102% of cost of coverage.		Cost to Employee: 50% of the cost of coverage.
Duration: Up to 18 months; coverage terminates with other group or Medicare enrollment.		Duration: Coverage terminates upon Medicare eligibility.
Spousal and Dependent Coverage: Yes		Spousal and Dependent Coverage: Yes

In most cases, early retiree coverage under Indiana law offers greater benefits than COBRA coverage. However, each situation is unique and you are ultimately responsible to determine which option is better for you.

Note: All eligible retirees and Dependents that enroll will be required to elect coverage in writing each year to continue their coverage. The Retired Employee is required to pay the amount as set by the Plan Administrator.

Enrolling in Early Retiree Coverage

If you decide to elect early retiree coverage under Indiana law, you will need to take the following steps:

- be enrolled in the medical plan at the date of your retirement; or
- provide written notice and enroll in the medical plan on or before the 90th day following your retirement date.

Your Spouse and Dependents must also either be enrolled in the medical plan at the time of your retirement, or, alternatively, must enroll on or before the 90th day following your retirement date to be eligible for early retiree coverage. If not enrolled during this period, the Spouse and/or Dependents may only enroll in the medical plan during a Special Enrollment. Special Enrollment rights for Early Retirees are limited to marriage, birth, adoption or placement for adoption.

Termination

If you are an Early Retiree, your eligibility to participate in the medical plan will terminate upon the date you become eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.* If you are an Early Retiree and decide to terminate your coverage prior to Medicare eligibility, coverage for your Spouse and Dependents will also terminate at that time.

If you are an Early Retiree and you die prior to Medicare eligibility, your Spouse will be eligible to participate in the medical plan until the earliest of: (a) the date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*; (b) the date s/he remarries; or (c) the date the Spouse becomes eligible for another employer-sponsored medical plan.

If you are an Early Retiree and your coverage terminates upon Medicare eligibility, your Spouse will be eligible to participate in the medical plan until the earliest of: (a) the date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*; or (b) if you die, the date that s/he remarries.

Coverage for other Dependents will terminate upon the earliest of: (a) the date the Dependent no longer satisfies the definition of “Dependent” established by the medical plan; (b) the date your coverage terminates as an Early Retiree; or (c) the date the Dependent becomes eligible for another employer-sponsored medical plan or Medicare. If a Dependent cannot work to support him/herself due to physical or mental disability, coverage for the Dependent will terminate when neither the Early Retiree nor the Spouse is covered by the medical plan. Verification of Dependent status may be required at any time.

Notwithstanding the foregoing, coverage for you, your Spouse and any Dependents will terminate immediately if you fail to pay your premiums in a timely manner. In addition, if the Plan Sponsor terminates the medical plan, coverage for you, your Spouse and any Dependents will terminate.

Benefits for Public Safety Employees Receiving Disability Benefits

If you are a public safety employee who is receiving disability benefits under the 1925 Police Pension Fund, the 1937 Firefighters' Pension Fund, the 1953 Police Pension Fund, the 1977 Police Officers' and Firefighters' Pension and Disability Fund or a sheriff's disability fund established pursuant to Indiana Code § 36-8-10, you may be eligible for continuing medical coverage as described in this section.

To elect continuing medical coverage, you will need to take the following steps:

- Be enrolled in the medical plan at the date of your disability; or
- Provide written notice and enroll in the medical plan within 90 days following the date you begin receiving disability benefits.

Your Spouse and Dependents must also either be enrolled in the medical plan at the time of your disability, or, alternatively, must enroll within 90 days following the date you begin receiving disability benefits. If not enrolled during this period, the Spouse and/or Dependents may only enroll in the medical plan during a Special Enrollment.

Termination

If you are a disabled public safety employee, your eligibility to participate in the medical plan will terminate upon the date you become eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.* If you are a disabled public safety employee and decide to terminate your coverage prior to Medicare eligibility, coverage for your Spouse and Dependents will also terminate at that time.

If you are a disabled public safety employee and you die prior to Medicare eligibility, your Spouse will be eligible to participate in the medical plan until the earliest of: (a) the date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*; (b) the date s/he remarries; or (c) the date the Spouse becomes eligible for another employer-sponsored medical plan.

If you are a disabled public safety employee and your coverage terminates upon Medicare eligibility, your Spouse will be eligible to participate in the medical plan until the earliest of: (a) the date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*; or (b) if you die, the date that s/he remarries.

Coverage for other Dependents will terminate upon the earliest of: (a) the date the Dependent no longer satisfies the definition of "Dependent" established by the medical plan; (b) the date your coverage terminates as a disabled public safety employee; or (c) the date the Dependent becomes eligible for another employer-sponsored medical plan or Medicare. If a Dependent cannot work to support him/herself due to mental retardation or physical or mental handicap, coverage for the Dependent will terminate when neither the disabled public safety employee nor

the Spouse is covered by the medical plan. Verification of Dependent status may be required at any time.

Notwithstanding the foregoing, coverage for you, your Spouse and any Dependents will terminate immediately if you fail to pay your premiums in a timely manner. In addition, if the Plan Sponsor terminates the medical plan, coverage for you, your Spouse and any Dependents will terminate.

Benefits for Surviving Spouses and Dependents of Public Safety Employees Who Die While in Active Service (Member of 1925 Police Pension Fund, the 1937 Firefighters' Pension Fund, the 1953 Police Pension Fund, or the 1977 Police Officers' and Firefighters' Pension and Disability Fund)

If the public safety employee was member of the 1925 Police Pension Fund, the 1937 Firefighters' Pension Fund, the 1953 Police Pension Fund, the 1977 Police Officers' and Firefighters' Pension and Disability Fund, the Plan Sponsor shall offer to provide and pay for health insurance coverage for the deceased employee's surviving Spouse and for each natural child, stepchild, or adopted child:

- until the child becomes eighteen (18) years of age;
- until the child becomes twenty-three (23) years of age if the child is enrolled in and regularly attending a secondary school or is a full-time student at an accredited college or university; or
- during the entire period of the child's physical or mental disability;

whichever period is longest. The health insurance provided to a surviving Spouse and child must be equal in coverage to that offered to active employees. The offer to provide and pay for health insurance coverage shall remain open for as long as there is a surviving Spouse or as long as a natural child, stepchild, or adopted child of the deceased employees is eligible for coverage in accordance with this section.

Benefits for Surviving Spouses and Dependents of Public Safety Employees Who Die While in Active Service (Not Member of 1925 Police Pension Fund, the 1937 Firefighters' Pension Fund, the 1953 Police Pension Fund, or the 1977 Police Officers' and Firefighters' Pension and Disability Fund)

Except as provided by Indiana law, a surviving Spouse or Dependent of a public safety employee who dies in the line of duty shall be entitled to continuing medical coverage.

To elect continuing medical coverage, you will need to take the following steps:

<u>Be enrolled in the medical plan as of the date of death of the public safety employee; or Provide written notice and enroll in the medical plan within 90 days following the date of death of the public safety employee.</u>

Termination

If you are the surviving Spouse of a public safety employee who dies in the line of duty, you will be eligible to participate in the medical plan until the earliest of: (a) the date that you become

eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; (b) the date you remarry; or (c) the date you become eligible for another employer-sponsored medical plan.

If you are the Dependent of a public safety employee who dies in the line of duty, you will be eligible to participate in the medical plan until the earliest of: (a) the date you no longer satisfy the definition of "Dependent" established by the medical plan; or (b) the date you become eligible for another employer-sponsored medical plan or Medicare. Verification of Dependent status may be required at any time.

Notwithstanding the foregoing, coverage for the surviving Spouse or Dependent of a public safety employee who dies in the line of duty will terminate immediately if premiums are not paid in a timely manner. In addition, if the Plan Sponsor terminates the medical plan, coverage for you, your Spouse and any Dependents will terminate.

Special Benefit for Medicare-Eligible Retirees

Medicare is the federally-funded medical plan for Americans aged 65 and over that covers medical expenses such as doctor's visits, hospital stays, drugs and other treatment. Most Americans are eligible for Medicare when they turn 65. There is an initial enrollment period of 7 months after one's 65th birthday, when one can enroll in Medicare for free.

If you are age 65 at retirement, then Medicare will be available as an option for medical insurance coverage. As a retiree, you may also obtain private insurance coverage.

The Plan Sponsor also has a unique benefit which provides continuing coverage to a Spouse of an Employee who retires after becoming eligible for Medicare coverage as provided by 42 U.S.C. § 1395 *et seq*.

To be eligible for this unique benefit, the retiree must satisfy the requirements for early retiree coverage under Indiana law (discussed previously), excluding the requirement that the retiree must ineligible on that date for Medicare coverage. In addition, your Spouse must:

- Be enrolled in the medical plan at the date of your retirement; or
- Provide written notice and enroll in the medical plan on or before the 90th day following your retirement date.

Your Spouse's eligibility to participate in the Plan will terminate upon the date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*, provided that you are still living. If you die prior to the date that your Spouse becomes eligible for Medicare coverage, s/he will be eligible to participate in the Plan until the earliest of: (a) the date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*; or (b) the date s/he remarries.

> *For example*, Robert Jones retires from the City of Columbus and elects the unique continuation benefit his wife. Mr. Jones is 67 years of age and his wife is 61. Mrs. Jones may be eligible to remain on the plan for 4 years.

Notwithstanding the foregoing, coverage for your Spouse will terminate immediately if premiums are not paid in a timely manner.

When Coverage Begins

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

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

The look-back measurement method applies to:

- All employees

The look-back measurement method involves three different periods:

- Measurement period
- Stability period
- Administrative period

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

If you are an ongoing employee, this measurement period *(Plan Sponsor uses a 12-month payroll calendar year as a measurement period)* is called the "standard measurement period." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the standard measurement period and any administrative period.

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

If you are a new non-seasonal employee who is expected to work full time, Plan Sponsor will determine your status as a full-time employee who is eligible for the Plan's health care benefits based on your hours of service for each *payroll calendar year (12 months).* Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

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

An administrative period is a short period between the measurement period and the stability period when City of Columbus performs administrative tasks, such as determining eligibility for

coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

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

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

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

For You

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

For Your Dependents

If you enroll your eligible dependents within 31 days of your initial eligibility, (sixty-one (61) days for a new birth), their coverage begins at the same time as yours.

When You and Your Dependents are Covered Employees

When both you and your spouse are covered Employees, each of you must choose coverage as either an Employee or as a dependent. You may not be covered under this Plan as both. Eligible dependent Children of covered Employees may not be enrolled as dependents of both Employees, whether the Employees are married or unmarried. In addition, a Child cannot be enrolled as an Employee and a dependent on the Plan.

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

Your Cost for Coverage

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

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

Enrolling for Coverage

New Hire Enrollment

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

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

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

Open Enrollment

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

Every 4th Quarter (time to be announced) during the Open Enrollment Period, covered Employees and their covered dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

During the designated Open Enrollment Period, Employees and their dependents who are Late Enrollees will be able to enroll in the Plan.

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

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

“Open Enrollment Period” shall mean the time frame specified by the Plan Administrator.

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

Effect of Section 125 Tax Regulations on this Plan

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

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each open enrollment. However, at any time throughout the year, you can make changes to your coverage within sixty-one (61) days of the following:

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

Qualifying Change in Status

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

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

- change in marital status (e.g., marriage, legal separation, annulment, or divorce);
- changes in the number of dependents (e.g., increase through birth, adoption, or placement of adoption, or decrease through death);
- a change in a dependent Child's eligibility due to age or eligibility for other coverage;
- a reduction or loss of your or a dependent's coverage under this or another plan;
- your Spouse's open enrollment period differs and you need to make changes to account for other coverage;
- a change in employment status for you or your Spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- if you have a change in employment status to less than 30 hours per week on average even if reduction does not result in loss of Plan eligibility, you may revoke your election of coverage under the health plan under the following conditions:
    - the revocation of the election of coverage under the group health plan must correspond to the intended enrollment for you (and any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage; however, the new coverage must be effective no later than the

first day of the second month after the month in which the original coverage is revoked;

- a change in your company work location or home address that changes your overall benefit options and/or prices;
- significant mid-year Plan changes (e.g., significant changes in the cost of coverage or significant curtailment of coverage);
- judgment, decree or court order, such as a QMCSO or NMSN, that mandates coverage for an otherwise eligible dependent;
- eligibility for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or seeking to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period;
- any of the HIPAA special enrollment events (please see section titled "Special Enrollment Rights");
- if you, your Spouse or dependent lose or become entitled to coverage under Medicare or Medicaid, you may commence, change, or cancel coverage for you, your Spouse or dependent under the health plan, as is consistent with the circumstances; and
- if you take a leave under the Family and Medical Leave Act of 1993 ("FMLA") you may revoke an existing election of accident or health plan coverage and make another election for the remaining portion of the period of coverage as may be provided for under the FMLA.

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

You should report a status change as soon as possible, but no later than sixty-one (61) days after the event occurs.

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

Special Enrollment Rights

If you decline enrollment for yourself or your dependents because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan if a special enrollment right occurs.

Special enrollment rights for an employee or dependent are triggered if:

1. The employee or dependent loses eligibility for non-COBRA coverage.

- Loss of eligibility includes loss of eligibility for coverage as a result of legal separation, divorce, attainment of the maximum age for child coverage under the plan, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing.
- Loss of eligibility also includes a situation where the employee no longer lives or works in an PPO's service area.
- Loss of eligibility also includes a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual (for example, Acme Company decides to stop offering benefits to all employees working in the Columbus distribution center).
- Loss of eligibility does not include a loss resulting from the failure of the employee or dependent to pay premiums on a timely basis or a termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

2. The employer terminates its contributions for non-COBRA coverage of the employee or dependent. Note that, unless there is a complete termination of employer contributions towards the coverage of an employee or dependent, increases in the cost of coverage will not trigger special enrollment rights.
3. If an employee or dependent has COBRA coverage, the employee or dependent exhausts the entire COBRA period (generally, 18, 29 or 36 months).
4. The employee or dependent becomes eligible for assistance, with respect to coverage under a plan through either a Medicaid plan under Title XIX of the Social Security Act, or the state Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. You must enroll under this Plan within sixty-one (61) days of the date you lose coverage or become eligible for premium assistance.
5. The employee acquires a new spouse or dependent by marriage, birth, adoption, or placement for adoption. In these cases (limited to # 4), the following individuals are entitled to special enrollment:
    - A current employee who is eligible but not enrolled;
    - A current employee who is eligible but not enrolled, and the Spouse of such employee;
    - A current employee who is eligible but not enrolled, and the newly acquired dependent of such employee;
    - The Spouse of an employee who is a Participant;
    - A current employee who is eligible but not enrolled, and the Spouse and newly acquired dependent; and
    - A newly acquired dependent of an employee who is a Participant.
6. Special enrollment is otherwise required by federal law.

Acquiring of a New Dependent

If you acquire a new dependent, such as a through marriage, dependent birth or an adoption or placement for adoption, coverage will take effect on the date of the marriage, birth, the date of the adoption, or placement for adoption, as long as you enroll the dependent within sixty-one (61) days of the date on which they became eligible.

A newborn child born while you are enrolled for medical coverage will automatically be covered on your Plan from birth for a period of sixty-one (61) days. Coverage will continue for the newborn as long as you enroll them within sixty-one (61) days of the date on which they became eligible. If you wait longer than sixty-one (61) days, you may not be able to enroll the newborn until the next annual enrollment period. Charges for nursery and physician care for the newborn will be applied toward the plan of the covered newborn. A separate deductible and coinsurance will apply to charges incurred by the newborn child.

When Coverage Ends

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

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the day your dependent is no longer eligible for coverage. However, for a dependent Child who reaches the limiting age, coverage will end on the last day of the calendar month of their 26th birthday as long as you are still active on the Plan.

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

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

Reinstatement of Coverage

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

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

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

Cancellation of Coverage

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

Rescission of Coverage

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

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

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

Coverage While Not at Work

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

If You Are Disabled or FMLA Approved Leave

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

If You Are Temporarily Laid Off

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

Leave of Absence

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

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

Continuation during Family and Medical Leave

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

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

If You Take a Military Leave of Absence

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

If You Are Permanently Laid Off

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

SECTION III: YOUR MEDICAL BENEFITS

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

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

This Plan contains a Participating Provider Organization (PPO) which is a group contracted providers that provide services at negotiated rates. Please refer to your identification card for information about your PPO network(s).

PPO name:	Inspire Network
Address:	PO Box 1787 Columbus, IN 47202
Telephone:	(844) 425-4281
Website:	www.siho.org

PPO name:	SIHO Network
Address:	PO Box 1787 Columbus, IN 47202
Telephone:	(844) 425-4281
Website:	www.siho.org

Out-of-Area PPO name:	PHCS (*Logo on back of ID card)*
Address:	1100 Winter St. Waltham, MA 02451
Telephone:	1-888-779-7427
Website:	www.multiplan.com

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

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

Tier benefit level for certain Out-of-Network services; otherwise, the payment will apply to the Out-of-Network benefit level.

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

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

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

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

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

If you use In-Network providers, the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when

you receive in-network benefits but in some cases, the provider or Claims Administrator may require you to do so.

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

Continuation of Care from a recently terminated In-Network Provider

When a provider ceases to be an In-Network Provider because of a termination of contract, the Participant will be notified of the provider's termination from the network. Certain health care services provided to the Participant may continue from the terminated provider at the same level of benefits as if the provider had not terminated. Terminated is defined as, with respect to a contract, the expiration or non-renewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or fraud.

If the Participant meets the definition of Continuing Care Patient, the Participant may be approved to continue care with the terminated provider for a limited time. In order for the Participant to continue care with the terminated provider, the Participant must submit a continuity of care request form to SIHO for review and approval. To request a continuity of care request form, please contact SIHO Member Services at 1-844-425-4281 or by email at member.services@siho.org.

If the request is approved, the Participant may continue to receive Medically Necessary health care and services from the provider until the earlier of; (i) the Participant is no longer a Continuing Care Patient; or (ii) 90 days from the triggering event, unless otherwise approved by the Plan.

Your Deductible

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

PPO Deductible Accumulation: Embedded

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

HDHP Deductible Accumulation: Non-Embedded

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

met before the benefit plan coverage takes effect. The family deductible may be met by any one or a combination of family members.

High Deductible Health Plan with Health Savings Account

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

Your Copayment ("Copay")

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

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

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

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

Your Coinsurance Amount

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

Your Out-of-Pocket Limit

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

PPO & HDHP Plan Out-of-Pocket Accumulation: Embedded

The Plan uses an embedded Out-of-Pocket Maximum which means when any one individual reaches the individual Out-of-Pocket Maximum, the Plan begins paying Covered Charges at 100%. If there are multiple Participants covered under the Plan, the family Out-of-Pocket Maximum amount may be met by a combination of Participants at which time the Plan begins paying Covered Charges at 100%.

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

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

Summary of Medical Benefits

PPO Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Out-of-Network Providers Tier 3
MAXIMUM ANNUAL BENEFIT AMOUNT	Unlimited		
DEDUCTIBLE, PER CALENDAR YEAR			
Per Individual	$750	$1,500	$1,500
Per Covered Family	$1,500	$3,000	$3,000
NOTE: *Amounts used to satisfy the Tier 1 Deductible accumulates toward the satisfaction of the Tier 2 Deductible and vice versa. Tier 3 does not cross apply with any other Network.*			
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Individual	$4,750	$6,000	$6,000
Per Covered Family	$9,500	$12,000	$12,000
NOTE: *Amounts used to satisfy the Tier 1 Maximum Out-of-Pocket accumulates toward the satisfaction of the Tier 2 Maximum Out-of-Pocket and vice versa. Tier 3 does not cross apply with any other Network.*			
NOTE: *The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: premiums, balance-billed charges, precertification penalties, and services this Plan does not cover.*			
Note: For a list of services that require Precertification, see the Pre-certification section.			
COVERED CHARGES			
Facility Services			
Inpatient Hospital/Facility Services			
Room and Board	80% after deductible	70% after deductible	60% after deductible
All Other Ancillary Services	80% after deductible	70% after deductible	60% after deductible
Pre-Admission Testing	80% after deductible	70% after deductible	60% after deductible
Sub-Acute Inpatient Facility	80% after deductible	70% after deductible	60% after deductible
Acute Rehabilitation Hospital	80% after deductible	70% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	70% after deductible	60% after deductible
**Calendar Year Maximum: 60 Days for Skilled Nursing*			
Outpatient Hospital/Facility Services			
Outpatient Surgery	80% after deductible	70% after deductible	60% after deductible
Diagnostic X-Rays	80% after deductible	70% after deductible	60% after deductible
CT Scan/MRI	80% after deductible	70% after deductible	60% after deductible
Chemotherapy/Radiation	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Ambulance Services			
Emergency Ambulance	80% after deductible		
NOTE: **Emergent Ambulance charges will apply to the Tier 1 benefit level. This includes non-emergent transportation from one facility to another facility.*			
Non-Emergent Ambulance	80% after deductible	70% after deductible	60% after deductible

Summary of Medical Benefits (*continued*)

PPO Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Out-of-Network Providers Tier 3
Emergency Room Services			
True Emergency*			
Facility Charges	80% after deductible		
All Physician Charges	80% after deductible		
NOTE: *Any charges incurred at an Out-of-Network provider due to True emergency will apply as In-Network benefits.*			
Non-Emergent			
Facility Charges	$150 copayment; then 80% after deductible	$150 copayment; then 70% after deductible	$150 copayment; then 60% after deductible
All Physician Charges	80% after deductible	70% after deductible	60% after deductible
Physician Services			
Primary Care			
Office visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Specialist Care			
Office Visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Urgent Care			
Office visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Inpatient & Outpatient Physician Services	80% after deductible	70% after deductible	60% after deductible
Lab Tests			
All office and outpatient labs provided at, or billed by Columbus Regional Hospital or a Columbus Regional Health Care Physician*	100% no deductible	100% no deductible	N/A
**This benefit does not apply to services provided in the Emergency Room or Inpatient.*			
All Other Place of Service *(such as Emergency Room and Inpatient)*	80% after deductible	70% after deductible	60% after deductible
All Other Physicians/Facilities regardless of location.	80% after deductible	70% after deductible	60% after deductible
Preventive Health Benefits (PHB)*			
Wellness Benefit*	100% no deductible	100% no deductible	100% no deductible
**For more complete information, please consult the Comprehensive PHB guidelines available on SIHO's website at www.siho.org.*			

Summary of Medical Benefits (*continued*)

PPO Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Out-of-Network Providers Tier 3
Mental Health/Substance Abuse			
Office Visit*	80% after deductible	70% after deductible	60% after deductible
**Includes Counseling/Therapy, Evaluation/Interview, Testing & Medication Management.*			
Inpatient	80% after deductible	70% after deductible	60% after deductible
Residential Care (RES)	80% after deductible	70% after deductible	60% after deductible
Partial Hospitalization (PHP)	80% after deductible	70% after deductible	60% after deductible
Intensive Outpatient (IOP)	80% after deductible	70% after deductible	60% after deductible
Therapy Services			
Occupational Therapy	80% after deductible	70% after deductible	60% after deductible
Physical Therapy	80% after deductible	70% after deductible	60% after deductible
Speech Therapy	80% after deductible	70% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	70% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	70% after deductible	60% after deductible
Pulmonary Rehabilitation	80% after deductible	70% after deductible	60% after deductible
Chiropractic/Spinal Manipulation*	80% after deductible	70% after deductible	60% after deductible
Calendar Year Maximum: 30 Visits. **Note: X-rays do not apply to the Calendar Year Maximum.*			
ABA Therapy	80% after deductible	70% after deductible	60% after deductible
Other Services			
Dialysis	80% after deductible	70% after deductible	60% after deductible
Second Surgical Opinion	80% after deductible	70% after deductible	60% after deductible
Durable Medical Equipment (DME	80% after deductible	70% after deductible	60% after deductible
Durable Medical Supplies	80% after deductible	70% after deductible	60% after deductible
Prosthetics	80% after deductible	70% after deductible	60% after deductible
Orthotics	80% after deductible	70% after deductible	60% after deductible
Home Health Care*	100% no deductible	100% no deductible	100% no deductible
**Calendar Year Maximum: 100 Visits*			
Hospice Care* *(includes bereavement counseling)*	80% after deductible	70% after deductible	60% after deductible
** Calendar Year Maximum: 3 months outpatient; 6 months inpatient*			
Maternity/Pregnancy*	80% after deductible	70% after deductible	60% after deductible
**Dependent Daughter Maternity Covered.*			
Morbid Obesity Treatment*	80% after deductible	70% after deductible	60% after deductible
**Calendar Year Maximum: $1,000*			
Temporomandibular Joint Disorder (TMJ)	80% after deductible	70% after deductible	60% after deductible
Organ/Tissue Transplant	80% after deductible	70% after deductible	60% after deductible
Wig/Hairpiece*	80% after deductible	70% after deductible	60% after deductible
**Initial purchase of a wig after chemotherapy*			
Hearing Aids*	80% after deductible	70% after deductible	60% after deductible
**Maximum of $1,500 every 36 months.*			

Summary of Medical Benefits

HDHP Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Out-of-Network Providers Tier 3
MAXIMUM ANNUAL BENEFIT AMOUNT	Unlimited		
DEDUCTIBLE, PER CALENDAR YEAR			
Per Individual	$1,500	$3,000	$3,000
Per Covered Family	$3,000	$6,000	$6,000
NOTE: *Amounts used to satisfy the Tier 1 Deductible accumulates toward the satisfaction of the Tier 2 Deductible and vice versa. Tier 3 does not cross apply with any other Network. The deductible is **"non-embedded"** meaning for family coverage, the entire family deductible must be met before any money is paid by the Plan.*			
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Individual	$4,750*	$6,000*	$6,000*
Per Covered Family	$9,500*	$12,000*	$12,000*
NOTE: *Amounts used to satisfy the Tier 1 Maximum Out-of-Pocket accumulates toward the satisfaction of the Tier 2 Maximum Out-of-Pocket and vice versa. Tier 3 does not cross apply with any other Network.*			
**Even though the deductible is non-embedded for family coverage, an individual will only need to meet the individual out-of-pocket maximum before the Plan pays at 100% for that individual.*			
NOTE: *The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: premiums, balance-billed charges, precertification penalties, and services this Plan does not cover.*			
Note: For a list of services that require Precertification, see the Pre-certification section.			
COVERED CHARGES			
Facility Services			
Inpatient Hospital/Facility Services			
Room and Board	80% after deductible	70% after deductible	60% after deductible
All Other Ancillary Services	80% after deductible	70% after deductible	60% after deductible
Pre-Admission Testing	80% after deductible	70% after deductible	60% after deductible
Sub-Acute Inpatient Facility	80% after deductible	70% after deductible	60% after deductible
Acute Rehabilitation Hospital	80% after deductible	70% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	70% after deductible	60% after deductible
**Calendar Year Maximum: 60 Days for Skilled Nursing*			
Outpatient Hospital/Facility Services			
Outpatient Surgery	80% after deductible	70% after deductible	60% after deductible
Diagnostic X-Rays	80% after deductible	70% after deductible	60% after deductible
CT Scan/MRI	80% after deductible	70% after deductible	60% after deductible
Chemotherapy/Radiation	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible

Summary of Medical Benefits (*continued*)

HDHP Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Out-of-Network Providers Tier 3
Ambulance Services			
Emergency Ambulance	80% after deductible		
NOTE: **Emergent Ambulance charges will apply to the Tier 1 benefit level. This includes non-emergent transportation from one facility to another facility.*			
Non-Emergent Ambulance	80% after deductible	70% after deductible	60% after deductible
Emergency Room Services			
True Emergency*			
Facility Charges	80% after deductible		
All Physician Charges	80% after deductible		
NOTE: *Any charges incurred at an Out-of-Network provider due to True emergency will apply as In-Network benefits.*			
Non-Emergent			
Facility Charges	80% after deductible	70% after deductible	60% after deductible
All Physician Charges	80% after deductible	70% after deductible	60% after deductible
Physician Services			
Primary Care			
Office visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Specialist Care			
Office Visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Urgent Care			
Office visit	80% after deductible	70% after deductible	60% after deductible
All Other Services	80% after deductible	70% after deductible	60% after deductible
Inpatient & Outpatient Physician Services	80% after deductible	70% after deductible	60% after deductible
Lab Tests			
All office and outpatient labs provided at, or billed by Columbus Regional Hospital or a Columbus Regional Health Care Physician	80% after deductible	70% after deductible	60% after deductible
All Other Place of Service *(such as Emergency Room and Inpatient)*	80% after deductible	70% after deductible	60% after deductible
All Other Physicians/Facilities regardless of location.	80% after deductible	70% after deductible	60% after deductible

Summary of Medical Benefits (*continued*)

HDHP Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Out-of-Network Providers Tier 3
Preventive Health Benefits (PHB)*			
Wellness Benefit*	100% no deductible	100% no deductible	100% no deductible
For more complete information, please consult the Comprehensive PHB guidelines available on SIHO's website at www.siho.org.			
Mental Health/Substance Abuse			
Office Visit*	80% after deductible	70% after deductible	60% after deductible
**Includes Counseling/Therapy, Evaluation/Interview, Testing & Medication Management.*			
Inpatient	80% after deductible	70% after deductible	60% after deductible
Residential Care (RES)	80% after deductible	70% after deductible	60% after deductible
Partial Hospitalization (PHP)	80% after deductible	70% after deductible	60% after deductible
Intensive Outpatient (IOP)	80% after deductible	70% after deductible	60% after deductible
Therapy Services			
Occupational Therapy	80% after deductible	70% after deductible	60% after deductible
Physical Therapy	80% after deductible	70% after deductible	60% after deductible
Speech Therapy	80% after deductible	70% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	70% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	70% after deductible	60% after deductible
Pulmonary Rehabilitation	80% after deductible	70% after deductible	60% after deductible
Chiropractic/Spinal Manipulation*	80% after deductible	70% after deductible	60% after deductible
Calendar Year Maximum: 30 Visits. **Note: X-rays do not apply to the Calendar Year Maximum.*			
ABA Therapy	80% after deductible	70% after deductible	60% after deductible
Other Services			
Dialysis	80% after deductible	70% after deductible	60% after deductible
Second Surgical Opinion	80% after deductible	70% after deductible	60% after deductible
Durable Medical Equipment (DME	80% after deductible	70% after deductible	60% after deductible
Durable Medical Supplies	80% after deductible	70% after deductible	60% after deductible
Prosthetics	80% after deductible	70% after deductible	60% after deductible
Orthotics	80% after deductible	70% after deductible	60% after deductible
Home Health Care*	80% after deductible	70% after deductible	60% after deductible
**Calendar Year Maximum: 100 Visits*			
Hospice Care* *(includes bereavement counseling)*	80% after deductible	70% after deductible	60% after deductible
** Calendar Year Maximum: 3 months outpatient; 6 months inpatient*			

Summary of Medical Benefits (*continued*)

HDHP Plan

	Inspire Network Providers Tier 1	SIHO Network Providers Tier 2	Out-of-Network Providers Tier 3
Maternity/Pregnancy*	80% after deductible	70% after deductible	60% after deductible
**Dependent Daughter Maternity Covered.*			
Morbid Obesity Treatment*	80% after deductible	70% after deductible	60% after deductible
**Calendar Year Maximum: $1,000*			
Temporomandibular Joint Disorder (TMJ)	80% after deductible	70% after deductible	60% after deductible
Organ/Tissue Transplant	80% after deductible	70% after deductible	60% after deductible
Wig/Hairpiece*	80% after deductible	70% after deductible	60% after deductible
**Initial purchase of a wig after chemotherapy*			
Hearing Aids*	80% after deductible	70% after deductible	60% after deductible
**Maximum of $1,500 every 36 months.*			

Eligible Expenses

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

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

- **Abortions (Therapeutic)**: your Plan includes benefits for a therapeutic abortion, which is an abortion permitted under Indiana law if, for reasons based upon the professional, medical judgment of the pregnant woman's physician: (i) the abortion is necessary when reasonable medical judgment dictates that performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life; (ii) the fetus is diagnosed with a lethal fetal anomaly; or (iii) the pregnancy is a result of “rape or incest” (as defined by SEA 1 – 2022 Special Session, IC 16-18- 2-306.7)
- **Acute care (inpatient) and rehab hospitals**: At an acute rehabilitation facility located in a freestanding hospital, or a rehabilitation unit in an acute care hospital. To qualify as an acute rehabilitation facility, the following must be available: medical care, physical therapy, occupational therapy, speech-language therapy, vocational rehabilitation, therapeutic recreation, psychological services, 24-hour nursing care and other services as needed. Patient must be capable of performing at least 3 hours of therapy a day, at least 5 days a week.
- **Allergy testing and treatment**: includes allergy testing, serum and injections.
- **Ambulance**: includes medically necessary professional ambulance services. A charge for this item will be a covered charge only if the service is to the nearest hospital or skilled nursing facility where necessary treatment can be provided unless the Claims Administrator finds a longer trip was medically necessary. Includes charges for local ground or air transportation by a professional ambulance service. Charges also include non-emergency transport when being transferred from one facility to another when medically necessary.
- **Ambulatory Surgical Center**: includes services and supplies provided by an Ambulatory Surgical Center in connection with a covered outpatient surgery. A Center is a licensed facility used mainly for performing outpatient surgery and does not provide for overnight stays.
- **Anesthesia**: includes anesthetics and the services of a licensed physician or certified registered nurse anesthetist (C.R.N.A.).
- **Approved Clinical Trials**:
  - Routine patient care costs that are covered:
    - those that would be covered for a patient not enrolled in a clinical trial
    - services required for the provision of the investigational item or service
    - services needed for reasonable and necessary care arising from the provision of the investigational item or service.

- Routine patient care costs that are not covered:
  - investigational item, device, or service, itself;
  - items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- In order to be considered a Covered Service, the following criteria must be met:
  - a physician must determine and document that the member is appropriate for a clinical trial; and
  - the member must meet the eligibility criteria of the trial.
- The trial must be:
  - conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition; **and is**
  - Federally-funded;
  - sponsored by FDA; or
  - a drug trial exempt from Investigational New Drug (IND) requirements.
- A trial is considered federally funded if it is approved and funded by one or more of these agencies:
  - National Institutes of Health
  - Centers for Disease Control
  - Agency for Healthcare Research Quality
  - Centers for Medicare and Medicaid Services
  - Department of Defense
  - Veterans Administration; or the
  - Department of Energy.
- If the Participant is eligible to participate in a clinical trial that is offered by both an In-Network provider and an Out-of-Network provider, only the trial offered by the network provider (and otherwise meeting the criteria of this section) will be considered a Covered Benefit.

- **Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder**: includes diagnosis and treatment.
- **Autism and Asperger's Syndrome (also known as Pervasive Developmental Disorders)**: coverage includes diagnosis and treatment, as well as Applied Behavior Analysis Therapy (ABA) for Autism. ABA Therapy involves the modification of situational events that typically precede the occurrence of a target behavior. These alterations are made to increase the likelihood of success or reduce the likelihood of problems occurring.
- **Blood**: includes blood and blood derivatives (if not replaced by or on behalf of the patient), including blood processing and administration services.

- **Cardiac Patient Exercise Program**: covered services for an individually prescribed exercise program for cardiac patients to improve cardiovascular function and physical work capacity. These services are only covered for those who have a history of bypass surgery, stable angina pectoris or acute myocardial infarction within the past twelve months. Services must be prescribed and authorized by the attending physician.
- **Cardiac Rehabilitation Phase I and II**: as deemed Medically Necessary provided services are rendered under the supervision of a Physician, in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery, initiated within 12 weeks after other treatment for the medical condition ends, and is performed in a Medical Care Facility. ***Phase III is not covered.***
- **Chemotherapy**: includes medically necessary and appropriate drugs and services of a physician or medical provider.
- **Chiropractic Care/Spinal Manipulations**: services by a licensed M.D., D.O or D.C. Chiropractic Care intended to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interfaces from or related to distortion, misalignment or subluxation of the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractic Care. X-Rays are not subject to the Calendar Year visit maximum.
- **Circumcision**
- **Contraceptives**: all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all people with reproductive capacity are covered under the Preventive Health Benefit to the extent required by the Affordable Care Act.
- **Diabetic Education**: including self-management training.
- **Diabetic Supplies**: not purchased through the pharmacy will be covered under major medical.
- **Diagnostic Lab and X-ray, Outpatient**: includes laboratory, X-ray, EKGs, and other non-surgical services performed to diagnose medical disorders by physicians throughout the United States; also includes advanced scanning and imaging work (e.g., CT scans, MRIs) and other similar advanced tests.
- **Dialysis**: treatment for acute renal failure or chronic irreversible renal insufficiency for removing waste materials from the body. Dialysis includes hemodialysis and peritoneal dialysis.
- **Durable Medical or Surgical Equipment**: rental of equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
- **Emergency Room Visits**: includes medical treatment for an emergency. An emergency is an accident or the sudden and unexpected onset of an acute condition, Illness, or severe symptoms that require immediate medical care. Examples include fractures, lacerations,

motor vehicle accidents, hemorrhage, shock, poisoning, or other conditions associated with deterioration of vital life functions.

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

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

- **Foot Care/Podiatry:** Covered services include the following:
  - care and treatment of fractures and dislocations of bones of the foot and surgical treatments (incision and drainage, removal of lesions, removal of infected toenails or nail roots);
  - surgical and non-surgical treatment of the feet including, but not limited to: weak, strained, flat, unstable or unbalance feet; bunions, heel spurs, ingrown toenails; metatarsalgia; tarsalgia; plantar fasciitis; and plantar fibromatosis;
  - in the case of metabolic (diabetes) or peripheral-vascular disease, coverage will include, treatment of corns, calluses, nail trimming, cutting and debriding of the toenails; and
  - custom-molded foot orthotics when prescribed by a Physician.
- **Genetic Testing**: coverage for genetic testing and counseling.
- **Hearing Services**: coverage includes the following:
  - charges for hearing exams and testing; and
  - hearing aids up to the limits shown in the Summary of Medical Benefits.
- **Hemodialysis and Peritoneal Dialysis Services**: includes the services of a person to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or other approved covered provider.
- **Home Health Care Services and Supplies**: charges for home health care services and supplies are covered only for care and treatment of an Injury or Illness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan. Services include but are not limited to, physical, speech, occupational or respiratory therapy by a licensed qualified therapist; nutrition counseling provided by or under the supervision of a registered dietician; or medical supplies, laboratory services, drugs, and medications prescribed by a Physician.

  Home Health Care must meet the following qualifications: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital

confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient. A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

- **Home Infusion Therapy**: charges for a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy.
- **Hospice Care Services and Supplies**: charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

  Bereavement counseling services by a licensed social worker or licensed pastoral counselor for the patient's immediate family (covered Spouse and/or dependent Children) is covered. Bereavement services must be furnished within six months after the patient's death.
- **Hospital Services**: includes hospital, ambulatory surgical center or birthing center charges for the following:
  - *Room and board* - For a semiprivate room, charges are covered at the most common rate; for a private room in a hospital with semiprivate rooms, charges are covered only up to the hospital's most common semiprivate room rate. However, if it is medically necessary to stay in a private room, the full charge will be a covered medical expense. For a private room in a private-room-only hospital, the full cost of the private room will be considered a covered medical expense.
  - services required for medical or surgical care, whether as an outpatient or inpatient, and other related services;
  - services of nursing staff and other hospital staff providing care;
  - emergency room services; and
  - medically necessary services.

  An inpatient hospital stay for the diagnosis of an Illness or Injury will be covered only if the stay is mandatory or is required for the safety of the patient or the success of a medical treatment or test. Also includes services that can be done on an outpatient basis, or services performed inpatient when a concurrent medical hazard exists that prevents the patient from being treated on an outpatient basis.
- **Human Organ and Tissue Transplants**
  - *Pre-certification Requirement for Transplant Evaluation*: expenses incurred in connection with the evaluation of a Plan Participant for any human organ or tissue transplant will be covered, but only after Referral and Precertification through the Claims Administrator has occurred. The Plan Participant or his Physician should contact the Claims Administrator for Precertification of an evaluation prior to the Referral to a transplant Physician. The Claims Administrator will assign a Case Manager to work with the Plan Participant closely through the transplant process.

- *Pre-certification Requirement for Transplant Procedure*: After the evaluation by a Plan-designated transplant Physician has occurred, the Plan Participant or the transplant Physician should contact the Case Manager. Medical information about the Plan Participant's condition and the proposed transplant protocol will be requested for review. The Case Manager will coordinate the review of the medical information for Medical Necessity and coverage determination. The Case Manager will communicate the determination to the Plan Participant and transplant Physician.
- *Covered Services*
  - Covered Transplant Procedures: any of the following adult or pediatric human organ and tissue transplant procedures determined to be Medically Necessary:
    - Heart;
    - Liver;
    - Bone marrow (related or unrelated);
    - Lung;
    - Kidney;
    - Pancreas;
    - Cornea;
    - Multivisceral/intestine;
    - Simultaneous pancreas/kidney;
    - Simultaneous heart/lung; and
    - Other method(s) of stem cell support, by whatever name called.
  - Transplant Services: any services directly related to a Covered Transplant Procedure including, but not limited to, Inpatient and Outpatient Hospital services, Physician services for diagnosis, treatment, and Surgery for a Covered Transplant Procedure, diagnostic services, and procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, as well as surgical, storage and transportation costs incurred and directly related to the successful acquisition of an organ or tissue used in an eligible and covered organ transplant. Transplant Services also include, but are not limited to, Durable Medical Equipment rental outside of the Hospital, prescription drugs including immunosuppressives, surgical supplies and dressings, and home health care.
  - Organ and/or Tissue Procurement: the payments for procurement expenses for a donor organ or tissue are covered when the Covered Transplant Procedure is performed by a specialty care Network Provider.

        - Testing/typing: charges testing/typing for prospective donors for bone marrow/stem cell transplants for a Covered Transplant Procedure as approved by the Plan.
    - *Specific Exclusions for Organ/Tissue Transplants*: there are no benefits for:
        - services and supplies of any Provider located outside of the United States of America, except for procurement services (subject to the amounts shown in the Maximums section), which will be limited to those nations which share the same protocols, standards, and registry with the U.S.A.;
        - services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied or received unless otherwise covered as a clinical trial;
        - implant of an artificial or mechanical heart or part thereof – this does not include replacement of a heart valve;
        - services for non-human organ transplants;
        - all other exclusions, limitations, or conditions set forth in this Plan, unless otherwise provided in this Human Organs and Tissue Transplants section;
        - services or supplies, including rehabilitation services, which are provide in a non-continuous chronology related to an actual transplantations performed within the effective eligibility of the Plan Participant under this Plan;
        - charges for organ transplant surgery, other than those provided in this Human Organs and Tissue Transplants section;
        - travel expenses, meals and lodging; and
        - transplants that are not medically recognized or that are experimental.
- **Infusion Therapy**: charges for a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously. Services include but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy.
- **Medical Foods**: Medical foods are considered a covered charge if intravenous therapy (IV) or tube feedings are Medically Necessary, total enteral or parenteral nutrition. Medical foods taken orally are not covered under the Plan, except for PKU formula when Medically Necessary.
- **Medical Supplies**: includes supplies such as casts, splints, dressings, catheters, colostomy bags, oxygen and syringes and needles for the treatment of allergies or diabetes.
- **Medicines**: includes medicines dispensed and administered during an inpatient stay. See Prescription Drug Benefits for outpatient prescription drug coverage information.
- **Mental Disorders and Substance Abuse**: includes care, supplies and treatment of Mental Health and Substance Abuse.

- Coverage for Mental Health treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act (MHPAES) of 2008, along with additional requirements established by the Consolidated Appropriations Act (CAA) of 2021.
- Coverage for Substance abuse includes inpatient, partial hospitalization, and outpatient treatment of substance abuse, as well as intensive outpatient programs if approved by the Plan. For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Note: Employee Assistance Program (EAP) - Employees and Dependents with mental/nervous or substance abuse problems may receive guidance for treatment alternatives through the Employee Assistance Program (EAP). This is a confidential counseling program created to help Employees identify those types of problems in their lives.

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

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

- Care provided by an EAP Counselor will be payable at 100% for up to six (6) visits. After six (6) visits, care will be covered consistent with the PPO and/or HDHP plan tier levels. In 2023, for one year, the Plan Sponsor will provide telehealth counseling through BetterHelp, or other similar telehealth counseling program, up to one appointment per week, per employee and dependent, and the assess usage to determine if this shall continue past 2023. Employees and dependents who wish to access BetterHelp should contact the Plan Sponsor's Benefits Specialist.
- **Military Medical Facility**: includes expenses for a U.S. military retiree and his/her covered dependents while confined in a military medical facility.
- **Morbid Obesity**: includes care and treatment for Morbid Obesity including surgical treatment, and complications requiring Medically Necessary intervention up to the annual maximum listed in the Summary of Medical Benefits. **Note**: weight loss medication is not covered.
- **Newborn Care**: includes services and supplies for a covered newborn who is sick or injured, including infant formula when needed for the treatment of inborn errors of metabolism while the infant is hospital-confined. Also includes hospital nursery services and routine newborn care provided during the birth confinement or on an outpatient basis for non-hospital births.

  A newborn child born while you are enrolled for medical coverage will automatically be covered on your Plan from birth for a period of sixty-one (61) days. Coverage will continue

for the newborn as long as you enroll them within sixty-one (61) days of the date on which they became eligible. If you wait longer than sixty-one (61) days, you may not be able to enroll the newborn until the next annual enrollment period. Charges for nursery and physician care for the newborn will be applied toward the plan of the covered newborn. A separate deductible and coinsurance will apply to charges incurred by the newborn child. Charges for a dependent child's newborn will not be covered.

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

  No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.
- **Orthotics**: includes orthopedic braces, casts, splints, trusses and other orthotics prescribed by a physician that are required for support of an injured or deformed part of the body as a result of a congenital condition or an accidental Injury or Illness.
- **Physician Care**: professional services of a Physician for surgical or medical services.
- **Preadmission Testing**: will be payable for diagnostic lab test and x-ray exams when:
  - performed on an outpatient basis within seven days before a Hospital confinement;
  - related to the condition which causes the confinement; or
  - performed in place of tests while Hospital confined.

  Covered Charges for this testing will be payable even if test shows the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.
- **Pregnancy**: care and treatment of pregnancy are covered the same as any other Illness, including charges provided by a licensed mid-wife. Covered expenses include one routine

ultrasound. Any ultrasound beyond the first test will be covered only if medically necessary. Pregnancy of a Dependent Daughter is also covered; however the newborn of the dependent will not be covered.

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

- **Private Duty Nursing**: provided by a licensed nurse (R.N., L.P.N. or L.V.N.) for inpatient only when care is medically necessary and the hospital's intensive care unit is filled or the hospital has no intensive care unit. Outpatient Private Duty Nursing is **not** covered.
- **Prosthetics**: includes the initial purchase of artificial limbs, eyes or other prosthetic appliances required to replace natural limbs, eyes or other body parts which have been lost due to an accidental Injury, Illness or surgery. Coverage includes repairs to return prosthetic devices to serviceable condition, replacement if prosthetic cannot be repaired, or replacement if needed due to natural growth or pathological change. Repairs or replacement for misuse or abuse of prosthetic is not covered.

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

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

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

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

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

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

- **Sexual Dysfunction/Impotence**: services are limited to the office visit and labs charges. Testosterone injections may be covered if Medically Necessary. A Letter of Medical Necessity (LMN) is required. Other medications may also be covered under the Prescription Drug Benefit.

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

  A Skilled Nursing Facility is a facility that meets all the below qualifications:
  - It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
  - Its services are provided for compensation and under the full-time supervision of a Physician.
  - It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
  - It maintains a complete medical record on each patient.
  - It has an effective utilization review plan.
  - It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
  - It is approved and licensed by Medicare.

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

  If two (2) or more surgical procedures are performed during the same operative session, the maximum benefit is as follows:
    - if all procedures are performed through the same incision or in the same natural body orifice; the amount for the procedure with the highest Maximum Eligible Charge;
    - if the procedures are performed in remote operative fields and through separate incisions; the amount for the procedure with the highest Maximum Eligible Charge plus 50% of the Maximum Eligible Charge for each other procedure;
    - if bilateral procedures are performed in separate operative fields, they are treated as one (1) procedure; the Plan will pay 1-1/2 times the Maximum Eligible Charge for the unilateral procedure; and
    - if an assistant surgeon is required, the reimbursement for the assistant surgeon's Covered Charge will not exceed 20% of either the surgeon's contracted rate for Network Physicians, or the Usual and Customary allowance for an Out-of-Network physician.
- **Surgical Dressings**: splints, casts and other devices used in reduction of fractures and dislocations.
- **Telehealth Services:** includes telehealth and video consultations (including e-visits and virtual check-ins) for treatment of an Illness or Injury. Benefits will be payable based on the provider's specialty classification (i.e., primary care, mental health/substance abuse, etc.) as set forth in the Summary of Medical Benefits and as otherwise provided in the plan document.
- **Temporomandibular Joint Dysfunction (TMJ):** surgical and non-surgical treatment of TMJ, including an oral appliance (mouth splint), myofascial pain dysfunction syndrome and/or orthognathic treatment. Coverage excludes orthodontia services by a Physician or Dentist.
- **Therapy, Short-Term**: includes the following rehabilitation therapy services provided on an outpatient basis:
    - <u>Physical Therapy</u>: includes services by a licensed therapist or physician for improvement of bodily function and provided in accordance with physician's order as to type, frequency and duration.

    - Occupational Therapy: includes services and supplies when provided by a certified occupational therapist under the direction of a physician that are needed to improve and maintain a patient's ability to function.
    - Speech Therapy: includes services of a licensed speech therapist when prescribed by a physician for any of the following:
        - surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); and
        - Injury or Illness.

  Maintenance care is not covered under any category above. Occupational therapy does not include coverage for recreational or social interaction.
- **Veterans Administration Hospital**: services for treatment of a non-service connected disability in a Veterans Administration hospital.
- **Vision Services**: covered services include:
    - medical and surgical treatment of diseases and/or injuries affecting the eye;
    - care and treatment of an abnormal condition such as strabismus, vergence dysfunction, or amblyopia, by visual training exercises (Orthoptic/Pleoptic Therapy); and
    - coverage for the initial pair of eyeglasses, contact lenses or intra-ocular lenses following cataract surgery only.
- **Wigs**: charges associated with the initial purchase of a wig/hairpiece after chemotherapy.

For More Information

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

Expenses Not Covered

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

Alternative Treatments

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

Counseling (*unless otherwise listed as covered*)

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

Custodial Care and Comfort/Convenience Items and Services

- custodial care (as defined above in the Definition section);
- care at halfway houses and group homes; and
- personal convenience items or equipment including but not limited to:
    - environmental device items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices;
    - modifications to your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, handrails, stair lifts, or ramps;
    - exercise equipment, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, first-aid supplies, and non-hospital adjustable beds; and
    - radio/television, telephone, guest service, and beauty/barber service.

Dental/Oral

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

Foot Care/Podiatry

- routine foot care including treatment of corns, calluses, nail trimming, cutting and debriding of the toenails, unless the care is necessary due to metabolic (diabetes) or peripheral-vascular disease; and
- hygienic and preventive maintenance foot care, including, but not limited to:
  - cleaning and soaking the feet;
  - applying skin creams in order to maintain skin tone;
  - other services that are performed when there is no localized Illness or Injury or symptom involving the feet; and
- over the counter (OTC) foot orthotics such as shoe inserts, arch supports, and non-custom-made foot orthotics.

Hearing Services

- charges for hearing aid batteries;
- charges for bone anchored hearing aids, or such similar devices including services, supplies or procedure in connection with the hearing devices; and
- charges for cochlear implants including any services, supplies, or procedures in connection with the cochlear implants.

Home Services/Nursing

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

Hospital Services

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

Medical Supplies/Appliances

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

Never Events

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

Obesity

- care and treatment for weight loss, including but not limited to: diet, health programs; health club dues; reversals, or weight reduction clinics and medications. Morbid Obesity treatment will be covered up to the limits shown in the Summary of Medical Benefits. ***Note:*** obesity screening and counseling are covered to the extent required by the Affordable Care Act and any other applicable laws or regulations.

Physical Appearance

- cosmetic services incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons. Services such breast reductions, rhinoplasty, vein procedures, or other possible cosmetic procedures that are Medically Necessary will require a Letter of Medical Necessity (LMN);
- exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by the Plan; and
- care and treatment for hair loss including alopecia, wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician. However, a wig/hairpiece will be covered if hair loss is a result from chemotherapy treatment.

Reproduction/Sexual

- an elective abortion unless listed as an Eligible Expense;
- sterilization reversals; and
- charges for services and supplies for testing and treatment of infertility, including, but not limited to, artificial insemination, gamete intra fallopian transfer (GIFT), and in vitro fertilization, except as specifically provided.

Services Provided by another Plan

- services or supplies of an Injury sustained or Illness contracted while on active duty in military service, unless payment is legally required;
- services and supplies covered by laws or regulations of any government agency, unless specifically covered under the Plan. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law; and
- services for any condition, illness, or injury, or any complication thereof arising out of or in the course of employment, when the Participant or covered dependent is furnished care or services covered hereunder, or could/might have been furnished such care or services if pursued or sought, according to the provisions of any Worker's Compensation or occupational disease law or insurance policy, or any other law or regulation of the United States (or any state, territory, or subdivision thereof), or according to any recognized legal remedy available to the Participant or covered dependent.

Travel-Related Expenses

- travel and accommodation expenses unless otherwise provided under the Plan for a particular service; and
- expenses for care or treatment outside of the United States, if travel was for the sole purpose of obtaining medical services.

Vision Services

- routine eye exams, eyeglasses, contact lenses, or related services, except the initial eyeglasses or contact lenses after a cataract operation; this exclusion does not apply to aphakic patients and soft lenses or sclera shells for use as corneal bandages except as may be covered under wellness benefits; and
- expenses for radial keratotomy, keratectomy, or any other surgery to correct nearsightedness, farsightedness, or refractive errors.

Miscellaneous

- services to treat injuries sustained or an Illness contracted while the Participant or covered dependent committed, conspired, or attempted to commit a felony or misdemeanor, or was engaged in an illegal occupation, conduct, or activity; this exclusions does not apply to an Injury or Illness contracted as the result of domestic violence or a medical (physical and/or mental) condition;
- services, supplies, care, or treatment for an injury or illness that results from engaging in a hazardous hobby or activity – a hobby or activity is hazardous if it is characterized by a constant threat of danger or risk of bodily harm; Hazardous hobbies or activities include skydiving, auto racing, and hang gliding;
- services, supplies, care, or treatment resulting from a Participant's or covered Dependent's illegal use of alcohol – the arresting officer's determination of inebriation will be sufficient for this exclusion; expenses will be covered for injured Participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan; this exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (physical and/or mental) condition; and
- services, supplies, care, or treatment resulting from a Participant's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a physician; expenses will be covered for injured Participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan; this exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (physical and/or mental) condition.
- services rendered by an unlicensed provider;
- care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan;
- medical and surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license;

- standby charges of a Physician;
- charges for any resident or intern of a hospital;
- services or supplies for an Illness, defect, disease, or Injury due to war or a warlike action in time of peace;
- experimental or investigational services or supplies (as defined above in the Definitions);
- charges incurred for which the Plan has no legal obligation to pay;
- any charges for maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur;
- services or supplies that are not medically necessary for diagnosing or treating your condition, as determined by the Plan;
- any charges in excess of the maximum amount payable under the Plan for a particular service or supply;
- services or supplies for which the patient does not have to pay, or for which no charges would be made if this coverage did not exist;
- charges that a school system is required by law to provide;
- charges for failure to keep a scheduled visit
- charges for completion of forms, including but not limited to claim forms, disability forms, and evidence of insurability forms;
- consultations between providers;
- services not recommended and approved by a physician or treatment, services, or supplies when the participant is not under the regular care of a physician that is appropriate for the Injury or Illness;
- professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service;
- immunizations or treatments required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage, adoption or to obtain/maintain a license of any type;
- services performed by a person who ordinarily resides in the participant's home or who is related to the Participant and/or his covered dependents as a Spouse, parent, Child, brother, or sister, whether the relationship is by blood or exists at law; and
- services, supplies, medications, or treatment required as a result of complications from a treatment not covered under the Plan, except for non-covered abortions.

Pre-certification

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

- Inpatient hospital admissions – medical and surgical
- Long Term Acute Care Hospital (LTACH) admissions
- Skilled Nursing Facility admissions
- Inpatient Rehab Facility admissions
- Inpatient Mental Health and/or Substance Abuse admissions – Hospital
- Residential Mental Health and/or Substance Abuse admissions
- Intensive Outpatient Therapy Programs
- Partial Hospitalization Therapy Programs
- Home Health care services – including nursing/PT/OT/infusion
- Hospice
- Oncology – Chemotherapy and Radiation
- Transplant Evaluations and Procedures
- Durable Medical Equipment – all rentals, any purchases greater than $1,000, includes Prosthetics
- Specialty Medications
- Speech Therapy
- Applied Behavioral Analysis (ABA Therapy)
- Dialysis
- Genetic Testing
- Neurological implants and implanted nerve stimulator devices - including but not limited to spinal cord stimulators and vagal nerve stimulators (VNS)

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

Procedure

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

The utilization review program is set in motion by a pre-certification request from the Provider by phone, fax, email or online through the Provider Portal, on behalf of the Plan Participant. It is ultimately the Plan Participant's responsibility to ensure that Precertification is obtained. We recommend that the Plan Participant follow-up with the attending, ordering, or requesting Provider to ensure that all medical information is provided to SIHO Medical Management. Confirmation of the certified treatment will be provided to the Plan Participant by letter, and relevant Provider, and the health care facility (if applicable) via fax, phone call, and/or letter. Contact SIHO Medical

Management **at least 48 hours or the next business day** before services are scheduled to be rendered with the following information:

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

In the event that a pre-certification request is denied by SIHO Medical Management, the Participant will be informed in writing. SIHO Medical Management may also contact the relevant Provider and health care facility (if applicable) via fax, phone call, and/or letter to inform them of the pre-certification denial. The Plan Participant or the Provider may appeal the decision.

Penalty for Non-compliance with Precertification

If the Plan Participant or his/her Provider does not follow pre-certification procedures and receive pre-certification from the Plan for the services, treatment, pharmaceuticals, and equipment as listed above or anywhere else in this Agreement, the services provided may be denied until the clinical information is received by SIHO Medical Management. Once the clinical information is received, SIHO Medical Management will conduct a retrospective review to determine the Medical Necessity of such services. If approved, the claim will be reopened and a 10% reduction up to $500 per claim may be applied. **Note:** pre-certification is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Plan.

Utilization Review

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

Case Management

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

The case manager will review the medical care provided to Plan Participants and may recommend alternative, cost-efficient programs of treatment. Such programs will be implemented only with the consent of the Plan Participant, his physician, and SIHO Medical Management, and may, in appropriate cases, provide for payment of benefits that would not otherwise be covered by the

Plan, if payment of such benefits is expected to accelerate recovery or reduce overall expenses. A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

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

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

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

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

SECTION IV: YOUR PRESCRIPTION DRUG BENEFITS

How the Plan Works

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

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

The pharmacy benefits available to you under the Plan are managed by OptumRx, your Pharmacy Benefits Manager (PBM). The management and other services the PBM provides include, among others, making recommendations to, and updating, the list of covered Prescription Drugs and the Formulary and managing a network of retail pharmacies.

The PBM, on behalf of the Plan, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regiments; drug interactions or drug/pregnancy concerns.

Prescription Drugs, unless otherwise stated herein, must be Medically Necessary and not Experimental and/or Investigational, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Plan can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Plan or utilization guidelines.

Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. You may purchase covered prescription drugs at a participating pharmacy. Any one pharmacy prescription is limited to a 30-day supply. For a list of participating pharmacies, please contact Rx Customer Service at 1-855-524-0381 or go to www.optumrx.com.

Present your ID card to the network pharmacy when you purchase covered prescription drugs. There are no claim forms to complete.

If You Use an Out-of-Network Retail Pharmacy

If you use an out-of-network retail pharmacy, there is no benefit.

Using the Mail-Order Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. The mail-order program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It

also can be used for any medication that is not needed immediately. For more information, please contact Rx Customer Service at 1-855-524-0381 or go to www.optumrx.com.

Direct Member Reimbursement

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

For more information regarding reimbursement, please contact Optum Rx at 1-855-524-0381 or visit www.optumrx.com.

Coverage Categories

There are multiple tiers in the prescription drug Plan; the "Summary of Pharmacy Benefits" shows your Coverage amounts.

Prior Authorization

Prior Authorization may be required for certain Prescription drugs (or the prescribed quantity of a particular drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system and the pharmacist is instructed to contact the PBM on behalf of the Plan. The PBM uses pre-approved criteria, developed by the Pharmacy and Therapeutics Committee. The PBM may contact your Provider if additional information is required to determine whether Prior Authorization should be granted. The PBM communicates the results of the decision to both you and your Provider.

If Prior Authorization is denied, you have the right to appeal through the appeals process.

For a list of the current Prescription Drugs requiring Prior Authorization, please contact Rx Customer Service at 1-855-524-0381 or go to www.optumrx.com.

Specialty Medications

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

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

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

Covered Prescription Drugs and Supplies

The following prescription drugs and supplies, among others, are covered under the Plan. **Note**: Prior authorization, age and/or quantity limits may apply:

- Hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order;
- Insulin, insulin pens, insulin cartridges, and pen needles;
- Diabetic supplies (lancets, lancing devices, alcohol swabs);
- Prescription prenatal vitamins;
- Specialty medication;
- Fertility medication and injections;
- Compound prescriptions containing at least one prescription ingredient in a therapeutic quantity;
- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) medication.
- Contraceptives: FDA-approved contraceptive methods for all women with reproductive capacity .
- Smoking-cessation medication to the extent required by the Affordable Care Act.
- Drugs used for the purpose of treating HIV/AIDS, unless considered experimental or investigational.
- Medication for erectile dysfunction (generic only).

Prescription Drug Expenses Not Covered

Note: The following exclusions are not exhaustive.

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

Administration: any charge for the administration of a covered Prescription Drug, except for certain vaccines, such as shingles, flu, and pneumonia when administered at the pharmacy.

Consumed on premises: any drug or medicine that is consumed or administered at the place where it is dispensed, except for certain vaccines, such as shingles, flu, and pneumonia when administered at the pharmacy.

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

Drugs used for cosmetic purposes: charges for drugs used for cosmetic purposes such as medications for hair growth or removal, eyelashes, and wrinkles.

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

FDA: any drug not approved by the FDA.

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

Immunization: immunization agents or biological sera.

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

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

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

Medical exclusions: a charge excluded under Medical Plan Exclusions.

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

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

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

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

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

Weight Loss Medication.

For More Information

If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the OptumRx at 1-855-524-0381.

Summary of Pharmacy Benefits

PPO Plan

PRESCRIPTION DRUG BENEFITS		
Prescription Benefits Manager (PBM) – OptumRx		
Prescription Copayments apply to the Medical Out-of-Pocket Maximums.		
Amounts listed are what member pays	**IN-NETWORK**	**NON-NETWORK**
Retail (*up to a 30-day supply*)		
Generic	$10 copayment	Not Covered
Preferred Brand	$30 copayment	Not Covered
Non-Preferred	$50 copayment	Not Covered
Retail and Mail Order (*up to a 90-day supply*)		
Generic	$25 copayment	Not Covered
Preferred Brand	$60 copayment	Not Covered
Non-Preferred	$120 copayment	Not Covered
Specialty and Biotech Medications (*up to a 30-day supply*)		
Generic	$10 copayment	Not Covered
Preferred Brand	$30 copayment	Not Covered
Non-Preferred	$50 copayment	Not Covered

HDHP Plan

PRESCRIPTION DRUG BENEFITS		
Prescription Benefits Manager (PBM) – OptumRx		
Prescription Deductible and Coinsurance apply to the Medical Out-of-Pocket Maximums.		
Amounts listed are what member pays	**IN-NETWORK**	**NON-NETWORK**
Retail (*up to a 30-day supply*)		
Generic	20% after deductible	Not Covered
Preferred Brand	20% after deductible	Not Covered
Non-Preferred	20% after deductible	Not Covered
Retail and Mail Order (*up to a 90-day supply*)		
Generic	20% after deductible	Not Covered
Preferred Brand	20% after deductible	Not Covered
Non-Preferred	20% after deductible	Not Covered
Specialty and Biotech Medications (*up to a 30-day supply*)		
Generic	20% after deductible	Not Covered
Preferred Brand	20% after deductible	Not Covered
Non-Preferred	20% after deductible	Not Covered

SECTION V: ADMINISTRATIVE INFORMATION

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

- how to contact the Plan Administrator;
- how to contact the Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under applicable Federal laws such as COBRA.

Plan Sponsor and Administrator

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

Plan Administrator

City of Columbus

123 Washington St.

Columbus, IN 47201

Tel: (812) 376-2570

Fax: (812) 376-2579

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

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

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

participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Benefit Year

The Benefit Year is January 1 through December 31.

Plan Year

The Plan Year is January 1 through December 31.

Plan Restated Effective Date

Restated January 1, 2023

Plan Number

501

Type of Plan

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

Identification Numbers

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

EIN: 35-6000989

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

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

Claims Administrators

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

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and

prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Medical /COBRA /Utilization Review

Claims Administrator

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

Agent for Service of Legal Process

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

City of Columbus, Indiana
City Hall
Office of Operations & Risk
123 Washington St.
Columbus, IN 47201

Future of the Plan

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

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

SECTION VI: PLAN ADMINISTRATION

Plan Administrator

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

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

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

Duties of Plan Administrator

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

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

Plan Administrator Compensation

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

Indemnity

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

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

Fiduciary

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

Fiduciary Duties

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

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

Named Fiduciary

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

Claims Administrator is Not Fiduciary

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

Clerical Error

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

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

Amending and Terminating Plan

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

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

SECTION VII: PROCEDURES FOR OBTAINING OR DETERMINING BENEFITS

Claim Filing

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

In order to be eligible for payment, the Claim must be submitted with receipts no later than March 31st of the year following the date of service. If the Claims Administrator approves the Claim, the Claims Administrator will reimburse the Participant or provider, as appropriate, for Covered Benefits less any applicable Copayments, Deductible, Coinsurance, penalty, and any amounts that the Claims Administrator has already paid to the Participant or the provider prior to receiving the Claim. The Claim should describe the occurrence, character, and extent of the Medical Care provided by the provider.

Out-of-Network Providers

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

Claim Form

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

Claim Determination

Pre-Service Claims

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

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

Post-Service Claims

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

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

Urgent Pre-Service Health Claims

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

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

Concurrent Care Claims

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

Grievances

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

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

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

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

If a Participant’s Grievance is denied in whole or in part, the Claim Administrator will notify the claimant, in writing or electronically, and the notice will include the following:

- the specific reason or reasons for the denial;
- reference to specific Health Plan provisions on which the denial is based;

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

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

Appeal Procedures

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

General

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

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

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

Claimant's Rights on Appeal

- The claimant will have the opportunity to submit written comments, documents, or other information relating to the Appeal. All such information must be submitted by the Participant or provider within 180 days of receipt.
- Upon request and free of charge, the claimant will be provided with reasonable access to and copies of all documents, records and other information relevant to the Appeal.

- The review will take into account all comments, documents, records and other information the claimant submits, whether or not presented or considered in the initial determination.
- No deference will be afforded to the initial determination.
- The review will be conducted by a person or persons different from the person who made the initial determination and who is not the original decision-maker's subordinate.
- If the decision is made on the grounds of a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination or that person's subordinate.
- The Claims Administrator will provide the claimant with the name of any medical or vocational expert who advised the Claims Administrator with regard to the Appeal.

Appeals Hearing Committee

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

Notification of Resolution of Appeal

- Pre-Service Appeals. In the case of an Appeal not involving urgent care, the Claims Administrator will notify the claimant of its decision within 30 days after it receives the request for review and sufficient information to make its determination.
- Urgent Care Appeals. In the case of an Appeal that relates to an Urgent Care matter, the Claims Administrator will notify the claimant of its decision within 48 hours after it receives the request for review and sufficient information to make its determination.
- Other Appeals. In the case of all other Appeals, the Claims Administrator will notify the claimant within 30 days after it receives the written request for review and sufficient information to make its determination.

Expedited Appeals

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

Initial Notice of Decision on Appeal

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

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

Subsequent Appeal Participants

- If an Appeal has been denied, the Plan has designated certain bodies and committees to participate in the review, recommendation, and decision-making process regarding subsequent appeals of an adverse Claims Administrator Appeal decision as follows:
  - The Board of Public Works and Safety ("Board of Works") will make the final determination regarding an Appeal after obtaining a recommendation from the IRC regarding the issues;
  - The Board of Works has designated and directed the Insurance Review Committee ("IRC") to review automatically any Appeal denials made by the Claims Administrator; and
  - The IRC has designated and directed the City of Columbus Medical Subcommittee ("Medical Subcommittee") to review the circumstances surrounding the Appeal

denial, including the Claim Administrator's reasons for denying the Appeal, and make a recommendation to the IRC regarding whether to uphold the Claims Administrator's decision at a private meeting.

Subsequent Appeal Process

- *Medical Subcommittee Review and Meeting*
    - Once an Appeal has been denied, a representative for the Claims Administrator will notify the IRC Chairperson, so that he or she may schedule a meeting for the Medical Subcommittee prior to the IRC meeting.
    - The Claims Administrator will also forward any information used or relied upon in making the Claim and/or Appeal determination, including its reasons for denying the Claim and/or Appeal, to the Medical Subcommittee for its review.
    - The claimant may attend the Medical Subcommittee's meeting and, if he or she so chooses, will have an opportunity to present information to the Medical Subcommittee for its consideration.
    - The Medical Subcommittee will review all provided information relating to the Appeal and prepare its recommendation to the IRC.
- *IRC Meeting*
    - After the Medical Subcommittee meeting, the IRC will hold a meeting at which the Medical Subcommittee will determine its recommendation to the Board of Works regarding the Appeal. Any meeting will be scheduled with the advice/counsel of the City Attorney as to whether the meeting should be scheduled as a private meeting or closed executive session.
    - If the claimant so chooses, he or she may also attend the IRC meeting to present information to the IRC regarding the Appeal at that time for the portion of the meeting designated for hearing from the claimant.
    - After the IRC has heard the Medical Subcommittee's recommendation and the claimant has had an opportunity to present information regarding the Appeal, the IRC will determine its recommendation to the Board of Works in the form of a vote on whether to uphold or overturn the Claim Administrator's decision on the Appeal with advice and counsel from the City Attorney.
- *Board of Public Works and Safety Meeting*
    - After the IRC has made its recommendation, such recommendation will be presented to the Board of Works for approval in writing.
    - If the Board of Works upholds the Claim Administrator's decision, the claimant will receive notice as is below provided. The process of considering the recommendation will follow the advice and counsel of the City Attorney (whether it is a public meeting, closed executive session, or a written review and decision).
    - If the Board of Works overturns (either in full or in part) the Claim Administrator's decision regarding the Appeal, the claimant will be notified in writing and the Claim will be reprocessed to the extent necessary.

Subsequent Notices of Decision on Appeal

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

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

External Review of Appeals Process

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

the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician. However, the medical review professional may have an affiliation under which the medical review professional provides health care services to Participants of the Claims Administrator and may have an affiliation that is limited to staff privileges at the health facility if the affiliation is disclosed to the claimant and to the Claims Administrator before commencing the review and neither the claimant nor the Claims Administrator objects to the affiliation.

- A claimant who files an Appeal under this final alternative is not subject to retaliation for exercising his or her right to an Appeal by an IRO The claimant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. The claimant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the IRO by providing any requested medical information or authorizing the release of necessary medical information.
- The Claims Administrator shall cooperate with the IRO by promptly providing any information requested by the IRO.
- The IRO shall make a determination to uphold or reverse the Claims Administrator's Appeal resolution based on information gathered from the claimant, the Claims Administrator, the treating physician, or any additional information that the IRO considers necessary and appropriate. For standard Appeals, the determination shall be made within 15 business days from the filing date of the request for external review. For expedited Appeals, the determination shall be made within 72 hours after the external review request is filed.
- When making the determination of the resolution of the Appeal, the IRO shall apply the standards of decision making that are based on objective clinical evidence and the terms of the claimant's benefit contract.
- The IRO shall notify the Claims Administrator and the claimant of the determination made under this section within 72 hours after making the determination. For expedited appeals, the notification will occur within 72 hours of the determination. The result of the determination is binding on the Claims Administrator.
- If at any time during the external review process the claimant submits information to the Claims Administrator that is relevant to the Claims Administrator's previous Appeal resolution and was not considered by the Claims Administrator during the Appeals hearing phase, the Claims Administrator shall reconsider the previous resolution under the Appeals hearing process. The IRO shall cease the external review process until the reconsideration by the Claims Administrator is completed.
- If additional information from the claimant results in the Claims Administrator's reconsideration of the Appeal at the hearing level, the Claims Administrator will notify the claimant of its decision within 15 days after the information is received. If the Appeal is

related to an Urgent Pre-Service Health Claim, the Claims Administrator will make a determination within 72 hours of receipt of the additional information.

- If the reconsideration determination made by the Claims Administrator's is adverse to the claimant, the claimant may request that the IRO resume the external review.

Notification of Decision

The IRO will communicate the decision on the Appeal, to both the claimant and SIHO Insurance Services, at the same time. Decisions on a standard and an expedited external Appeal will be communicated within 72 hours of the decision being reached.

Coordination of Benefits (COB)

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

Allowable Expense means a health care expense, including coinsurance or copayments without reduction for any applicable deductible that is covered at least in part under any of the plans covering the Participant. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. The following are examples of expenses or services that are ***not*** Allowable Expenses:

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

Determining the Allowable Expense when this Plan is not primary

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

methodology, and this Plan provides its benefits or services on the basis of negotiated fees or contracted amounts, this Plan's payment arrangement shall be the Allowable Expense for this Plan, unless otherwise indicated below in Coordination with Medicare section.

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

Standard Coordination of Benefits

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

Your medical benefits are coordinated with benefits from:

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

How Standard Coordination Works

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

Order of Benefit Determination Rules

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

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- This Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.
- If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

- The Plan which covers a person as an Employee (neither laid off nor retired) or a dependent of an Employee (neither laid off nor retired) would pay primary before those of a plan which covers the person as a COBRA beneficiary.
- The Plan which covers a person as an Employee (neither laid off nor retired) would pay primary before those of the Plan which covers that person as a laid-off or Retired Employee. The Plan which covers a person as a dependent of an Employee (neither laid off nor retired) would pay primary before those of the Plan which covers a person as a dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply:
    - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply;
    - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan);
    - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary;
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
- When an Adult Dependent Child (age eighteen (18) to the limiting age), has two (2) or more plans, benefits for that Adult Child shall be determined in the following order:
    - First, the plan covering the Adult Child as an Employee;
    - Second, the plan of the Spouse or, if applicable, significant other living in the same residence covering the Adult Child as a Dependent; and
    - Third, the plan of the parent covering the Adult Child as a Dependent.

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

Coordination with Medicare

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

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

The Plan also coordinates with Medicare as follows.

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

For Maximum Benefit

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

Subrogation and Reimbursement

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

Right of Recovery

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

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

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

- require that the overpayment be returned when requested; or

- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Right to Subrogation

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

The Plan will be subrogated to, and will succeed to, all rights of recovery from any or all third-parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any Illness or Injury caused by any third-party regardless of whether you choose to pursue that claim or seek such recovery.

The Plan reserves the right to use the services of qualified professionals to pursue such claims or attempt to recover funds due to the Plan. You must cooperate with the Plan and any of its representatives who pursue such claims or recoveries on behalf of the Plan.

Right to Reimbursement

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

Third-Parties

The following persons and entities are considered third-parties:

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

Pay and Pursue

If the Plan receives claims for expenses that were either the result of the alleged negligence of another person, or which arise out of any claim or cause of action which may accrue against any third-party responsible for Injury or death to the Plan Participant, the Plan may choose to advance benefits. When the Plan advances benefits, the Plan Participant, by accepting benefits agrees to the following terms and conditions. When the Plan advances benefits, it is doing so only because, and in reliance upon, the Plan Participant's promise to abide by the terms and conditions of the Plan and requires the Plan Participant to complete a subrogation questionnaire, sign an

acknowledgment of the Plan's Subrogation rights and sign an Agreement. This is called pay and pursue.

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

When This Provision Applies To You

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

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

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

Further, as a condition of receiving benefits under this Plan, you and/or your covered dependents agree to take no action which in any way prejudices the rights of the Plan. If it becomes necessary

for the Plan to enforce this provision by initiating any action against you or your dependent (the Plan Participant), then you and/or your dependent agree to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

Furthermore, the Plan may reduce or deny any future benefits by the amount of any recovery received, but not reimbursed, by you or your covered dependent for an accident or Injury for which the Plan erroneously paid benefits or for which you, your covered dependents, or anyone who receives benefits under the Plan refuses to cooperate with the above-referenced obligations and activities.

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

SECTION VIII: YOUR OTHER RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections as follows:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements (if applicable).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable) and an updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, or if eligible to participate in the Plan, your dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free-of-charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request the certificate before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under the Plan, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Mail Stop C1-22-06, Baltimore, MD 21244-1850 or, for issues related to claims and appeals processes, the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

SECTION IX: YOUR HIPAA/COBRA RIGHTS

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

HIPAA applies to medical and prescription drug plans that make up the Plan, which is administered to comply with the applicable provisions of HIPAA.

Protected Health Information and its Disclosure

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

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

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

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

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

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

In accordance with the Breach Notification Rule (45 CFR §§164.400-414) and other relevant laws or regulations, the Plan Sponsor agrees to notify both participants, the Department of Health and Human Services, and any other relevant authorities or affected parties, as required by law, of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor or any of its relevant Business Associates become aware.

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

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

Certificate of Creditable Coverage

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

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

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

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

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

Continuing Health Care Coverage through COBRA

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

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

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

If you have a new Child during the COBRA continuation period by birth, adoption, or placement for adoption, your new Child is considered a qualified beneficiary. Your new Child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the Child within sixty-one (61) days of the Child's birth/adoption/placement for adoption. If you do not enroll the Child under your coverage within sixty-one (61) days, you will have to wait until the next open enrollment period to enroll your Child.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 60-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

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

COBRA Qualifying Events and Length of Coverage

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

18-Month Continuation

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

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

- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

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

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

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

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

36-Month Continuation

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

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

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

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

COBRA Notifications

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

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

Cost of COBRA Coverage

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

COBRA Continuation Coverage Payments

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

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

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

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

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

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

How Benefit Extensions Impact COBRA

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

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

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

When COBRA Coverage Ends

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

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan, even though the subsequent plan has a pre-existing condition exclusion, so long as the individual has enough creditable coverage to satisfy the subsequent plans pre-existing condition exclusion.
- If the individual does not have enough creditable coverage to meet the new plan’s requirement, he or she may continue to purchase COBRA coverage until the earlier of the day he or she is eligible for the new coverage, or 36 months.
- The individual becomes entitled to Medicare.
- The Plan Sponsor terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11 month extension period.

SECTION X: GENERAL PROVISIONS

No Obligation to Continue Employment

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

Payment of Benefits

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

Payment of Benefits to Others

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

Non-Alienation of Benefits

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

Expenses

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

Fraud

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

Typographical or Administrative Error

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

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

Severability

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

Incontestability

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

Limitation of Action

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

Governing Law

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

Conformity with Statutes and Regulations

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

Non-discrimination

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

Discrimination is Against the Law

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

exclude people or treat them differently because of race, religion, color, national origin, age, disability, or sex.

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

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

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

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

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

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

Language Assistance Services

English: ATTENTION: Our Member Services department has free language interpreter services available for non-English speakers. Call 844.425.4281 (TTY: 800.743.3333)

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844.425.4281 (TTY: 800.743.3333).

Chinese:注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844.425.4281 (TTY: 800.743.3333).

Burmese:

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

ဖုန်းနံပါတ် 800.443.2980 (TTY: 800.743.3333) သို့ ခေါ်ဆိုပါ။

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844.425.4281 (TTY: 800.743.3333).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844.425.4281 (ATS : 800.743.3333).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844.425.4281 (TTY: 800.743.3333).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844.425.4281 (TTY: 800.743.3333).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844.425.4281 (TTY: 800.743.3333)번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844.425.4281 (телетайп: 800.743.3333).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844.425.4281 (رقم هاتف الصم والبكم: 800.743.3333).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 844.425.4281 (TTY: 800.743.3333) पर कॉल करें।

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 844.425.4281 TDD/TTY 800.743.3333 uffrufe.

Dutch: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 844.425.4281 (TDD/TTY 800.743.3333).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 844.425.4281 (TTY: 800.743.3333) 'ਤੇ ਕਾਲ ਕਰੋ।

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844.425.4281（TTY: 800.743.3333）まで、お電話にてご連絡ください。

ADOPTION OF THE PLAN

The City of Columbus, as stated herein, is hereby adopted as of January 1, 2023. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this ___________ day of ________________________________, 20___.

BY: ______________________________________

TITLE: ______________________________________

On Behalf of the City of Columbus, Indiana