PLAN DOCUMENT

FOR

CITY OF CARMEL

EMPLOYEE HEALTH BENEFIT PLAN

January 1, 2020

TABLE OF CONTENTS

PLAN SPECIFICATIONS 1

INTRODUCTION 3

MEDICAL BENEFITS (PLAN A) 4

SCHEDULE OF MEDICAL BENEFITS 4
- Lifetime Maximum Benefits 4
- Benefit Period 4
- Calendar Year Deductibles 4
- Coinsurance Percentages 4
- Out-of-Pocket Maximums 4
- Benefit Limits for Eligible Expenses 4
- Penalty for Failure to Precertify 5
- 8

MEDICAL BENEFITS (PLAN B) 9

SCHEDULE OF MEDICAL BENEFITS 9
- Lifetime Maximum Benefits 9
- Benefit Period 9
- Calendar Year Deductibles 9
- Coinsurance Percentages 9
- Out-of-Pocket Maximums 9
- Benefit Limits for Eligible Expenses 9
- Penalty for Failure to Precertify 10
- 13

COST CONTAINMENT PROCEDURES 14

- Precertification 14
- Concurrent Review 14
- Post-Service Clinical Review 15
- Exceptions 15
- Request Categories and Time Frames 15
- Large Case Management/Alternate Treatment 16

PREFERRED AND NON-PREFERRED PROVIDERS 17

- Preferred Providers 17
- Non-Preferred Providers 17
- Exceptions to Non-Preferred Level of Benefits 17

DESCRIPTION OF MEDICAL BENEFITS 18

MEDICAL EXCLUSIONS 28

MEDICARE 31

Active Employees and their Spouses Aged 65 and Over 31
Disabled Employees Under Age 65 31
Participants Eligible for Medicare by Reason of End Stage Renal Disease 31
COBRA Participants 32
Benefit Calculation 32

PRESCRIPTION DRUG BENEFITS 33

SCHEDULE OF PRESCRIPTION DRUG BENEFITS 33
Plan A 33
Plan B 33

DESCRIPTION OF PRESCRIPTION DRUG BENEFITS 34

ELIGIBLE PRESCRIPTION DRUG EXPENSES 34
PRESCRIPTION DRUG EXCLUSIONS 36

DENTAL BENEFITS 36

SCHEDULE OF DENTAL BENEFITS 36
Maximum Benefits 36
Calendar Year Deductibles 36
Coinsurance Percentages 36

DESCRIPTION OF DENTAL BENEFITS 37
Incurred Date of Dental Services 37
Predetermination of Benefits 37
Alternate Procedures 38

ELIGIBLE DENTAL BENEFITS 38
Preventive Services 38
Basic Services 38
Major Services 39
Prosthesis Replacement Rule 39
Orthodontia Services 39

DENTAL EXCLUSIONS 40

ELIGIBILITY PROVISIONS 42

ELIGIBILITY 42
Eligible Employees 42
Eligible Dependents 43
Verification of Dependent Eligibility 45

ENROLLMENT 45
Waiting Period 45
Effective Date for Normal Enrollment 45
Special Enrollment Period Provision Due to Other Coverage 45
Special Enrollment Period Provision Due to Dependent Acquisition 46
Open Enrollment 47

TERMINATION **47**
Termination of Employee Coverage 47
Continuation of Coverage for Retirees and Early Retirees 48
Termination of Dependent Coverage 48
Dependent Spouse of a Retiree 48

LEAVES OF ABSENCE **50**

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT **51**

Qualifying Event 51
Qualified Beneficiaries 51
Notification Requirements 51
Clerical Error by Employer/Plan Administrator 53
Election of Coverage 53
Period of Continued Coverage 54
Subsequent Qualifying Event 54
Period of Continued Coverage for Disabled Person 54
Description of Coverage 55
Cost and Payment of Coverage 55
When Continuation Coverage Begins 56
Dependents Acquired During Continuation 56
End of Continuation Coverage 56
The Plan Administrator and Contact Information 57
Continuation of Coverage for Members of Indiana National Guard and Reserves 57

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT **59**

Disclosure of PHI to Plan Sponsor 59
Use and Disclosure of PHI by Plan Sponsor 59
Covenants by Plan Sponsor 59
Electronic Protected Health Information 60
Adequate Separation 60

GENERAL PLAN EXCLUSIONS **61**

COORDINATION OF BENEFITS **63**

Other Plans 63
Order of Benefit Determination 63
Subrogation/Recovery Rights 64

CLAIMS INFORMATION **66**

Procedure for Filing a Claim 66
Pending a Claim 66
Types of Claims 66
When Health Claims Must be Filed 67
Timing of Claims Decisions 67
Notification of an Adverse Benefit Determination 69
Appeals of Adverse Benefit Determinations 70
Foreign Claims 72
Overpayments 72

GENERAL PROVISIONS **73**

Administration of the Plan 73
Amendment or Termination of the Plan 74
Assignment 74
Clerical Error 74
Conformity with Statute(s) 74
Conformity with the Law 74
Construction 75
Effective Time 75
Entire Plan 75
Facility of Payment 75
Fiduciary Operation 75
Free Choice of Physicians 76
Incontestability 76
Misrepresentation 76
Nondiscrimination 76
Obligation to Provide Requested Information 76
Plan is Not a Contract 76
Plan Funding 76
Protection Against Creditors 76
Right of Recovery 77
Severability 77
Tax Consequences 77
Worker's Compensation 77

DEFINITIONS **78**

PLAN SPECIFICATIONS

NAME, ADDRESS AND TELEPHONE NUMBER OF THE EMPLOYER/PLAN SPONSOR:

City of Carmel
One Civic Square
Carmel, IN46032
(317) 571-2400

EMPLOYER IDENTIFICATION NUMBER (EIN):

35-6000972

PLAN NAME:

City of Carmel Employee Health Benefit Plan

PLAN NUMBER:

501

MEDICAL GROUP NUMBER (AS ASSIGNED BY ANTHEM):

004007834

DENTAL GROUP NUMBER (AS ASSIGNED BY ANTHEM)

275896

PLAN EFFECTIVE DATE:

March 1, 1993

PLAN RESTATED:

January 1, 2019

PLAN YEAR:

The financial records of the Plan are kept on a calendar year basis.

TYPE OF PLAN:

Group health benefits that include medical, prescription drug and dental.

NAME, ADDRESS AND TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR, NAMED FIDUCIARY AND AGENT FOR SERVICE OF LEGAL PROCESS:

The Board of Public Works and Safety of the City of Carmel, Indiana (the "BPW")
One Civic Square
Carmel, IN 46032
(317) 571-2400

The Plan Administrator has the sole discretionary authority to control and manage the operation and administration of the Plan, subject, however, to applicable law. The BPW may designate the Mayor as its representative for routine matters of administration.

NAME, ADDRESS AND TELEPHONE NUMBER OF THE THIRD PARTY ADMINISTRATOR:

Medical

Anthem Blue Cross and Blue Shield
220 Virginia Avenue
Indianapolis, IN 46204
844-453-4508

Dental

Anthem Dental Claims
P.O. Box 1115
Minneapolis, MN 55440-1115
844-453-4508

The Third Party Administrator is contracted by the Plan Administrator to provide claims payment, eligibility management and other administrative and consulting services.

INTRODUCTION

The City of Carmel, herein referred to as the "Employer," established the City of Carmel Employee Health Benefit Plan, herein referred to as the "Plan," effective March 1, 1993, for the benefit of employees and their eligible dependents. The Plan is hereby amended and restated in its entirety, effective January 1, 2004.

The Plan is written, adopted and operated for the sole purpose of providing medical, prescription drug and dental benefits to Plan participants. The Plan agrees to provide the benefits set forth in this document in accordance with all provisions and conditions established herein.

The City of Carmel Board of Public Works and Safety, as the Named Fiduciary and Plan Administrator, has full discretionary authority to interpret and apply all the Plan provisions, including, but not limited to, issues concerning eligibility and determination of benefits. Final authority to construe and apply the provisions of this Plan rests exclusively with the Plan Administrator.

The Employer intends to maintain this Plan indefinitely; however, the Plan Administrator reserves the right at any time, in its sole discretion, to modify or amend, in whole or in part, any or all of the provisions of the Plan. Any such amendments will be in writing, setting forth the modified provisions of the Plan and the effective date of the modifications, and will be signed by the Plan Administrator. Such modification or amendment will be duly incorporated in writing into the master copy of the Plan on file with the Plan Administrator, or a written copy thereof will be deposited with such master copy of the Plan.

The Employer reserves the right to terminate the Plan for any reason at any time. Upon termination, the rights of the participants to benefits are limited to claims incurred up to the date of termination.

SCHEDULE OF MEDICAL BENEFITS (PLAN A)

(see Description of Medical Benefits for detailed explanation of the following provisions)

LIFETIME MAXIMUM BENEFITS:

Inpatient/Outpatient Hospice Care (combined) — 365 days/365 visits

BENEFIT PERIOD: — Calendar Year (unless otherwise stated)

CALENDAR YEAR DEDUCTIBLES:

	Preferred	Non-Preferred
Individual Plan Deductible	$2,000	$4,000
Family Plan Deductible	$4,000	$8,000

The following items do not apply toward satisfaction of the calendar year deductible:

- penalties incurred for noncompliance;
- charges for services and supplies not eligible under this Plan;
- charges that exceed the amount allowed by the Plan; and
- charges for services deemed not medically necessary.

When the participant utilizes BOTH preferred and non-preferred providers during the calendar year, the maximum year deductible will not exceed the non-preferred provider deductible.

COINSURANCE PERCENTAGES:

	Preferred	Non-Preferred
Individual Coinsurance Percentage	100%	100%
Family Coinsurance Percentage	100%	100%

OUT-OF-POCKET MAXIMUMS:

	Preferred	Non-Preferred
Individual	$2,000	$4,000
Family	$4,000	$8,000

The following items do not apply toward the calendar year out-of-pocket expense maximum:

- penalties incurred for noncompliance;
- charges for services and supplies not eligible under this Plan;
- charges that exceed the amount allowed by the Plan; and
- charges for services deemed not medically necessary.

When the participant utilizes BOTH preferred and non-preferred providers during the calendar year, the maximum out-of-pocket expense will not exceed the non-preferred provider maximum.

BENEFIT LIMITS FOR ELIGIBLE EXPENSES:

Preferred Provider benefits will not be subject to "reasonable and customary."

	PREFERRED BENEFIT	NON-PREFERRED BENEFIT
PHYSICIAN'S CHARGES FOR OFFICE VISIT	100%	100%
Deductible Applies:	Yes	Yes
PHYSICIAN'S CHARGES FOR SERVICES RENDERED AT TIME OF OFFICE VISIT	100%	100%
Deductible Applies:	Yes	Yes
PHYSICIAN'S CHARGES FOR SERVICES RENDERED IN ABSENCE OF OFFICE VISIT	100%	100%
Deductible Applies:	Yes	Yes
ALLERGY SHOTS	100%	100%
Deductible Applies:	Yes	Yes
PHYSICIAN HOSPITAL VISITS	100%	100%
Deductible Applies:	Yes	Yes
RETAIL HEALTH CLINIC VISIT	100%	100%
Deductible Applies:	Yes	Yes
EMPLOYEE HEALTH CLINIC VISIT	100%	N/A
Deductible Applies:	No	N/A
SURGEON OR ANESTHESIOLOGIST CHARGES	100%	100%
Deductible Applies:	Yes	Yes
AMBULANCE CHARGES	100%	100%
Deductible Applies:	Yes	Yes
DURABLE MEDICAL EQUIPMENT	100%	100%
Deductible Applies:	Yes	Yes
EMERGENCY ROOM FACILITY	100%	100%
Deductible Applies:	Yes	Yes (preferred deductible)
EMERGENCY ROOM PHYSICIAN	100%	100%
Deductible Applies:	Yes	Yes (preferred deductible)
HEARING EXAM (See Preventive Services)		

	PREFERRED BENEFIT	NON-PREFERRED BENEFIT
HEARING AIDS	100% of allowable amount*	100% of allowable amount*
Deductible Applies:	Yes	Yes
Maximum per 60-Month Period	**one hearing aid per ear**	

*The allowable amount for a hearing aid is determined by the Third Party Administrator based on reasonable and customary charges. Any amount over the allowable amount, and any charges for upgraded or add-on devices, are the responsibility of the covered member and are not covered by this Plan.

HOME HEALTH CARE	100%	100%
Deductible Applies:	Yes	Yes
Calendar Year Maximum	**100 visits**	
INPATIENT HOSPICE CARE	100%	100%
Deductible Applies:	Yes	Yes
Lifetime Maximum	**365 days or 365 visits**	
INFERTILITY TREATMENT	100%	100%
Deductible Applies:	Yes	Yes
Lifetime Maximum	**$5,000**	
OUTPATIENT HOSPICE CARE	100%	100%
Deductible Applies:	Yes	Yes
Lifetime Maximum	**365 visits or 365 days**	
INPATIENT & INTENSIVE CARE FACILITY CHARGES	100%	100%
Deductible Applies:	Yes	Yes
ORGAN/TISSUE TRANSPLANT	100%	NA
Deductible Applies:	Yes	NA
CHIROPRACTIC CARE	100%	100%
Deductible Applies:	Yes	Yes
Calendar Year Maximum	**40 visits**	
ORTHOTIC DEVICES	100%	100%
Deductible Applies:	Yes	Yes
OUTPATIENT SURGICAL FACILITY	100%	100%
Deductible Applies:	Yes	Yes
PATHOLOGY AND/OR LABORATORY TESTS	100%	100%
Deductible Applies:	Yes	Yes
RADIOLOGY TESTS	100%	100%
Deductible Applies:	Yes	Yes
PREVENTIVE SERVICES	100%	100%
Deductible Applies:	No	Yes

Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA). See PREVENTIVE SERVICES under DESCRIPTION OF MEDICAL SERVICES for more detailed information.

These services include routine or periodic exams (including school enrollment exams, but excluding sports exams), vaccinations (including many childhood vaccines, age 60+ shingles vaccines and some travel vaccines), pelvic exams, pap tests, labs or x-rays, annual dilated eye examinations for diabetic retinopathy, routine vision screenings for disease or abnormality, routing hearing screenings, routine mammograms, routine PSA tests, bone density tests, routine colorectal cancer examinations and related lab tests and routine colonoscopies.

Also included under preventive services are costs for physician-supervised tobacco-cessation and hospital-sponsored non-surgical weight loss programs. Any weight loss program must receive approval from the Plan Administrator prior to the date the participant starts the program. Participants are responsible for the up-front cost of such a program, and will be reimbursed 100% of that cost upon confirmation of successful completion.

	PREFERRED BENEFIT	NON-PREFERRED BENEFIT
PREVENTIVE SERVICES FOR WOMEN	100%	100%
Deductible Applies:	No	Yes

Preventive Services for Women as required under the Patient Protection and Affordable Care Act (PPACA). See PREVENTIVE SERVICES under DESCRIPTION OF MEDICAL SERVICES for more detailed information.

WELLNESS SCREENING*	100%	N/A
Deductible Applies:	No	N/A

***This benefit applies to screening provided through the City's Wellness program.**

SKILLED NURSING FACILITY	100%	100%
Deductible Applies:	Yes	Yes

Calendar Year Maximum ..... 90 days

THERAPY (PHYSICAL, OCCUPATIONAL, SPEECH, VISION AND OTHER)	100%	100%
Deductible Applies:	Yes	Yes

WEIGHT LOSS TREATMENT (NON-SURGICAL)
(See Preventive Services)

TOBACCO CESSATION TREATMENT
(See Preventive Services)

INPATIENT PSYCHIATRIC & SUBSTANCE ABUSE CARE	100%	100%
Deductible Applies:	Yes	Yes
OUTPATIENT PSYCHIATRIC & SUBSTANCE ABUSE CARE	100%	100%
Deductible Applies:	Yes	Yes
AUTISM SPECTRUM DISORDER APPLIED BEHAVIORAL ANALYSIS	100%	100%
Deductible Applies:	Yes	Yes

Weekly Maximum .....20 hours

PENALTY FOR FAILURE TO PRECERTIFY

Some of the services and procedures covered under the Plan require precertification. In-network providers are responsible for obtaining precertification on the participant's behalf. If the participant goes out of network, he is responsible to ensure that the precertification requirements, as detailed under Cost Containment Procedures, are satisfied. Participants can call the customer service number listed on the medical identification card to determine whether precertification is required.

Failure to precertify out-of-network services and procedures will cause eligible expenses to be reduced by a penalty of $500 per occurrence.

SCHEDULE OF MEDICAL BENEFITS (PLAN B)

(see Description of Medical Benefits for detailed explanation of the following provisions)

LIFETIME MAXIMUM BENEFITS:

Inpatient/Outpatient Hospice Care (combined) — 365 days/365 visits

BENEFIT PERIOD: — Calendar Year (unless otherwise stated)

CALENDAR YEAR DEDUCTIBLES:

	Preferred	Non-Preferred
Individual Deductible	$750	$1,500
Family Deductible	$1,500	$3,000

The following items do not apply toward satisfaction of the calendar year deductible:

- copays;
- penalties incurred for noncompliance;
- charges for services and supplies not eligible under this Plan;
- charges that exceed the amount allowed by the Plan; and
- charges for services deemed not medically necessary.

When a participant utilizes BOTH preferred and non-preferred providers during the calendar year, the maximum calendar year deductible will not exceed the non-preferred provider deductible.

COINSURANCE PERCENTAGES:

	Preferred	Non-Preferred
Individual Coinsurance Percentage	80%	60%
Family Coinsurance Percentage	80%	60%

OUT-OF-POCKET MAXIMUMS:

	Preferred	Non-Preferred
Individual	$1,500	$3,000
Family	$3,000	$6,000

The out-of-pocket maximum includes deductibles, copays and coinsurance. The following items do not apply toward the calendar year out-of-pocket expense maximum:

- penalties incurred for noncompliance;
- charges for services and supplies not eligible under this Plan;
- charges that exceed the amount allowed by the Plan; and
- charges for services deemed not medically necessary.

When the participant utilizes BOTH preferred and non-preferred providers during the calendar year, the maximum out-of-pocket expense will not exceed the non-preferred provider maximum.

BENEFIT LIMITS FOR ELIGIBLE EXPENSES:

Preferred Provider benefits will not be subject to "reasonable and customary."

	PREFERRED BENEFIT	NON-PREFERRED BENEFIT
PHYSICIAN'S CHARGES FOR OFFICE VISIT	100%	60%
Copay Applies:	Yes ($50 per visit)	No
Deductible Applies:	No	Yes
PHYSICIAN'S CHARGES FOR SERVICES RENDERED AT TIME OF OFFICE VISIT	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
PHYSICIAN'S CHARGES FOR SERVICES RENDERED IN ABSENCE OF OFFICE VISIT	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
ALLERGY SHOTS	100%	60%
Copay Applies:	Yes ($20 per injection)	No
Deductible Applies:	No	Yes
PHYSICIANHOSPITAL VISITS	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
RETAIL HEALTH CLINIC VISIT	100%	60%
Copay Applies:	Yes ($25 per visit)	No
Deductible Applies:	No	Yes
EMPLOYEE HEALTH CLINIC VISIT	100%	N/A
Copay Applies:	No	N/A
Deductible Applies:	No	N/A
SURGEON OR ANESTHESIOLOGIST CHARGES	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
AMBULANCE CHARGES	100%	60%
Copay Applies:	Yes ($100 per trip)	No
Deductible Applies:	No	Yes
DURABLE MEDICAL EQUIPMENT	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes

	PREFERRED BENEFIT	NON-PREFERRED BENEFIT
EMERGENCY ROOM FACILITY	100%	100%
Copay Applies:	Yes ($250 per visit)	Yes ($250 per visit)
Deductible Applies:	No	No
EMERGENCY ROOM PHYSICIAN	80%	80%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
HEARING EXAM (See Preventive Services)		
HEARING AIDS	80% of allowable amount*	60% of allowable amount*
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
Maximum per 60-Month Period	**one hearing aid per ear**	

*The allowable amount for a hearing aid is determined by the Third Party Administrator based on reasonable and customary charges. Any amount over the allowable amount, and any charges for upgraded or add-on devices, are the responsibility of the covered member and are not covered by this Plan.

HOME HEALTH CARE	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
Calendar Year Maximum	**100 visits**	
INFERTILITY TREATMENT	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
Lifetime Maximum	**$5,000**	
INPATIENT HOSPICE CARE	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
Lifetime Maximum	**365 days or 365 visits**	
OUTPATIENT HOSPICE CARE	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
Lifetime Maximum	**365 visits or 365 days**	
INPATIENT & INTENSIVE CARE FACILITY CHARGES	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
ORGAN/TISSUE TRANSPLANT	80%	NA
Copay Applies:	No	NA
Deductible Applies:	Yes	NA
Blue Distinction Centers for Transplants	**not subject to deductible or coinsurance**	

	PREFERRED BENEFIT	NON-PREFERRED BENEFIT
CHIROPRACTIC CARE	100%	60%
Copay Applies:	Yes ($50 per visit)	No
Deductible Applies:	No	Yes
Calendar Year Maximum		**40 visits**
ORTHOTIC DEVICES	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
OUTPATIENT SURGICAL FACILITY	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
PATHOLOGY AND/OR LABORATORY TESTS	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
RADIOLOGY TESTS	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
PREVENTIVE SERVICES	100%	60%
Copay Applies:	No	No
Deductible Applies:	No	Yes

Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA). See PREVENTIVE SERVICES under DESCRIPTION OF MEDICAL SERVICES for more detailed information.

These services include routine or periodic exams (including school enrollment exams, but excluding sports exams), vaccinations (including many childhood vaccines, age 60+ shingles vaccines and some travel vaccines), pelvic exams, pap tests, labs or x-rays, annual dilated eye examinations for diabetic retinopathy, routine vision screenings for disease or abnormality, routing hearing screenings, routine mammograms, routine PSA tests, bone density tests, routine colorectal cancer examinations and related lab tests and routine colonoscopies.

Also included under preventive services are costs for physician-supervised tobacco-cessation and hospital-sponsored non-surgical weight loss programs. Any weight loss program must receive approval from the Plan Administrator prior to the date the participant starts the program. Participants are responsible for the up-front cost of such a program, and will be reimbursed 100% of that cost upon confirmation of successful completion.

PREVENTIVE SERVICES FOR WOMEN	100%	60%
Copay Applies:	No	No
Deductible Applies:	No	Yes

Preventive Services for Women as required under the Patient Protection and Affordable Care Act (PPACA). See PREVENTIVE SERVICES under DESCRIPTION OF MEDICAL SERVICES for more detailed information.

	PREFERRED BENEFIT	NON-PREFERRED BENEFIT
WELLNESS SCREENING*	100%	100%
Copay Applies:	No	N/A
Deductible Applies:	No	N/A
*This benefit applies only to screening provided through the City's Wellness program.		
SKILLED NURSING FACILITY	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
Calendar Year Maximum		**90 days**
THERAPY (PHYSICAL, OCCUPATIONAL, SPEECH,VISIONAND OTHER)	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
WEIGHT LOSS TREATMENT (NON-SURGICAL) (See Preventive Services)		
TOBACCO CESSATION TREATMENT (See Preventive Services)		
INPATIENT PSYCHIATRIC & SUBSTANCE ABUSE CARE	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
OUTPATIENT PSYCHIATRIC & SUBSTANCE ABUSE CARE	100%	60%
Copay Applies:	Yes ($50 per visit)	No
Deductible Applies:	No	Yes
AUTISM SPECTRUM DISORDERAPPLIED BEHAVIORAL ANALYSIS	80%	60%
Copay Applies:	No	No
Deductible Applies:	Yes	Yes
Weekly Maximum		**20 hours**

PENALTY FOR FAILURE TO PRECERTIFY

Some of the services and procedures covered under the Plan require precertification. In-network providers are responsible for obtaining precertification on the participant's behalf. If the participant goes out of network, he is responsible to ensure that the precertification requirements, as detailed under Cost Containment Procedures, are satisfied. Participants can call the customer service number listed on the medical identification card to determine whether precertification is required.

Failure to precertify out-of-network services and procedures will cause eligible expenses to be reduced by a penalty of $500 per occurrence.

COST CONTAINMENT PROCEDURES

The Plan includes the processes of precertification, concurrent review and post-service clinical review to determine when services should be covered by the Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing medical necessity, the use of specific procedures and, where appropriate, the setting or place where they are performed.

PRECERTIFICATION

Precertification is a required review of a service, treatment or admission for a benefit coverage determination, which must be obtained prior to the service, treatment or admission date. In an emergency situation, precertification must be obtained within two (2) business days after the service, treatment or admission commences.

Precertification will be based on multiple criteria, including medical policy, clinical guidelines, pharmacy and therapeutics guidelines and other relevant industry guidelines. Inpatient admissions and many outpatient surgeries, procedures, treatments, therapies, tests, devices and equipment may be subject to precertification requirements. For childbirth admissions, precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

The Plan requires that covered services be medically necessary for benefits to be provided. The Third Party Administrator may determine that a service that was initially prescribed or requested is not medically necessary if the member has not previously tried alternative treatments which are more cost effective. In addition, when setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be medically necessary if they are performed in a higher cost setting.

Responsibility for precertification depends on where the treatment is performed:

1. For all in-network treatment, the provider is responsible for obtaining precertification.

2. **For all treatment provided out-of-network, the participant is responsible for obtaining precertification**. If the participant or provider does not obtain the required precertification, the participant will be subject to a $500 penalty. Participants can call the customer service number on their insurance identification card to determine whether precertification is required.

A participant is entitled to receive, upon request and free of charge, reasonable access to any documents relevant to his precertification request by contacting the customer service number on his identification card.

PRECERTIFICATION DOES NOT GUARANTEE COVERAGE OR PAYMENT FOR THESERVICE OR PROCEDURE REVIEWED

CONCURRENT REVIEW

It may be necessary for inpatient care to extend beyond the number of days initially certified. Additional days, beyond those certified at admission, must also be certified.

The Third Party Administrator's utilization management team will monitor the patient's progress throughout the hospital stay to assure that discharge is not delayed by inadequate planning, and that each day of confinement is medically necessary and appropriate.

POST-SERVICE CLINICAL REVIEW

A claim may be reviewed retrospectively to determine the medical necessity or experimental/ investigative nature of a service, treatment or admission that did not require precertification.

The Third Party Administrator will utilize its clinical coverage guidelines and other applicable policies and procedures to assist in making medical necessity decisions. The clinical coverage guidelines may be reviewed and updated periodically.

EXCEPTIONS

The Third Part Administrator may, from time to time, waive, enhance, modify or discontinue certain cost-containment procedures if, in its discretion, such change furthers the provision of cost effective, value based and/or quality services.Exceptions to any process, provision or claim will bedetermined by the specific circumstances that apply in that case, and will not constitute a precedent for future decisions.

The Third Party Administrator may also identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, the Third Party Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to Plan participants.

REQUEST CATEGORIES AND TIME FRAMES

1. **Prospective Non-Urgent:** A request for precertification that is conducted prior to the service, treatment or admission.

   Decision and notification will be made within 15 calendar days of receipt of request.

2. **Prospective Urgent:** A request for precertification that in the opinion of the treating provider or any physician with knowledge of the participant's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the participant, inhibit the ability of the participant to regain maximum function or subject the participant to severe pain that cannot be adequately managed without such care or treatment.

   Decision and notification will be made within 72 hours of receipt of request.

3. **Concurrent Urgent:** A request for precertification that is conducted during the course of outpatient treatment or during an inpatientadmission.

   Decision and notification will be made within 24-72 hours of receipt of request, depending onwhether there has been a previous certification, and the status of the previous certification.

4. **Retrospective:** A request for precertification that is conducted after the service, treatment or admission has occurred. .

   Decision and notification will be made within 30 calendar days of receipt of request.

If additional information is needed to make a decision, the Third Party Administrator will notify the requesting provider and send written notification to the participant of the specific information necessary to complete the review. If the Third Party Administrator does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in its possession.
Notification may be given verbally (via telephone) or in writing (via USPS, email or fax).

LARGE CASE MANAGEMENT/ALTERNATE TREATMENT

When a participant's condition warrants (e.g., chronic illness or catastrophic injury), Utilization Review will contact the participant's attending physician to ensure that all available resources are being considered to maximize treatment and recovery. Rehabilitation, public assistance and alternate forms of treatment are subject to consideration.

Normal provisions of the Plan may be waived as part of the large case management process when it is reasonable to expect a cost effective result from an alternative treatment without sacrifice to the quality of patient care. If a proposed alternate treatment is approved by the medical community and shown to be cost effective, the Plan may allow expenses that would not otherwise be covered.

Consideration for alternate treatment will be determined by the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that participant or any other participant.

The use of large case management or alternate treatment is a voluntary program, which the participant may choose to accept or decline.

PREFERRED AND NON-PREFERRED PROVIDERS

The Plan incorporates a preferred provider organization. The participant has the choice of using either a preferred provider or a non-preferred provider. Eligible expenses provided by a participating provider will be payable at the preferred level. Eligible expenses provided by a non-participating provider will be payable at the non-preferred level. A list of participating providers is available from the Employer without a charge.

PREFERRED PROVIDERS

A preferred provider is a physician, hospital or ancillary service provider that has an agreement in effect with the preferred provider organization to accept a reduced rate for services rendered to participants. This is known as a negotiated rate. The preferred provider cannot bill the participant for any amount in excess of the negotiated rate. Because the participant and the Plan save money when services or supplies are obtained from providers participating in the preferred provider organization, benefits are usually greater than those available when using the services of a non-preferred provider.

NON-PREFERRED PROVIDERS

A non-preferred provider does not have an agreement in effect with the preferred provider organization, and has not negotiated a reduced rate for services. The participant is responsible for the balance due after benefits are paid under the Plan. This results in greater costs to the Plan and greater out-of-pocket expenses for the participant.

All charges from non-preferred providers are subject to limitations based on what is reasonable and customary.

EXCEPTIONS TO NON-PREFERRED LEVEL OF BENEFITS

Under the following circumstances only, services and supplies rendered by a non-preferred provider shall be payable at the preferred provider level of benefits:

1. If a participant requires emergency transport by ambulance and/or emergency medical treatment. Charges for the ambulance, emergency room or immediate care facility, physicians and related services, including radiology, anesthesiology and pathology, will be covered as preferred provider charges. If the participant is admitted to a hospital after emergency treatment, eligible hospital charges will be covered as preferred provider charges.

2. If a participant uses a preferred facility or practice, but the provider who performs the services and bills for the services is not a member of the preferred provider organization. Or, if a participant uses a physician in the preferred provider organization, but the facility or practice that bills for the service is not a member of the preferred provider organization.

3. If a participant uses a preferred provider to perform radiology and pathology (laboratory) tests, but the tests are interpreted by a service provider outside the preferred provider organization.

4. If a participant uses an operating surgeon and surgical facility (if applicable) that are preferred providers, but the assistant surgeon and/or anesthesiologist is a not a member of the preferred provider organization.

DESCRIPTION OF MEDICAL BENEFITS

The Plan provides payment for a wide range of medical expenses. To be considered an eligible expense, charges must be incurred due to an injury, illness or pregnancy, and the service or treatment must be medically necessary. In addition, the service or supply must be recommended or approved by a physician. All benefits are subject to the reasonable and customary provision (except as otherwise stated herein) and all other limitations and exclusions of the Plan.

A charge is incurred on the date the service is performed or the supply is purchased.

The City of Carmel will comply with all requirements of the Affordable Care Act (ACA), the Mental Health Parity Act (MHPA) and all other applicable federal and state regulations.

AMBULANCE SERVICES

Charges by a local ambulance service for medically necessary ground transportation to the nearest medical facility. Ambulance services for transportation from one facility to another when the first facility is not fully equipped to properly treat the patient's condition.

Charges for air ambulance transportation to the nearest medical facility for treatment of a serious medical illness or injury when ground transportation cannot be utilized due to terrain, distance or severity of the participant's condition.

Charges for ambulance services for convenience or non-emergency care shall not be an eligible expense.

ANESTHESIA

Charges for anesthesia and its administration.

BIRTHING CENTER

Charges for services and supplies rendered in a qualified birthing center.

CHIROPRACTIC CARE/MANUAL MANIPULATION OF THE SPINE

Charges made by a physician for manual manipulation of the spine, as stated in the Schedule of Medical Benefits. Such charges include office visits, spinal manipulations, allied spinal modalities and x-rays of the spine. The chiropractic benefit does not include blood tests or hair analysis

CLINICAL TRIALS

Charges made for routine patient services associated with clinical trials approved and sponsored by the federal government for life-threatening conditions or diseases, as mandated by the Affordable Care Act (ACA). The following criteria must be met, which list is intended to comply with the requirements of the ACA and may be updated in accordance with amendments to the Act or its regulatory provisions:

1. the clinical trial is listed on the National Institutes of Health website www.clinicaltrials.gov as being sponsored by the federal government;

2. the trial investigates a treatment for a life-threatening condition or disease and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective non-experimental treatment for the disease exists;

3. the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";

4. the trial is approved by the institutional review board of the institution administering the treatment; and
5. coverage will not be extended to clinical trials conducted at non-participating facilities if a person is eligible to participate in a covered clinical trial from a participating provider.

CONTRACEPTIVES

Charges for contraceptive devices and medications that are not available through the Prescription Drug Benefit, including diaphragms, IUDs, implants and injectables. Office visits related to contraceptive management, as well as the specific service rendered in the office, will be paid as shown in the Schedule of Medical Benefits.

COSMETIC SURGERY

Charges for cosmetic surgery will be eligible only under the following circumstances:

1. if the cosmetic surgery is the necessary result of an accidental injury;

2. if the cosmetic surgery is to correct birth abnormalities of a child; or

3. if the surgery is necessary for reconstructive purposes following another surgery.

Charges for cosmetic surgery related to or required due to weight loss, whether or not recommended by a physician, are not covered.

For mammoplasty and reconstructive mammoplasty services, see Mammoplasty in this section.

DENTAL SERVICES

Charges for dental services will be eligible only if the treatment is:

1. necessary as the result of an accidental injury to the natural teeth, if performed within twenty-four (24) months after the injury; or

2. performed in a hospital, if hospitalization is medically necessary.

DIAGNOSTIC SERVICES AND SUPPLIES

Charges for diagnostic testing including, but not limited to, laboratory tests, ultrasounds, x-rays, basal metabolism tests, electrocardiograms, electroencephalograms, magnetic imaging, nuclear medicines, pneumoencephalograms or similar well-established diagnostic tests generally approved by physicians throughout the United States for the participant's condition.

DIALYSIS

Charges for services, equipment and supplies for the treatment of acute renal failure or chronic irreversible renal insufficiency, including hemodialysis and peritoneal dialysis. Includes dialysis performed at a renal facility or in the home.

DIABETES MANAGEMENT

Charges as shown below for insulin and non-insulin dependent diabetics as well as participants who have elevated blood sugar levels due to pregnancy or other medical conditions:

1. durable medical equipment, including blood glucose monitors, insulin pumps and podiatric appliances related to diabetes;

2. medical supplies, including insulin pump supplies (such as tubing), blood monitor kits and blood glucose calibration solutions;
3. training by a physician, including a podiatrist with recent education in diabetes management, but limited to the following: medically necessary visits when diabetes is diagnosed; visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management; visits when education or refresher training is prescribed by the physician; and medical nutrition therapy related to diabetes management.

The following items will be considered an eligible expense under the Prescription Drug Program: charges for insulin, disposable syringes, needles, lancets and test strips when prescribed with insulin—one copayment is applicable when dispensed at the same time. The quantity of the supplies must correspond to the amount of insulin dispensed.

DURABLE MEDICAL EQUIPMENT

Charges for rental or purchase of durable medical equipment, whichever is economically justified.Replacement of purchased durable medical equipment that is needed as a result of natural growth or pathological changes, or to maintain functionality. Routine maintenance of the equipment is an eligible expense if needed to keep the equipment functional.

EMERGENCY ROOM

Charges for treatment received in an emergency room. Non-emergency services provided in an emergency room will not be considered eligible expenses. Non-emergency expenses will be covered only if:

- You were directed to the emergency room by another medical provider;
- Services were provided to a child under the age of 14;
- There isn't an urgent care or retail clinic within 15 miles; or
- The visit occurs on a Sunday or a major holiday.

GENETIC COUNSELING AND GENETIC TESTING

Charges for genetic counseling and genetic testing that is medically necessary.

HEARING EXAM

Charges for a hearing exam, as stated in the Schedule of Medical Benefits.

HOME HEALTH CARE

Charges for home health care, as stated in the Schedule of Medical Benefits, when ordered and supervised by a physician as part of a written health care program and provided in lieu of confinement in a hospital or skilled nursing facility for the same or related condition.

A home health care visit is considered to be:

1. a visit of four (4) hours or less for part-time or intermittent nursing care by an R.N., L.V.N. or L.P.N., or for personal care by a home health aide; or

2. a single visit by a physical, occupational, inhalation or speech therapist.

HOSPICE CARE

Charges for the following hospice care services provided in an inpatient hospice facility or in the patient's home, as stated in the Schedule of Medical Benefits:

1. room and board charged by the hospice;

2. part-time nursing care or personal care by a home health care aide;

3. miscellaneous services and supplies provided by hospice care providers;

4. medical social services and counseling services given to the patient and his covered family members by a licensed social worker or licensed pastoral counselor.

The patient must be certified by a physician as being terminally ill with six (6) months or less to live.

HOSPITAL

Charges made by a hospital for:

1. room, board and general nursing care for a semi-private room (charges for a private room when not prescribed as medically necessary by a physician will be eligible up to the most common semi-private room charge of the hospital; charges for a private room will be an eligible expense if the hospital has private rooms only, or if confinement in a private room is medically necessary);

2. intensive care unit, cardiac care unit, burn unit or similar critical care unit;

3. operating, recovery and delivery rooms;

4. pre-operative and post-operative care;

5. services of a physician, anesthesiologist, radiologist and pathologist;

6. anesthesia, oxygen or other gases, and the rental of equipment to administer them;

7. x-rays and laboratory tests;

8. therapeutic supplies and drugs, including but not limited to non-legend vitamins and minerals, over the counter medications, oral swabs and toothettes, and smoking cessation medications when dispensed during an inpatient confinement;

9. medical care and treatment provided in the form of outpatient services or emergency care;

10. blood transfusions, including the cost of whole blood or plasma not donated or replaced;

11. ancillary services while hospital confined (limited to one admission kit per confinement) or on an outpatient basis; and

12. other medical services and supplies necessary for the participant's care.

The Plan will recognize diagnostic related grouping or per diem charges as eligible expenses for hospital confinement where mandated by law.

INFERTILITY TREATMENT

Charges for treatment of underlying medical conditions related to the inability to conceive.

Charges for infertility services, including artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), subject to the limits shown in the Schedule of Medical Benefits. The fertility benefit does not include surrogacy or fertility medications.

MAMMOPLASTY

Charges for the following procedures:

1. medically necessary reduction mammoplasties;
2. removal of a breast implant to the extent that such removal is medically necessary and not due to cosmetic reasons such as appearance, size, shape or comfort;

3. replacement of a breast implant to the extent that:

   a) the charge for the removal of the breast implant is covered; and
   b) the insertion of the initial breast implant would have been a covered expense under this Plan.

As required by the Women's Health and Cancer Rights Act of 1998, charges for a reconstructive mammoplasty will be eligible after a medically necessary mastectomy as follows:

1. for reconstruction of the breast on which the mastectomy was performed;

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

3. for prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

MEDICAL AND SPECIAL SUPPLIES

Charges for, but not limited to, the following medical and special supplies:

1. surgical supplies;

2. casts, splints, cervical collars and trusses;

3. colostomy bags and supplies required for their use;

4. catheters;

5. oxygen and other gas therapy, and its administration;

6. electronic heart pacemakers;

7. the first pair of glasses or contact lenses, but not both, needed as the result of cataract surgery;

8. soft lenses or sclera shells intended for use in the treatment of an illness or injury to the eye;

9. medical supplies including, but not limited to, dressings, swabs, gauze and bandages when applied by a provider in connection with medical treatment; however, such supplies purchased by the participant for take-home use are not considered eligible expenses, even if recommended by a physician.

MEDICAL FOOD

Charges for medical food for treatment of an inherited metabolic disease. "Medical food" is defined as a food formulated by the selective use of nutrients and manufactured for the dietary treatment of a specific condition.

"Inherited metabolic disease" is defined as a disease:

1. caused by inborn errors of amino acid, organic acid or urea cycle metabolism; and

2. treatable by the dietary restriction of one (1) or more amino acids.

Eligible medical food will be treated as a prescription drug under the Schedule of Medical Benefits.

MIDWIFE DELIVERY SERVICES

Charges for delivery services provided by a certified nurse-midwife.

NEWBORN CARE

Charges for newborn care while the mother is confined for delivery. Such care shall include, but is not limited to:

1. nursery care;
2. professional services;
3. routine tests; and
4. circumcision.

A newborn child of an employee will automatically be covered for the first thirty (30) days of life; the child must be added to the Plan for coverage to continue after thirty (30) days.

NURSING SERVICES

Charges made by a registered graduate nurse (R.N.) or licensed practical nurse (L.P.N.) for medically necessary professional nursing services.

ORGAN AND/OR TISSUE TRANSPLANT

Charges for non-experimental (as designated by the Food and Drug Administration) organ and/or tissue transplant.

The reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charges for removal of the organ and the hospital's charge for storage or transportation of the organ, will be considered an eligible expense.

Expenses incurred by a live organ donor who is not covered under this Plan will be covered for each organ transplant procurement. If both the recipient and the donor are covered under this Plan, the expenses will be treated separately.

If the organ recipient is not a Plan participant, expenses incurred by an organ donor who is a Plan participant are not eligible expenses.

The Plan does not cover organ and/or tissue transplants performed at non-network facilities.

ORTHOTIC DEVICES

Charges for the initial purchase, fitting and repair of orthopedic braces (including corrective shoes, if attached to the braces), splints and other appliances used to support or restrain a weak or deformed body part. Replacement will be covered only if needed as a result of natural growth or pathological changes, or to maintain functionality. Corrective or orthopedic shoes not attached to a brace are not covered.

Charges for custom molded orthotics for acquired deformities of the foot such as claw toe, hallux rigidus, hallux valgus, hallux flexus, hallux malleus and hallux varus. Appliances for palliative treatment of the foot including, but not limited to, heel lifts, foot pads and arch supports are not covered.

OUTPATIENT SURGICAL FACILITY

Charges for use of an outpatient surgical facility.

PERVASIVE DEVELOPMENTAL DISORDERS

Charges for the treatment of pervasive developmental disorders, limited to treatment prescribed by the treating physician in accordance with a treatment plan. Pervasive developmental disorder means a neurological condition, including neurodevelopment disorders, within the autism spectrum. The treatment of pervasive developmental disorders includes applied behavioral analysis, which will be paid as shown in the Schedule of Benefits. This benefit is subject to precertification rules.

PHYSICIAN SERVICES

Charges made by a physician for office, hospital or home visits, medical care or surgery. If a physician performs two (2) or more surgical procedures in one (1) surgical session, he will be paid for each procedure at the same rate as if it were performed separately.

PODIATRY SERVICES

Charges made by a physician for office visits, surgery or treatment of medical conditions of the feet. Eligible expenses shall include:

1. surgical procedures or injections involving the bones, nerves, muscles or tendons of the foot or ankle;

2. capsular or bone surgery for treatment of bunions;

3. complete or partial removal of the nail or nail matrix affected by disease, infection or fungus;

4. cutting or removal of corns, calluses or toenails if done in connection with an underlying medical condition such as diabetes or peripheral vascular disease.

PREGNANCY

Charges for prenatal care, delivery, post-natal care and complications for a covered employee, spouse or dependent child. Pregnancy benefits are eligible as any other medical condition. This benefit includes medical complications arising from the physical state of pregnancy.

The Plan shall cover charges for abortions only when the life of the mother would be endangered by continuation of the pregnancy.

In addition, the Plan includes the following Statement of Rights:

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT:

Under federal law, group health plans and health issuers offering group health coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a

shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six [96] hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (or ninety-six [96] hours).

PREVENTIVE SERVICES

Charges for preventive services as follows:

Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) include the following:

1. Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;

2. Vaccinations for routine use in children, adolescents or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

4. The complete list of recommendations and guidelines can be found at: http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

Services as shown above include routine or periodic exams (including school enrollment exams, but excluding sports exams), vaccinations, pelvic exams, pap tests, labs or x-rays, annual dilated eye examinations for diabetic retinopathy, routine vision screenings for disease or abnormality, routing hearing screenings, routine mammograms, routine PSA tests, bone density tests, routine colorectal cancer examinations and related lab tests and routine colonoscopies.

Also included under preventive services are costs for physician-supervised tobacco-cessation and hospital-sponsored non-surgical weight loss programs. Any weight loss program must receive approval from the Plan Administrator prior to the date the participant starts the program. Participants are responsible for the up-front cost of such a program, and will be reimbursed 100% of that cost upon confirmation of successful completion.

Charges for preventive services for women as follows:

1. Annual well-woman preventive care visit for adult women to obtain recommended age and developmentally-appropriate services, including preconception and prenatal care (additional visits are covered, if necessary, to obtain all recommended preventive services based on risk factors and health status);

2. Gestational diabetes screening for women 24-28 weeks pregnant, and those at high risk of developing gestational diabetes;

3. Human papillomavirus (HPV) DNA testing for women age 30 and older every three years, regardless of pap smear results;

4. Annual counseling on sexually transmitted infections for sexually-active women;

5. Annual screening and counseling on human immunodeficiency virus (HIV) infections for sexually active women;

6. All FDA-approved contraceptive methods, sterilization procedures, patient education and counseling, excluding abortifacient drugs. FDA-approved oral contraceptives will be covered with no cost sharing when a generic (if available) is dispensed. If a participant requests brand when generic is available, the participant will be responsible for the applicable deductible (Plan A) or copay (Plan B).

7. Comprehensive lactation support and counseling from trained providers, as well as rental fees for breastfeeding equipment for pregnant and postpartum women; and

8. Screening and counseling for interpersonal and domestic violence.

PROSTHETICS

Charges for the initial purchase, fitting and repair of a prosthesis for a wholly or partially missing body part. Replacement will be covered only if needed as a result of natural growth or pathological changes, or to maintain functionality.

PSYCHIATRIC & SUBSTANCE ABUSE CARE

Charges for inpatient and outpatient treatment of psychiatric disorders and substance abuse, as stated in the Schedule of Medical Benefits. Charges shall be considered inpatient psychiatric or substance abuse care when the charges incurred include a room and board charge.

SECOND SURGICAL OPINION

Charges for second surgical opinions as follows:

1. If the participant has been advised to have a surgical procedure performed, the Plan will pay for obtaining a second opinion as to the medical necessity for that surgery. A participant may obtain a second opinion from any physician who is not an associate of the physician who made the original recommendation for surgery.

2. Charges for x-ray and laboratory testing required by the physician in order to render a second opinion are also included in this benefit.

Charges incurred for a second surgical opinion must be billed as such to be eligible under this benefit. Charges for a third opinion will also be eligible if the first two (2) opinions conflict.

SKILLED NURSING FACILITY

Charges made by a skilled nursing facility after a hospital confinement, including:

1. room and board up to the lesser of:

   a) the facility's regular daily charge for a semi-private room; or
   b) fifty percent (50%) of the regular daily charge for a semi-private room in the hospital from which the patient was transferred; and

2. other services and supplies.

Benefits will be paid as stated in the Schedule of Medical Benefits.

Care in the facility must begin within fourteen (14) days after leaving the hospital. The hospital confinement must have been for at least three (3) days. The care must be needed for the same disability that caused the hospital confinement and must be supervised by a physician.

A convalescent period ends when the patient is discharged from the facility for more than fourteen (14) days. A new convalescent period begins when the participant is readmitted to the facility within fourteen (14) days of discharge from another hospital confinement of at least three (3) days.

STERILIZATION

Charges for elective sterilization procedures such as tubal ligations and vasectomies. Eligible expenses under this Plan shall not include reversal, or attempted reversal, of these procedures.

THERAPY SERVICES

Charges for radiation therapy, chemical therapy, physical therapy, occupational therapy, inhalation therapy, vision therapy, orthopedic therapy and cardiac rehabilitation, if prescribed by a physician. Therapy is eligible only for the purposes of restoring bodily function due to illness, injury or congenital anomaly, and only if the therapy is expected to result in significant improvement of the specific defects.
Speech therapy by a licensed speech therapist or speech pathologist to:

1. restore or rehabilitate a loss or impairment of speech resulting from an injury, illness or medical procedure; however, a loss or impairment caused by a mental, psychoneurotic or personality disorder is not covered;

2. develop or improve speech after surgery to correct a birth defect; or

3. develop or improve speech for a participant over the age of twenty-three (23), provided the therapy does not continue for more than a twelve (12) month period.

WEIGHT LOSS TREATMENT

Charges for non-surgical weight loss treatment, but only for participants with a body mass index (BMI) of thirty (30) kilograms per meter squared or higher. Eligible weight loss expenses shall include only those expenses that are medically necessary, including hospital-sponsored, non-surgical programs, office visits, laboratory tests and prescription drugs. (Prescription drugs for weight loss will be covered under the prescription drug benefit.) Bariatric surgery will NOT be considered an eligible expense. Other ineligible expenses include, but are not limited to, food, food replacements, dietary supplements, weight loss group membership fees, exercise or fitness classes, gym membership fees and other costs related to diet and exercise.

MEDICAL EXCLUSIONS

(exclusions in addition to General Plan Exclusions)

1. Charges for examinations to determine the need for contact lenses, eyeglasses or other optical aids, or for the purchase, fitting or adjustment of such. However, charges for the initial examination and initial purchase of lenses after cataract surgery, initial prosthetic lenses, sclera shells following intra-ocular surgery, soft contact lenses due to a medical condition and treatment of aphakia are eligible expenses.

2. Charges for services and supplies related to correcting refractive defects of the eye, including, but not limited to, radial keratotomy by whatever name called, or other eye surgery to correct near sightedness, far sightedness or astigmatism.

3. Charges for services or supplies related to the teeth, nerves or roots of the teeth, gingival tissue or alveolar processes except as provided in the Description of Medical Benefits under Dental Services.

4. Charges incurred 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, except as provided in the Description of Medical Benefits under Dental Services.

5. Charges for services and supplies related to dental implantology.

6. Charges for services for upper or lower jaw augmentation or reduction procedures (orthognathic surgery), unless the result of an accidental injury.

7. Charges for hearing tests and audiograms that are not performed in connection with an illness, injury or medical condition, examinations to determine the needs for hearing aids and the purchase and fitting of hearing aids, except as provided in the Description of Medical Benefits under Hearing Exam and Hearing Aids.

8. Speech therapy, except as described under in the Description of Medical Benefits under Therapy.

9. Charges for the rental, purchase or use of personal convenience items, including, but not limited to, air conditioners, air purification units, allergy-free pillows, blanket or mattress covers, weighted blankets, blood pressure instruments, electric heating units, exercise equipment, hot tubs, humidifiers, orthopedic mattresses, home traction devices, physical exercise equipment, stair lifts, swimming pools and whirlpools, even if prescribed by a physician.

10. Charges billed by a hospital for services and supplies for personal convenience and hygiene, including, but not limited to television, telephone, father's kits or visitor's meals.

11. Charges for services and supplies related to custodial or convalescent care or care provided in rest homes, health resorts, homes for the aged, halfway houses or places mainly for domiciliary or custodial care.

12. Charges for services and supplies for routine, cosmetic or palliative foot care, including, but not limited to, treatment of toenails, bunions, corns, calluses, fallen arches, weak feet or chronic foot strain, except as provided in the Description of Medical Benefits under Podiatry Services.

13. Charges for services and supplies for cosmetic purposes, except as provided in the Description of Medical Benefits under Cosmetic Surgery.

14. Charges for wigs, artificial hair pieces, hair transplants, prescription drugs or any other treatment to conceal or eliminate hair loss, except when hair loss is the result of burns, chemotherapy, radiation therapy or surgery; then the purchase of a wig or artificial hairpiece is limited to one every two years.

15. Charges for surgical breast reconstruction, breast augmentation or breast implants, except as provided in the Description of Medical Benefits under Mammoplasty.

16. Charges for chemical face peels or abrasion of the skin, even if prescribed by a physician.

17. Charges for counseling services, including religious, marital and sex counseling, unless provided in connection with a condition, illness or injury that is covered under this Plan.

18. Charges for services and supplies related to milieu therapy or situation therapy (confinement in an institution primarily to change or control one's environment), including, but not limited to, halfway houses and residential treatment facilities. However, medically necessary fees incurred during confinement in these facilities may be eligible.

19. Charges for travel for environmental change, even if prescribed by a physician.

20. Charges for vocational or cognitive therapy.

21. Charges for services and supplies for the purpose of controlling harmful habits or promoting self-help, except as stated in the Schedule of Benefits under Preventive Services.

22. Charges for services and supplies for the purpose of achieving conception and/or pregnancy through surrogacy or the use of fertility medications. See Infertility Services for eligible infertility expenses.

23. Charges for the reversal of an elective surgical sterilization.

24. Charges incurred for an elective abortion, unless the life of the mother is threatened by the continued pregnancy. However, charges for complications arising from an abortion, whether the abortion itself is eligible or not, will be considered an eligible expense.

25. Charges for services and supplies related to sexual dysfunctions or inadequacies, including sexual therapy, counseling, penile prosthesis, medications and all other procedures and equipment developed for male impotency.

26. Charges for services and supplies related to transsexualism, gender dysphoria or sexual reassignment or change, including, but not limited to, medications, implants, hormone therapy, surgery, therapy and counseling.

27. Charges for laetrile and its administration.

28. Charges for the transplantation of non-human, mechanical or artificial organs.

29. Charges for non-medical services and supplies or for special instruction and education beyond the period necessary to diagnose learning deficiencies or behavioral problems.

30. Charges for non-medical expenses such as training, educational instruction or educational materials, even if they are performed or prescribed by a physician, except services for education and nutrition counseling that are incurred in connection with a diagnosed diabetic condition or eating disorder.

31. Charges for anesthesia by hypnosis or anesthesia for non-eligible services.

32. Charges for prescription drugs that are reimbursable under the Prescription Drug Benefits section of this Plan or excluded under the Prescription Drug Benefits section of this Plan.

33. Charges for private duty nursing, except as provided in the Description of Medical Benefits under Home Health Care or Hospice Care.

34. Charges for bariatric surgery.

35. Home traction devices.

36. Charges billed by a chiropractor for blood tests or hair analysis.

MEDICARE

This section is subject to the terms of Medicare laws and regulations. Any changes in the laws and regulations related to Medicare will apply to the provisions of this section.

ACTIVE EMPLOYEES AND THEIR SPOUSES AGED 65 AND OVER

All health benefits to which a covered employee and covered spouse are entitled under the Plan will be paid before and without regard to any payments that would be available under Medicare, unless and until the employee or spouse declines in writing coverage for health benefits under the Plan.

If an active employee is enrolled in any part of Medicare, he cannot be enrolled in Plan A.

If the active employee or his spouse retains Plan B as primary coverage, then Medicare will supplement payments of this Plan.

If the active employee declines coverage under the Plan for health benefits, he and all of his dependents will not be eligible for any health benefits under this Plan. If his dependent spouse rejects coverage under the Plan for health benefits, the spouse will not be eligible for any health benefits under this Plan.

DISABLED EMPLOYEES UNDER AGE 65

This Plan will be the primary plan for totally disabled employees who are covered under this Plan while entitled to Medicare disability benefits, only if the totally disabled employee is:

1. actively working; or

2. not actively working, but meets ALL of the following five conditions:

   a) retains employment rights in the industry;
   b) has not had his or her membership in the employee organization terminated by the employer or union that provides the coverage;
   c) is not receiving disability payments from any employer for more than six (6) months;
   d) is not receiving Social Security disability benefits; and
   e) has employer provided health coverage that is NOT COBRA continuation coverage.

If an employee is receiving wages from which FICA is deducted (the first six [6] months of employer disability benefits are subject to FICA taxes), the employee is considered currently employed, therefore Medicare is secondary. However, once FICA is no longer deducted, Medicare will become primary.

The Plan will remain the primary payor for dependents who are entitled to Medicare coverage as long as the Plan is the primary payor for the disabled employee. Once the Plan becomes secondary to Medicare for the disabled employee the Plan will also become the secondary payor for the dependent who is entitled to Medicare.

PARTICIPANTS ELIGIBLE FOR MEDICARE BY REASON OF END STAGE RENAL DISEASE

After becoming eligible for Medicare due to End Stage Renal Disease (ESRD), benefits of this Plan shall be primary during the initial thirty (30) month period. Medicare will be the primary payor thereafter.

COBRA PARTICIPANTS

All health benefits due to continuation of coverage to which a covered employee and covered dependent are entitled to under the Plan will be paid secondary, after Medicare pays as primary payor.

BENEFIT CALCULATION

If a participant does not enroll for coverage under Part A and Part B of Medicare or does not make due claim for Medicare benefits, the Plan Administrator will calculate benefits as if he were enrolled in both parts of Medicare and full claim for benefits had been made.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

(see Description of Prescription Drug Benefits for detailed explanation of the following provisions)

PLAN A:

Participant pays 100% of all prescription charges until deductible is met; Plan pays 100% of all eligible prescription expenses thereafter. Plan will pay only for generic drugs (after participant meets deductible) unless there is no generic equivalent or a brand drug is required by participant's provider. If a generic is available, a Participant who elects to use a brand drug as a matter of preference will be responsible for the difference in cost between the brand and the generic prescription.

NOTE: There is no charge to participants for any prescribed generic FDA-approved oral contraceptive.

PLAN B:

Plan will pay only for generic drugs under the copay arrangement detailed below, unless there is no generic equivalent or a brand drug is required by participant's provider. If a generic is available, a Participant who elects to use a brand drug as a matter of preference will be responsible for the brand copayment plus the difference in cost between the brand and the generic prescription.

Pharmacy Copay:
(each prescription fill, see dispensing limitations)

Generic Formulary Drugs	$10 per 30-day supply (or portion thereof)
Brand Name Formulary Drugs	$60 per 30-day supply (or portion thereof)
Non-Formulary Drugs	$100 per 30-day supply (or portion thereof)
Covered Percentage after Copay	100%

Dispensing Provision: Up to a maximum of a 90-day supply

Prescription Drug Card copays are not eligible expenses under the medical Plan.

NOTE: There is no charge to participants for any prescribed generic FDA-approved oral contraceptive.

Mail Order Copay:
(each prescription fill, see dispensing limitations)

Generic Formulary Drugs	$20 per 90-day supply (or portion thereof)
Brand Name Formulary Drugs	$120 per 90-day supply (or portion thereof)
Non-Formulary Drugs	$200 per 90-day supply (or portion thereof)
Covered Percentage after Copay	100%

Dispensing Provision: Up to a maximum of a 90-day supply

Mail Order Program copays are not eligible expenses under the medical Plan.

DESCRIPTION OF PRESCRIPTION DRUG BENEFITS

Charges eligible under the Prescription Drug Benefit will not be eligible for benefits as a medical expense under the Plan.

Upon presentation of a valid identification card for this Plan, a participant may obtain medications that are prescribed by a licensed physician from participating pharmacies. Alternatively, maintenance medications may be obtained through a mail order program for convenience and cost savings. For each prescription order and each refill, the program requires that the participant pay the full cost before the deductible is met or no cost after the deductible is met (Plan A), or the copayment (Plan B) for each generic or brand name drug shown in the Schedule of Prescription Drug Benefits. There is no charge for any prescribed, FDA-approved oral contraceptive or contraceptive device under Plan A or Plan B.

Participating pharmacies and the mail order pharmacy will dispense prescriptions in a quantity not to exceed the amount stated in the Schedule of Prescription Drug Benefits.

Charges for federal legend drugs, prescription drugs and compound medications containing at least one federal legend drug are eligible expenses, with the conditions and exceptions listed below.

ELIGIBLE PRESCRIPTION DRUG EXPENSES

1. Charges for federal legend drugs (those requiring the label, "Caution: Federal law prohibits dispensing without a prescription") and drugs that may only be dispensed by written prescription under State law.

2. Charges for compound drugs when a commercially available dosage form of a medically necessary medication is not available, all the ingredients of the compound drug are FDA approved and require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Non FDA-approved, non-proprietary multisource ingredients that are vehicles essential for compound administration may be covered.

3. Charges for insulin, disposable syringes, needles, lancets and test strips when prescribed with insulin—one copayment is applicable when dispensed at the same time. The quantity of the supplies must correspond to the amount of insulin dispensed.

4. Charges for oral contraceptives available by prescription only.

5. Charges for immunosuppressants.

6. Charges for interferons.

7. Charges for behavioral syndrome drugs.

8. Charges for legend and non-legend tobacco cessation products, including prescription medications, patches, gum, nasal spray and inhalers.

9. Charges for injectable drugs.

10. Charges for isotretinoin.

11. Charges for tretinoin, for participants under age twenty-six (26) only.

12. Charges for legend vitamins and hematinics.

13. Charges for legend dental vitamins, rinses and fluoride agents.

14. Charges for FDA approved male impotency medications, up to a maximum of six (6) pills in twenty-nine (29) days or eighteen (18) pills per ninety (90) days.

PRESCRIPTION DRUG EXCLUSIONS

(exclusions in addition to General Plan Exclusions)

1. Charges for drugs provided and/or administered in a physician's office or hospital, or any setting other than home use.

2. Charges for more than a ninety (90) day supply of a drug, or any amount in excess of the quantity prescribed.

3. Charges for refills not authorized by a physician, or refills dispensed after one (1) year from the date of the original order (six [6] months if a federally controlled drug).

4. Charges for non-legend drugs (other than insulin), or drugs not prescribed by a licensed physician or not dispensed by a licensed pharmacist.

5. Charges for experimental or investigational drugs, including compound medications for non-FDA approved use, unless such drugs are covered under the Clinical Trial provisions of the Description of Medical Benefits.

6. Charges for DESI Drugs (drugs determined by the Food & Drug Administration as lacking substantial evidence of effectiveness).

7. Charges for vaccination agents, vaccines, allergy extract, biological sera, blood or blood plasma.

8. Charges for insulin supplies, including, but not limited to, alcohol swabs, blood glucose monitors, blood monitor kits and blood glucose calibration solutions.

9. Charges for anorectics, dietary aids and food supplements.

10. Charges for fertility drugs.

11. Charges for hair growth agents.

12. Charges for vitamins, minerals and food supplements not medically necessary for the treatment of a specific illness or condition.

13. Charges for cosmetic drugs.

14. Charges for over-the-counter medications.

15. Charges for the administration of drugs.

16. Charges for therapeutic equipment, devices or appliances, including hypodermic needles and syringes, except as provided under Eligible Expenses above; charges for other non-medical substances, even if prescribed by a physician.

SCHEDULE OF DENTAL BENEFITS

(see Description of Dental Benefits for detailed explanation of the following provisions)

MAXIMUM BENEFITS:

Maximum Calendar Year Benefit per Participant (Non-Orthodontia) $2,500

Maximum Lifetime Benefit per Participant for Orthodontia $2,500

CALENDAR YEAR DEDUCTIBLES:

Basic and/or Major Services:
Individual Deductible $50
Family Deductible $100
(Deductible waived for Preventive and Orthodontia Services)

COINSURANCE PERCENTAGES:

Preventive Services 100%
Basic Services 80%
Major Services 50%
Orthodontia Services 50%

DESCRIPTION OF DENTAL BENEFITS

The dental benefit provides payment for eligible dental expenses charged to the participant by a dentist or physician.

Eligible dental charges will be paid as shown in the Schedule of Dental Benefits, provided the participant has elected dental coverage and the expenses incurred are eligible and not shown as limited or excluded under the Plan.

When a participant is covered under the Plan for both Medical and Dental Benefits, eligible expenses will first be considered for eligibility under the portion of the Plan covering medical expenses before being considered for eligibility under Dental Benefits.

INCURRED DATE OF DENTAL SERVICES

In order for benefits to be payable, the participant must be covered on the date the dental treatment is received. Most dental treatment is considered to have been received on the date the work is done. However, there are some kinds of treatment that take a period of time to complete. In these cases, treatment will be considered to have been received on the dates shown below:

1. as to fixed bridgework, crowns, inlays, onlays and gold restorations, the date the tooth or teeth are first prepared;

2. as to full or partial removable dentures, the date the impression is taken;

3. as to root canal work, the date the tooth is opened;

4. as to a course of orthodontic treatment, the date the first appliance is installed; and

5. as to all other services, the date the service is performed.

PREDETERMINATION OF BENEFITS

If the expected cost of a proposed course of dental treatment is $200 or more, the participant should ask the attending dentist to submit a predetermination of benefits request to the Third Party Administrator before work is begun. The Third Party Administrator will advise the dentist and the participant if the proposed services are limited or ineligible.

The predetermination information must include the following:

1. the diagnosis;

2. a complete description of the services to be performed or provided, using American Dental Association nomenclature and codes;

3. the itemized cost of each service; and

4. the estimated length of treatment.

Dental x-rays, models and any additional information needed to evaluate the predetermination must be provided to the Third Party Administrator, if requested.

Whether or not a predetermination of benefits request was filed, benefits will be paid based on the basis of charges actually submitted.

ALTERNATE PROCEDURES

Dentists may use different types of materials or different procedures in order to correct the same problem. Because some types of dental work are more costly than others, the Plan will only pay for the least expensive form of services and supplies that are both appropriate to correct the problem and meet with accepted dental standards. This does not mean that the participant cannot choose to elect the more expensive form of treatment, but the participant will have to pay any charges over the amount that the Plan does not consider necessary.

If there is any doubt whether the dentist is using more costly materials, services or supplies than necessary, the participant should have the dentist submit a Predetermination of Benefits as described above.

ELIGIBLE DENTAL BENEFITS

Eligible dental charges are listed below, subject to the reasonable and customary provision. The Third Party Administrator will determine the reasonable and customary charge by comparing the charges for comparable treatment made by other dentists in the service area. If the dentist's charge is more than the reasonable and customary charge, the amount over the reasonable and customary charge will not be an eligible expense under the Plan.

PREVENTIVE SERVICES

1. Charges for periodic oral examinations (limited to two [2] per calendar year).
2. Charges for dental prophylaxis treatments (limited to two [2] per calendar year).
3. For participants less than fifteen (15) years of age, charges for topical application of fluoride (limited to one [1] per calendar year).
4. For participants less than twelve (12) years of age, charges for space maintainers, including all adjustments necessary during the six (6) months after installation.
5. For participants less than twelve (12) years of age, charges for sealants on posterior permanent teeth (limited to two [2] topical applications per tooth).
6. Charges for bitewing dental x-rays (limited to two [2] series per calendar year).
7. Charges for one (1) complete series of x-rays or one (1) panograph per five (5) year period.
8. Charges for mouth guards to prevent bruxism (limited to once every five [5] years).

BASIC SERVICES

1. Emergency palliative treatment.
2. Fillings using either composite (white) resin or amalgam (silver) restorations on both anterior and posterior teeth.
3. Local and general anesthetics used in oral surgery.
4. Periodontics.
5. Endodontics (including related x-rays).

6. Charges for restorations involving inlays and onlays, and gold, plastic or porcelain crowns, but only if the tooth cannot be restored with either a composite (white) resin or amalgam (silver) filling.

7. Recementation of crowns, inlays and bridgework.

8. Relining of dentures (limited to once every two [2] years).

9. Injectable antibiotics.

10. Extractions (including orthodontic extractions).

10. Provisional splints.

MAJOR SERVICES

1. Charges for initial installation of fixed bridgework, including inlays and crowns to replace one (1) or more extracted natural teeth.

2. Charges for initial installation of partial or full removable dentures (including adjustments for the six [6] month period following installation) to replace one (1) or more extracted natural teeth.

3. Charges for replacement of existing bridgework, or the addition of teeth on existing bridgework, subject to the Prosthesis Replacement Rule.

4. Charges for replacement of an existing partial or full removable denture, or the addition of teeth to a partial removable denture, subject to the Prosthesis Replacement Rule.

5. Charges for a dental implant, but only if the implant is both:

   a) the least expensive course of treatment adequate to restore the mouth to normal form and function as dentally necessary; and
   b) less damaging to surrounding teeth and tissues than alternative forms of treatment.

7. Commissure splints.

PROSTHESIS REPLACEMENT RULE

Replacement or additions to existing dentures or bridgework will be covered only if:

1. the replacement or addition of teeth is required to replace one (1) or more extracted teeth; or

2. the existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement.

ORTHODONTIA SERVICES

1. Charges for cephalometric x-ray (payable only when submitted with eligible orthodontic treatment or an eligible orthodontic work-up).

2. Charges for diagnostic casts (limited to casts made for orthodontic purposes).

3. Charges for surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes.

4. Charges for orthodontic appliances for tooth guidance.

5. Charges for fixed or removable appliances to correct harmful habits.

The Plan pays for orthodontic treatment as shown in the Schedule of Dental Benefits. Benefits are not payable for expenses incurred for retention of orthodontic relationships. Benefits for orthodontic treatment are payable only for active orthodontic treatment for the listed services.

If orthodontic treatment is stopped for any reason before it is complete, the Plan will pay only for eligible services and supplies actually provided.

DENTAL EXCLUSIONS

(exclusions in addition to General Plan Exclusions)

1. Charges for treatment, services or supplies that are not customarily performed for the care of a specific condition, according to accepted dental standards.

2. Charges for any services rendered by someone other than a licensed dentist or auxiliary personnel under the dentist's direct supervision.

3. Charges for replacement or modification of a partial or full removable denture or bridgework, or for adding teeth to any of these, within five (5) years after the denture or bridgework is installed, unless the appliance cannot be made serviceable.

4. Charges to replace lost, missing or stolen dentures or other prosthetic devices, or charges to make a spare appliance or device.

5. Charges to replace or repair an orthodontic appliance.

6. Charges for treatment of a congenital or developmental malformation, including orthognathic treatment.

7. Charges for the diagnosis and treatment of temporomandibular joint disorder.

8. Charges for appliances, restorations or procedures used for:

   a) altering vertical dimension or restoring or maintaining occlusion; or
   b) replacing tooth structure lost from abrasion or attrition.

9. Charges for mouth guards for athletic purposes.

10. Charges for a pulp vitality test, unless rendered with other procedures.

11. Charges for an acid etch unless it is an integral part of the placement of a composite restoration.

12. Charges for bite registration or bite analysis.

13. Charges for services or supplies used primarily for cosmetic purposes, such as whitening, personalization of prosthetic devices or appliances, or veneers, facings or similar properties of crowns or pontics placed on or replacing teeth in back of the second bicuspid.

14. Charges for oral hygiene, plaque control programs, dietary instruction or other educational programs.

15. Charges for personal supplies or equipment, including, but not limited to, water piks, toothbrushes or floss holders.

16. Charges for the completion of claim forms, reports or itemized bills.

17. Charges for missed dental appointments.

If the participant changes dentists during a treatment program, the benefits provided will be the same as if only one (1) dentist had completed the program.

ELIGIBILITY PROVISIONS

Coverage provided under this Plan for employees and their dependents shall be in accordance with the Eligibility, Enrollment and Termination provisions stated below.

ELIGIBILITY

ELIGIBLE EMPLOYEES

1. A full-time employee or an official elected or appointed as Mayor, Judge, Clerk-Treasurer or Common Council Member who:

   a) is employed by the Employer or the Carmel Clay Board of Parks and Recreation;
   b) has completed the waiting period; and
   c) is actively at work.

2. An early retiree who:

   a) was a police officer, firefighter or a civilian employee of the Employer or the Carmel Clay Board of Parks and Recreation, or was an official elected or appointed as Mayor, Judge or Clerk-Treasurer of or for the Employer;
   b) completed twenty (20) years of active service (whether consecutive or not) with the Employer or the Carmel Clay Board of Parks and Recreation;
   c) was a participant in the Plan on the final day of employment; and
   d) is not eligible for Medicare.

   An employee who is terminated for just cause or gross misconduct (or resigns in lieu of termination) and/or who is convicted of one or more felony offenses is not eligible for benefits under this section.

   OR

   An early retiree who:

   a) was a civilian employee of the Employer or the Carmel Clay Board of Parks and Recreation, or was an official elected or appointed as Mayor, Judge or Clerk-Treasurer of or for the Employer;
   b) reached age fifty-five (55) on or before his retirement date;
   c) completed twenty (20) years of creditable employment with a public employer, ten (10) years of which must have been completed immediately preceding the retirement date;
   d) completed at least fifteen (15) years of participation in PERF on or before the retirement date;
   e) was a participant in the Plan on the final day of employment; and
   f) is not eligible for Medicare.

3. A retiree who:

   a) was employed as a police officer or firefighter by the Employer;
   b) qualifies for a retirement or disability benefit under a pension plan offered by the Employer (including, but not limited to, the 1925, 1937 and 1977 plans);
   c) was a participant in the Plan on the final day of employment; and
   d) is not eligible for Medicare.

   OR

A retiree who:

a) was a civilian employee of the Employer;
b) qualifies for an unreduced pension or a disability benefit through the Public Employees' Retirement Fund;
c) was a participant in the Plan on the final day of employment; and
d) is not eligible for Medicare.

A retiree must submit a written request for retiree insurance benefits within ninety (90) days of his retirement date. If a retiree waives coverage or fails to submit a timely written request for coverage, then such retiree will not be eligible for retiree benefits under this Plan at any time thereafter.

4. The spouse and/or dependent child(ren) of an employee who dies "in the line of duty," as defined by City policy, and who:

   a) was a participant in the Plan on the date of the employee's death; and
   b) is not eligible for Medicare.

   Only the spouse, or, if there is no spouse, the oldest child, will be classified as an eligible employee; all others will be classified as dependents.

Temporary employees, part-time employees, seasonal employees, leased employees, individuals paid by a third party that is not related to the Employer and independent contractors are not eligible employees under this Plan.

ELIGIBLE DEPENDENTS

Eligible dependents are:

1. The employee's legal spouse or registered domestic partner, if the spouse or domestic partner is not covered under this Plan as an employee;

2. The employee's child under age twenty-six (26); and

3. The employee's disabled dependent child age twenty-six (26) or over, who meets the criteria listed below.

A newborn child of an employee or an employee's registered domestic partner must be enrolled within thirty (30) days of birth in order to have coverage from birth.

The Plan Administrator reserves the right to require full documentation of any claim for dependent qualification including, but not limited to, copies of birth certificates, marriage certificates and divorce decrees, verification of domestic partner status, copies of federal income tax returns, and adoption, guardianship or placement orders giving the employee legal responsibility for a dependent child.

No participant is eligible for coverage both as an employee and as a dependent. If both parents of a child are covered employees under this Plan, the child may be covered as the dependent of only one parent.

If both parents are covered employees under this Plan, and the spouse carrying dependent coverage terminates coverage under the Plan, dependent coverage can be transferred to the spouse who remains covered by the Plan, provided that individual continues to be an eligible employee. A spouse who terminates coverage may also be covered as a dependent under the remaining spouse's coverage.

Adopted Children/Legal Guardianships

An adopted child of an employee or a registered domestic partner will be eligible for coverage as of the date of legal placement for adoption, or the date of actual adoption, whichever occurs first. A child who is related to the employee by blood or marriage and for whom the employee has assumed legal guardianship will be eligible for coverage on the date the guardianship becomes effective.

Coverage under the Plan for an adopted child or a child under legal guardianship will be the same coverage that is available to all other dependent children under the Plan

Disabled Dependent Child

Coverage for an unmarried disabled dependent child may be continued after age 26, provided the child was disabled prior to his 26th birthday.

An initial certification form must be submitted at least 30 days prior to the dependent's 26th birthday. The certification requires evidence that the dependent:

1. is permanently disabled due to a mental or physical incapacity; and

2. relies on the covered employee for financial support.

The Plan Administrator may require periodic proof of a continuing disability, but not more frequently than every other year. Such proof may include a medical examination at the Plan's expense. Failure to provide satisfactory proof upon request may result in termination of the dependent's coverage.

A child who becomes disabled after age 26 will not be eligible to re-enroll for coverage as a disabled dependent child under the Plan.

Qualified Medical Child Support Orders (QMCSO)

An eligible dependent shall also include any other child of a participant or his spouse who is recognized in a Qualified Medical Child Support Order (QMCSO). A qualified medical child support order is a medical child support order issued by a court or through a State administrative process that creates or recognizes an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or qualified beneficiary is eligible.

If the medical child support order is determined to be a QMCSO, each named child will be covered by the Plan in same manner as any other dependent child covered by the Plan.

If it is determined that the order is not a Qualified Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within thirty (30) days of receipt of that appeal.

To be considered a Qualified Order the medical child support order must contain the following information:

1. the name and last known mailing address of the participant and the name and address of each alternate recipient to be covered by the Plan;

2. a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which the type of coverage is to be determined;

3. the period to which such order applies; and

4. each Plan to which such order applies.

This Plan will not provide any type or form of benefit or any option not otherwise provided under the Plan for any child covered by a QMCSO, and all other dependent eligibility, effective date and termination provisions will apply.

VERIFICATION OF DEPENDENT ELIGIBILITY

An employee is responsible for providing verification, as requested by the Plan Administrator, that his dependent is initially eligible and remains eligible for participation in the Plan. Failure to provide such verification may lead to denial of dependent coverage under the Plan at the time of initial application, or to the dependent's termination from the Plan.

ENROLLMENT

WAITING PERIOD

The waiting period for coverage under the Plan is the thirty (30) days immediately following the employee's date of full-time hire.

Days in which the employee does not meet the definition of a full-time active employee due to an illness or injury will be counted toward the satisfaction of the waiting period as if the employee were a full-time active employee. The Employer must have official notification of the illness or injury.

An individual employed for fewer hours than required to be eligible for coverage, who subsequently increases hours worked to the required level, will be credited only with time worked while meeting the definition of an eligible employee for purposes of determining the effective date of coverage.

A former employee who is reemployed by the Employer following an absence of less than one (1) year will not be considered a new employee for purposes of satisfaction of the waiting period. For all other purposes pertaining to the Plan, the former employee will be treated as a new employee. After an absence of more than one (1) year, a former employee will be considered a new employee for all purposes pertaining to the Plan.

EFFECTIVE DATE FOR NORMAL ENROLLMENT

The employee must file a written application with the Employer for himself and his eligible dependents within thirty (30) days of his full-time hire date. (The employee must enroll for employee benefits in order to also enroll for dependent benefits.) The effective date of coverage under this Plan as the result of normal enrollment will be the first day following the satisfaction of the waiting period.

The employee is responsible for timely forwarding to the Employer the application for enrollment. If the employee fails to enroll for coverage for himself or any eligible dependents within thirty (30) days, he will be able to enroll only during an Open Enrollment period unless he qualifies for enrollment under the Special Enrollment provisions below.

SPECIAL ENROLLMENT PERIOD PROVISION DUE TO OTHER COVERAGE

An employee and/or dependent who did not enroll for coverage under this Plan because he had other coverage when he initially became eligible for coverage under this Plan may request a special enrollment period under this provision if he is no longer eligible for the other coverage. The employee must provide the Employer with written proof of the loss of coverage and the

reason for the loss. A special enrollment period will be granted if the employee and/or dependent loses eligibility due to one or more of the following:

1. divorce or legal separation;
2. termination of other employment;
3. reduction in the number of hours of employment;
4. cessation of the employer contributions (by any current or former employer) for the other coverage;
5. exhaustion of COBRA benefits;
6. death of the employee.
7. the employee or a dependent is covered under Medicaid or any state's Child Health Insurance Program (CHIP), and the coverage is terminated as a result of the loss of eligibility under either Medicaid or CHIP; or
8. the employee or a dependent becomes eligible for a premium assistance subsidy for group health coverage under Medicaid or CHIP.

The end of any extended benefits period that has been provided due to any of the above items 1 through 8 will also be considered a loss of eligibility.

Loss of eligibility will also include the decision to discontinue coverage provided by another employer during the other employer's designated open enrollment period that does not coincide with the Plan's open enrollment period.

Loss of eligibility does not include failure of the individual to pay premiums or contributions on a timely basis or termination of other coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

An employee and/or dependent who loses eligibility for the reasons described in items 1-6 above must apply for coverage under the Plan within thirty (30) days of losing his other coverage. If coverage is requested within thirty (30) days, the effective date of coverage under this Plan will be the date of the loss of eligibility for other coverage. If the employee fails to enroll for coverage for himself or any eligible dependents within thirty (30) days, he will be able to enroll only during an Open Enrollment period.

An employee and/or dependent who loses eligibility for the reasons described in items 7-8 above must apply for coverage under the Plan within sixty (60) days of losing his coverage under Medicaid or CHIP or his determination of eligibility for a premium assistance subsidy under Medicaid or CHIP. If coverage is requested within six (60) days, the effective date of coverage under this Plan will be the date of loss of eligibility for Medicaid or CHIP or the date the premium subsidy under Medicaid or CHIP begins. If the employee fails to enroll for coverage for himself or any eligible dependents within sixty (60) days, he will be able to enroll only during an Open Enrollment period.

SPECIAL ENROLLMENT PERIOD PROVISION DUE TO DEPENDENT ACQUISITION

An eligible employee who previously declined coverage, but then acquires a new dependent, may request a special enrollment period for himself and his eligible dependents. A special enrollment period will be granted for one (1) or more of the following events:

1. a marriage (the new spouse may be added, and/or the spouse's children who qualify as eligible dependents);
2. the birth, adoption, placement for adoption of a new child, or commencement of legal guardianship (the child and/or the spouse may be added).

In the case of birth, adoption, placement or legal guardianship, the spouse must be given a special enrollment period (if otherwise eligible) even if coverage under the Plan was previously declined.

The employee must make written application for employee and/or dependent coverage under the Plan within thirty (30) days of the acquisition of the dependent. The effective date of coverage as the result of a special enrollment period will be the date of the event (marriage birth, adoption, placement or guardianship) if coverage is requested within thirty (30) days of the event. If the employee fails to enroll for coverage for himself or any eligible dependents within thirty (30) days, he will be able to enroll only during an Open Enrollment period.

An employee who is already enrolled in the Plan and adds a new dependent during a special enrollment period may also elect to change plans during the special enrollment period.

An employee and/or dependent who enrolls during a special enrollment period is not treated as a late enrollee.

OPEN ENROLLMENT

Open enrollment is the period designated by the Employer each year during which the employee makes coverage elections for the following calendar year.

Absent a Special Enrollment period, the open enrollment period allows an employee the opportunity to enroll for coverage, terminate coverage, add or delete dependent coverage or select another plan option. An employee must make written application for coverage during the open enrollment period. Coverage for any employee or dependent who is enrolling during an open enrollment period shall become effective January 1 of the succeeding calendar year.

TERMINATION

TERMINATION OF EMPLOYEE COVERAGE

Employee coverage will end on the earliest of the following dates:

1. thirty (30) days after the date employment is terminated, if the employee is not eligible for retiree or early retiree coverage or does not elect such coverage;

2. thirty (30) says after the date the employee no longer qualifies as an eligible employee, if the employee is not eligible for retiree or early retiree coverage or does not elect such coverage;
3. the date on which the employee fails to make the required contribution;

4. the date the Plan is terminated;

5. the date the employee becomes eligible for Medicare due to having attained the age of 65, if covered as a retiree or an early retiree, or as the spouse of an employee who dies in the line of duty; or

6. the date the employee dies.

Proof of loss of coverage shall be provided as necessary.

CONTINUATION OF COVERAGE FOR RETIREES AND EARLY RETIREES

An employee who qualifies as a retiree or an early retiree (hereinafter jointly referred to as "retiree") may elect to continue coverage for himself and his eligible dependents if he notifies the Plan Administrator of his intent, in writing, within ninety (90) days after his retirement date. The employee must be a Plan participant at the time of retirement in order to be eligible for retiree coverage. If an employee declines coverage at the time of retirement, he is not eligible for reenrollment at a later date unless he is reemployed by the City in a full-time capacity.

An employee will have the opportunity to elect a plan change (B or C) at the time he requests retiree coverage. Such request must also be in writing. Dependents and coverages may not be added or deleted except as allowed elsewhere under the Plan's eligibility rules.

TERMINATION OF DEPENDENT COVERAGE

Dependent coverage will end on the earliest of the following dates:

1. the date the employee's coverage ends;

2. the date the dependent ceases to qualify as an eligible dependent under the Plan (a spouse will not cease to be an eligible dependent until the participant provides written proof of divorce or legal separation; a child who is classified as an eligible employee due to the death of a parent/employee in the line of duty will be subject to the age restrictions imposed on all other dependents);

3. December 31 of the year the participant requests that dependent coverage end as part of the annual open enrollment process

4. the end of the period for which the employee made any required contributions, if the employee fails to make any further required contributions;

5. the date the Plan is changed to end coverage for a class to which the dependent belongs;

6. The date the dependent becomes covered as an employee;

7. the date the dependent enters the armed forces of any country on a full-time active-duty basis;

8. the date the dependent becomes eligible for Medicare due to having attained the age of 65, if the employee is covered as a retiree or an early retiree;

9. the date the Plan is terminated; or

10. the date the eligible dependent dies.

Proof of loss of coverage shall be provided as necessary.

A dependent who ceases to be eligible for coverage under the Plan may be eligible for COBRA coverage.

DEPENDENT SPOUSE OF A RETIREE

The spouse of an employee who qualifies as a retiree or an early retiree (hereinafter jointly referred to as "retiree") may continue to be enrolled in the Plan after the retiree becomes eligible for Medicare due to having attained the age of 65 or dies. Coverage may be continued until the date the spouse becomes eligible for Medicare due to having attained the age of 65, provided that the spouse makes timely payment of the required contributions. Other dependents already in the Plan

at the time of the retiree's Medicare eligibility or death may remain in the Plan, but no new dependents may be added.

LEAVES OF ABSENCE

This Plan shall comply at all times with the provisions of the Family and Medical Leave Act of 1993 (FMLA).

An employee on leave of absence may continue coverage for himself and his eligible dependents in accordance with Ordinance D-1490-00 if:

1. the employee is on a duly approved medical leave or personal leave, or has been suspended for disciplinary reasons or pending resolution of criminal charges; and

2. the employee pays the required bi-weekly contribution to the Employer on or before each payday.

If the employee does not return to work after commencement of a leave of absence, his coverage will continue until the date the coverage would otherwise cease as described under Termination of Employee Coverage above. However, coverage under this Plan will not extend more than six (6) months beyond commencement of FMLA leave or personal leave if the employee does not return to work during that period, unless the employee is eligible for coverage as a retiree or an early retiree.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) CONTINUATION OF COVERAGE

The federal law commonly referred to as COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of benefit ("COBRA Continuation Coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This section is intended to inform the participant, in a summary fashion, of the participant's rights and obligations under the COBRA Continued Coverage provisions of the law. If an eligible participant does not choose COBRA Continuation Coverage, the participant's coverage under the Plan will end.

COBRA Continuation Coverage applies to medical benefits under the Plan and also to any prescription drug, dental and/or vision coverage if covered under the Plan prior to the qualifying event. The participant will only be entitled to receive COBRA Continuation Coverage for the coverage(s) the participant elects to continue during the election process as described herein.

In all instances of interpretation and/or application, the Plan shall conform to the legislative provisions in effect on the date of the qualifying event.

QUALIFYING EVENT

A qualifying event is any of the following events, which would normally result in termination of coverage. These events will qualify a participant to continue coverage as a qualified beneficiary beyond the termination date described under Eligibility Provisions.

1. Death of the employee.

2. The employee's termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for coverage under the Plan.

3. Divorce or legal separation from the employee.

4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.

5. Dependent child no longer satisfying the eligibility requirements of the Plan.

QUALIFIED BENEFICIARIES

As used herein, a qualified beneficiary is a participant who loses coverage under the Plan as the result of a qualifying event.

NOTIFICATION REQUIREMENTS

The Third Party Administrator must be notified of a qualifying event in order to offer COBRA Continuation Coverage to qualified beneficiaries. The notice must be submitted in writing either by the Employer, or by the covered employee or a dependent. The nature of the qualifying event determines which party is responsible for notifying the Third Party Administrator. After receiving written notice of a qualifying event, the Third Party Administrator will provide required notices to the COBRA beneficiary as described below.

Notification By Covered Employee Or Dependent

The covered employee or dependent must notify the Plan Administrator when eligibility for COBRA Continuation Coverage results from either of the following events:

1. Divorce or legal separation from the covered employee.

2. A dependent child no longer meets the eligibility requirements of the Plan.

The covered employee or dependent must provide this notice to the Plan Administrator within sixty (60) days of either the qualifying event or the date of loss of coverage.

The covered employee or dependent, or their representative, must deliver this notice **in writing** to the Employer. The Employer or the Third Party Administrator shall require that any additional information be provided, when necessary to validate the qualifying event, before deeming the notice to be properly submitted. If the requested information is not provided within the time limit set forth above, the Third Party Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited his rights to COBRA Continuation Coverage.

To protect the COBRA rights of covered employees and dependents, it is very important that covered employees and dependents keep the Third Party Administrator informed of their current mailing address. Any notices will be sent to individuals at their last known address. It is the responsibility of covered employees and dependents to advise the Third Party Administrator of any address changes in a timely manner in order to ensure that notices, such as those regarding their rights under COBRA, are deliverable.

For individuals who are requesting an extension of COBRA Continuation Coverage due to a disability, the individual must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial eighteen (18) month COBRA Continuation Coverage period and no later than sixty (60) days after the Social Security Administration's determination. When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within thirty (30) days of such change in status.

These notification requirements also apply to an individual who, while receiving COBRA Continuation Coverage, has a second or subsequent qualifying event. See Subsequent Qualifying Event for additional information.

Failure to provide notice to the Plan Administrator in accordance with the provisions of this notice requirement will result in the participant forfeiting his rights to COBRA Continuation Coverage under this provision.

Notification By Employer

The Employer is responsible for notifying the Plan Administrator when eligibility for COBRA Continuation Coverage results from any events other than divorce or legal separation, or a dependent becoming ineligible.

The Employer shall provide this notice to the Third Party Administrator within thirty (30) days of either the qualifying event or date of loss of coverage. The Employer must include information that is sufficient to enable the Third Party Administrator to determine the Plan, the covered employee, the qualifying event and the date of the qualifying event.

Notification By Plan Administrator

Election Notice: Once the Third Party Administrator receives proper notification that a qualifying event has occurred, COBRA Continuation Coverage shall be offered to each of the qualified beneficiaries by means of a COBRA Election Notice. The time period for providing the COBRA Election Notice shall generally be fourteen (14) days following receipt of notice of the qualifying event.

Notice of Ineligibility: In the event that the Third Party Administrator determines that the covered employee and/or dependent(s) are not entitled to COBRA coverage, the Third Party Administrator shall notify the covered employee and/or dependent(s). This notice shall include an explanation of why the individual(s) may not elect COBRA Continuation Coverage. A notice of ineligibility shall be sent within the same time frame as described for a COBRA Election Notice.

Notice of Early Termination: The Third Party Administrator shall provide notice to a qualified beneficiary of a termination of COBRA Continuation Coverage that takes effect on a date earlier than the end of the maximum period of COBRA Continuation Coverage that is applicable to the qualifying event. The Third Party Administrator shall notify the qualified beneficiary as soon as possible after determining that coverage is to be terminated. This notice shall contain the reason coverage is being terminated, the date of termination, and any rights that the individual may have under the Plan, or under applicable law, to elect alternative group or individual coverage.

CLERICAL ERROR BY EMPLOYER/PLAN ADMINISTRATOR

Should the Employer fail to notify its Third Party Administrator of a qualifying event within the statutory required time frames or otherwise make a clerical error regarding a participant's right to COBRA Continuation Coverage, such failure will not constitute a forfeiture of the participant's rights to COBRA Continuation Coverage under this provision.

ELECTION OF COVERAGE

A qualified beneficiary has sixty (60) days from the date the notice is sent or the date that coverage is lost, whichever is later, to decide whether to elect COBRA Continuation Coverage. Each person who was covered under the Plan prior to the qualifying event has a separate right to elect COBRA Continuation Coverage on an individual basis, regardless of family enrollment. For example, the employee's spouse may elect COBRA Continuation Coverage even if the employee does not elect the coverage. COBRA Continuation Coverage may be elected for one (1),several or all dependent children who are qualified beneficiaries and a parent may elect COBRA Continuation Coverage on behalf of any dependent child.

The participant also has special enrollment rights under HIPAA which allow the participant to enroll in another group health plan for which the participant is otherwise eligible when the participant's coverage under this Plan terminates due to a qualifying event. The participant also has the same special enrollment rights at the end of the COBRA Continuation Coverage if the participant receives continued coverage for the maximum period available under COBRA.

If a qualified beneficiary chooses to have continued coverage, he must submit a written COBRA Election Notice to the Third Party Administrator. The Third Party Administrator must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

1. the date coverage under the Plan would otherwise end; or
2. the date the notice is sent by Third Part Administrator notifying the person of his or her rights to COBRA Continuation Coverage.

If the qualified beneficiary does not elect continuation of coverage within the sixty (60) day election period, his coverage under the Plan will end.

PERIOD OF CONTINUED COVERAGE

The law requires that a qualified beneficiary who elects COBRA Continuation Coverage be afforded the opportunity to maintain COBRA Continuation Coverage for thirty-six (36) months unless he loses coverage under the Plan because of a termination of employment or reduction in hours. In that case, the required COBRA Continuation Coverage period is eighteen (18) months.

SUBSEQUENT QUALIFYING EVENT

This eighteen (18) month period may be extended if a subsequent or second qualifying event (for example, divorce, legal separation, a qualified beneficiary's becoming entitled to Medicare or dying) occurs during that eighteen (18) month period. A second event may be a valid qualifying event only if it would have been a valid first qualifying event. That is, a second qualifying event shall qualify only if it would have caused a participant to lose coverage under the Plan if the first qualifying event had not occurred. A second or subsequent qualifying event is therefore limited to the following qualifying events:

1. death of the employee;

2. divorce or legal separation from the employee;

3. child's loss of dependent status under the Plan.

The covered employee's Medicare entitlement may also be considered a subsequent or second qualifying event for any dependents who are qualified beneficiaries following the first qualifying event, but only if the Medicare entitlement would have resulted in loss of coverage under the Plan had the first qualifying event not occurred.

Under no circumstances, however, will coverage last beyond thirty-six (36) months from the date of the event that originally made the participant eligible to elect coverage. Only a person covered prior to the original qualifying event or a child born to or placed for adoption with a covered employee during a period of COBRA continuation is eligible to continue coverage beyond the original eighteen (18) month period as the result of a subsequent qualifying event. Any other dependent acquired during COBRA Continuation Coverage is not eligible to continue coverage beyond the original eighteen (18) month period as the result of a subsequent qualifying event.

PERIOD OF CONTINUED COVERAGE FOR DISABLED PERSON

A qualified beneficiary who is totally disabled may extend COBRA Continuation Coverage from eighteen (18) months to twenty-nine (29) months. Non-disabled family members may also elect to extend COBRA Continuation Coverage even if the disabled individual does not elect to extend his coverage.

The disabled person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial eighteen (18) month COBRA Continuation Coverage period and no later than sixty (60) days after the latest of the following:

1. the date of the Social Security Administration's determination;

2. the date of the qualifying event;

3. the date the qualified beneficiary would lose coverage under the Plan; or

4. the date the qualified beneficiary is informed of the obligation to provide the disability notice, either through this Plan document or the initial COBRA Election Notice provided by the Third Party Administrator.

When the Social Security Administration has determined that a person is no longer disabled, federal law requires that person to notify the Third Party Administrator within thirty (30) days of such change in status. COBRA Continuation Coverage will be terminated in the month that begins thirty (30) days after the final determination is made by the Social Security Administration.

DESCRIPTION OF COVERAGE

COBRA Continuation Coverage will be identical to the coverage provided under the Plan to similarly situated participants who have not experienced a qualifying event.

COST AND PAYMENT OF COVERAGE

The Employer requires that qualified beneficiaries pay the entire costs of their COBRA Continuation Coverage, plus a two percent (2%) administrative fee. This must be remitted to the Employer or the Employer's designated representative, on or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

The premium for an extended COBRA Continued Coverage period due to a total disability may also be higher than the premium due for the first eighteen (18) months. If the disabled person elects to extend coverage the Employer may charge one-hundred-fifty percent (150%) of the contribution during the additional eleven (11) months of COBRA Continuation Coverage. If only the non-disabled family members elect to extend coverage the Employer may charge one-hundred-two percent (102%) of the contribution.

For purposes of determining monthly costs for continued coverage, a person originally covered as an employee or as a spouse will pay the rate applicable to a covered employee if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to a covered employee.

The initial payment must be made within forty-five (45) days after the date the person notifies the Employer that he has chosen to continue coverage. The initial payment must be the amounts needed to provide coverage from the date continued benefits begin, through the date of election.

Thereafter, payments for continued coverage are to be made monthly. These monthly payments are due on a date described in the Participant's Election Notice. If the premium is not received by the due date, the Employer will suspend coverage as of the first day of the coverage period until the monthly payment has been received. However, a thirty (30) day grace period is allowed for receipt of this monthly payment before Plan termination becomes effective. Accordingly, if a monthly payment is received after coverage was suspended but prior to expiration of the thirty (30) day grace period, coverage will be retroactively reinstated (going back to the first day of the coverage period).

There shall be no grace period for making payments, other than the grace period described above.

If the initial payment or any subsequent monthly payment is received that is insufficient by an insignificant amount, a notice will be sent to the participant at the participant's the last known address. The remaining amount must be sent within thirty (30) days to continue coverage.

WHEN CONTINUATION COVERAGE BEGINS

When COBRA Continuation Coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the qualifying event or loss of coverage, as applicable to the Plan, so that no break in coverage occurs. Coverage for dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

DEPENDENTS ACQUIRED DURING CONTINUATION

A spouse or dependent child newly acquired during COBRA Continuation Coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the Plan applies to enrollees during COBRA Continuation Coverage. A dependent acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with a covered employee during a period of COBRA Continuation Coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

END OF CONTINUATION COVERAGE

COBRA Continuation Coverage will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of termination of employment of the covered employee or a reduction of hours.

2. Twenty-nine (29) months from the date continuation began for those participants whose coverage ended because of a termination or reduction of hours, and the qualified beneficiary was totally disabled (see Period of Continued Coverage for Disabled Person).

3. Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the covered employee, divorce or legal separation from the covered employee, a child's loss of dependent status or Medicare entitlement.

4. The end of the period for which contributions are paid if the participant fails to make a payment on the date specified by the Employer or by the end of the grace period.

5. The date coverage under this Plan ends and the Employer offers no other group health benefit plan.

6. The date the participant first becomes entitled to Medicare after the COBRA election.

7. The date the participant first becomes, after the date of the election, covered under any other group health plan.

8. The date the participant is terminated from the Plan for cause, provided an active covered employee would be terminated under the Plan for the same cause.

In the case of participants receiving an eleven (11) month disability extension, coverage will terminate the month that begins thirty (30) days after the date of the Social Security Administration's final determination that the qualified beneficiary is no longer disabled.

The Plan Administrator shall provide notice of any early termination. See Notification by Plan Administrator.

THE PLAN ADMINISTRATOR AND CONTACT INFORMATION

A participant may obtain additional information about his COBRA Continuation of Coverage rights from the Third Party Administrator or the Employer. If a participant wants a copy of the Plan document, he should contact the Employer.

In order to protect the participant's rights, the covered employee should keep the Plan Administrator informed of any changes to his address and the addresses of family members. The participant should also keep a copy, for his records, of any notices the participant sends to the Plan Administrator.

The name, address and telephone number of the Employer and the Third Party Administrator are shown on Page 1 on this Plan document.

CONTINUATION OF COVERAGE FOR MEMBERS OF INDIANA NATIONAL GUARD AND RESERVES

In the event the employee is required to be absent from work as the result of duty in the Uniformed Services, coverage for medical benefits may be continued for the employee in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

As used herein, Uniformed Services means the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Period of Continued Coverage Under the USERRA Provision

Coverage may be continued for the employee and his dependents for a period that shall equal the lesser of the following:

1. the 24-month period beginning on the date on which the employee's absence begins; or

2. the period beginning on the date on which the employee's absence begins and ending on the day after the date on which the employee fails to apply for or return to a position of employment.

Notification and Election

The employee must notify the Employer in writing of his wish to continue coverage. The employee's election is due at the earliest of the following:

1. If the Employer notifies the employee of his right to continue coverage before coverage would otherwise end, then the employee's election must be submitted to the Employer no later than 31 days after the date the employee's coverage would have otherwise terminated.

2. If the Employer notifies the employee of his right to continue coverage after coverage has terminated, then the employee's election must be submitted within 31 days following the date of notification by the Employer.

Cost and Payment of Coverage

Under USERRA, the Employer may require the employee or dependent to pay the full cost of the continued coverage. However, the City of Carmel requires employees on military duty to make the same contribution as is required of active employees. Premiums are due bi-weekly on paydays, unless alternate arrangements are made with the Clerk-Treasurer's office.

Termination of Coverage

The continuation of coverage ends at the earliest of the following:

1. When the employee or dependent becomes covered under another group health plan;
2. Upon the expiration of the continued period of coverage as set forth herein;
3. When the required payments are not received on a timely basis;
4. When the health plan is terminated and not replaced by the Employer with another health plan.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The provisions of the Standards for Privacy of Individually Identifiable Health Information (Health Privacy Rule) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulate the use and disclosure of Protected Health Information (PHI). Each Plan participant is provided with a NOTICE OF PRIVACY PRACTICES outlining how the Plan will use and disclose his PHI, and his legal rights with respect to PHI. In addition, a complete statement of HEALTH INFORMATION PRIVACY POLICIES AND PROCEDURES is available upon request.

The Health Privacy Rule regulates how PHI may be disclosed to and used by the Plan Sponsor, which is distinct from the Plan itself.

DISCLOSURE OF PHI TO PLAN SPONSOR

The Plan shall disclose PHI to the Plan Sponsor only to the extent necessary for the Plan Sponsor to perform Plan administrative functions, including review and revision of Plan benefits, Plan cost and expense analysis, review and analysis of annual renewal issues, resolution of issues related to Plan's stop-loss insurance, assisting Plan participants with claim or eligibility questions, preparation of any Plan filings required by applicable Federal and/or State laws and regulations, audit and quality assurance activities and other administrative functions reasonably related to the Plan Sponsor's responsibilities.

USE AND DISCLOSURE OF PHI BY PLAN SPONSOR

The Plan Sponsor shall use or disclose PHI only to the extent necessary to perform Plan administrative functions listed above.

COVENANTS BY PLAN SPONSOR

The Plan Sponsor covenants and agrees that:

1. The Plan Sponsor shall not use or further disclose any PHI received from the Plan, except as permitted in this document or as required by law.

2. The Plan Sponsor shall require each of its subcontractors or agents to whom the Plan Sponsor may provide PHI to agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Plan Sponsor.

3. The Plan Sponsor shall not use or disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or employee benefit plans.

4. The Plan Sponsor shall report to the Plan any impermissible or improper use or disclosure of PHI not authorized by Plan documents.

5. The Plan Sponsor shall make PHI available to the Plan to permit participants to inspect and copy their PHI contained in a designated record set.

6. The Plan Sponsor shall make a participant's PHI available to the Plan to permit participants to amend or correct PHI contained in a designated record set that is inaccurate or incomplete, and Plan Sponsor shall incorporate amendments provided by the Plan.

7. The Plan Sponsor shall make available the information required to provide an accounting of disclosures.

8. The Plan Sponsor shall make its internal practices, books and records relating to the use and disclosure of PHI available to the Plan and to the Department of Health and Human Services or its designee for the purpose of determining the Plan's compliance with HIPAA and the Health Privacy Rule.

9. When PHI is no longer needed for the purpose for which disclosure was made, the Plan Sponsor shall, if feasible, return to the Plan or destroy all PHI that the Plan Sponsor received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor shall restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

10. The Plan Sponsor shall use its best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

11. The Plan Sponsor shall ensure that rules regarding adequate separation required by the Health Privacy Rule are established.

ELECTRONIC PROTECTED HEALTH INFORMATION

The Plan Sponsor agrees that if it creates, receives, maintains or transmits any Electronic Protected Health Information (ePHI) on behalf of the Plan, it will:

1. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of such ePHI;

2. ensure that the adequate separation between the Plan and the Plan Sponsor with respect to ePHI is supported by reasonable and appropriate security measures;

3. ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such ePHI; and

4. report to the Plan any security incident of which it becomes aware concerning ePHI.

ADEQUATE SEPARATION

The Plan Sponsor represents that adequate separation exists between the Plan and Plan Sponsor so that PHI will be used only for Plan administration.

1. Only members of the Board of Public Works and Safety (the "Board"), which serves as the Plan Administrator, and employees of the Plan Sponsor listed in Appendix A to the City of Carmel Health Information Privacy Policies and Procedures shall have access to participants' PHI.

2. The members of the Board and the employees listed in Appendix A to the City of Carmel Health Information Privacy Policies and Procedures shall have access to and use of PHI only to the extent necessary to assist with plan administrative functions performed by the Plan Sponsor for the Plan, or to the extent not inconsistent with the Health Privacy Rule.

3. Any individual who suspects that one of the members of the Board or one of the employees listed in Appendix A to the City of Carmel Health Information Privacy Policies and Procedures has made an improper use or disclosure of PHI shall immediately contact the Director of Human Resources, who is the City's Privacy Official, at 317-571-2471. An employee who is responsible for an improper use or disclosure of PHI may be subject to disciplinary action.

GENERAL PLAN EXCLUSIONS

1. Charges for services and supplies that are specifically excluded under this Plan.

2. Charges for services and supplies that exceed the annual and/or lifetime maximum benefits stated in the Schedule of Benefits.

3. Charges that were incurred before the participant was covered under this Plan or after his termination.

4. Charges for claims not received within the Plan's filing limit deadlines, as specified under the section entitled Claims Information.

5. Charges for services and supplies for which no charge has been made, or for which the participant has no legal obligation to pay.

6. Charges for services and supplies rendered by a provider who is a close relative of the participant, or who resides with the participant.

7. Charges for services billed by a health care provider who is an employee of a hospital or facility and is paid by the hospital or facility for the services rendered.

8. Charges for services and supplies not recommended or approved by a licensed physician, or charges incurred when the participant is not under the care of a physician.

9. Charges for treatment and services provided by a non-licensed provider or those that do not require a license to provide, and charges for treatment and services that exceed the scope of the provider's license.

10. Charges for services and supplies that are not provided in accordance with generally accepted professional medical standards.

11. Charges for services and supplies obtained outside of the United States if the participant traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies.

12. Charges for services and supplies that are in are in excess of the reasonable and customary charge, except as otherwise stated herein.

13. Charges for services and supplies that are not medically necessary, except as otherwise provided herein.

14. Charges for services and supplies that are either experimental or investigational, unless such services and supplies are covered under the Clinical Trials provision of the Description of Medical Benefits.

15. Charges for services or supplies that result from an illness or injury arising out of or in the course of employment for wage or profit.

16. Charges for services and supplies for any military service-related injury or illness.

17. Charges for confinement, services and supplies in a hospital owned or operated by the United States government, or any government outside the United States, in which the participant is entitled to receive benefits, except for the reasonable cost of services and supplies that are billed pursuant to federal law by the Veterans Administration or the Department of Defense of the United States, for services and supplies that are eligible herein

and that are not incurred during or from service in the Armed Forces of the United States or any other country.

18. Charges for services and supplies furnished or paid for by the federal or State government or one of their agencies (except as required by Medicare, Medicaid or other applicable laws or regulations).

19. Charges for services and supplies related to any illness, injury or disability caused by or attributed to active participation in a war, riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized military forces.

20. Charges for services and supplies incurred as the result of an illness or injury caused by or contributed to by engaging in a felony for which the participant was convicted by a court of competent jurisdiction.

21. Charges for services and supplies incurred as a result of an intentionally self-inflicted injury, except if the injuries resulted from a medical condition, including a mental/nervous disorder.

22. Charges for an illness or injury resulting from speed contests, whether on land, in the air or on or in water.

23. Charges for an illness or injury resulting from sky or scuba diving.

24. Charges for an illness or injury suffered by a participant due to the action or inaction of any other party, if the participant fails to provide information as required under the section entitled Subrogation/Recovery Rights.

25. Charges for telephone calls or telephone consultations, failure to keep a scheduled appointment, completion of claim forms, attending physician statements and other reports or requests for information.

26. Charges for sales tax, mailing fees and surcharges incurred due to nonpayment.

Charges for expenses that are payable under one section of this Plan will not be payable under any other section of this Plan.

COORDINATION OF BENEFITS

(Coordination of Benefits does not apply to the
Prescription Drug Card/Mail Order Program Benefits)

The Coordination of Benefits provision is intended to prevent costly duplication of benefits. This Plan will be coordinated with all other plans under which a participant is covered for benefits that are also covered under this Plan. The total benefits available under all plans will not exceed one hundred percent (100%) of the allowable expenses. The participant shall refund to the Employer any excess the participant may have been paid.

OTHER PLANS

For coordination of benefits purposes, "other plan" includes any plan, policy or coverage providing benefits or services for, or by reason of, medical, dental or vision care. Such other plan(s) may include, without limitation:

1. group insurance or any other arrangement for coverage for participants in a group, whether on an insured or uninsured basis, including, but not limited to hospital indemnity benefits and hospital reimbursement-type plans;

2. hospital or medical service organization on a group basis, group practice and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. a licensed Health Maintenance Organization (HMO);

4. any coverage for students that is sponsored by, or provided through, a school or other educational institution;

5. any coverage under a government program and any coverage required or provided by any statute;

6. group automobile insurance coverage;

7. individual automobile insurance coverage;

8. individual automobile insurance coverage based upon the principles of "no-fault" coverage;

9. any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits; and

10. labor/management trustee, union welfare, employer organization or employee benefit organization plans.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination. The plan with primary responsibility must first pay its full benefit before this Plan will pay remaining covered expenses.

1. Automobile Insurance
   The Plan pays secondary to all Medical Payments (MedPay), Personal Injury Protection (PIP) and No-Fault coverage.

2. No Coordination of Benefits Provision
   If the other plan does not have a provision for coordination of benefits, its benefits are payable before all other plan(s).

3. Member/Dependent
   The plan that covers the participant as an employee pays as though no other plan existed. The remaining eligible expenses are paid under a plan that covers the participant as a dependent.

4. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the calendar year pays first. The plan covering the parent whose birthday falls later in the calendar year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

5. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply. Instead:

   a) If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
   b) In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

6. Active/Inactive
   The plan covering a participant as an active employee, or as that participant's dependent, pays first. The plan covering that participant as a laid off or retired employee, or as that participant's dependent, pays second.

7. Continuation of Coverage
   A plan covering a participant as an employee, a retiree or a dependent pays before a plan offered under a continuation of coverage provision in accordance with state or federal law.

8. Longer/Shorter Length of Coverage
   If none of the above rules determine the order of benefits, the plan covering a participant longer pays first. The plan covering that participant for a shorter time pays second.

For the purposes of determining the applicability of and implementing the terms of the Coordination of Benefits provision of the Plan, the Plan may, without the consent of or notice to any participant, release to or obtain from any insurance company or any other organization any information with respect to any participant that the Plan deems to be necessary for such purposes. Any participant claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

SUBROGATION/RECOVERY RIGHTS

Participants of this Plan agree to the following as a condition precedent to participating in and receiving benefits under this Plan:

1. Participants shall reimburse the Plan for all medical, dental or vision benefits paid to them or on their behalf, when any recovery is obtained from any source, including a person, corporation, entity, automobile insurer (including uninsured and underinsured coverage), malpractice insurer or other insurer or fund. The Plan shall have the right to first reimbursement out of any recovery obtained from any source for the injury or condition for which the participant claims an entitlement of benefits under the Plan.

2. Participants shall subrogate the Plan for any and all claims, causes of action or rights that they presently have or that may arise against any source (as delineated in paragraph (1) immediately preceding), which source has or may have caused, contributed to or aggravated the injury or condition for which the participant claims an entitlement of benefits under this Plan. The Plan's right to subrogation shall take first priority in the disbursement of any funds received from any source, and the make-whole doctrine shall not apply.

The Plan may pend the payment of any and all claims until a completed reimbursement agreement is received from the participant seeking payment of benefits from the Plan. If circumstances warrant, the Plan may pend the payment of any and all claims until liability is legally determined.

In the event that a participant settles with, recovers from or is reimbursed from any source, the participant agrees to hold any and all recoveries in trust for the benefit of the Plan, and to reimburse the Plan for all past, present and future benefits paid on his behalf as a result of the injuries or conditions giving rise to reimbursement.

Should the participant choose not to pursue recovery from any source that may be liable, the Plan is authorized to pursue, sue, compromise or settle any such claims in the participant's name and/or on his behalf, and the Plan is authorized to execute any and all documents necessary to pursue said claims. The participant agrees to fully cooperate with the Plan in the prosecution of any such claims, which cooperation includes taking all action reasonably necessary to assist the Plan in making a recovery and refraining from any action that could adversely affect the Plan's ability to make a recovery.

The Plan is not responsible for any attorney fees and costs incurred by the participant in collecting from the responsible party, and the common fund doctrine shall not apply. Moreover, the participant shall reimburse the Plan for any costs and attorney fees incurred by the Plan, if the Plan must file suit against the participant to enforce its subrogation/reimbursement rights under this section.

The Plan Administrator has the sole authority, discretion and responsibility to make all decisions related to exercise and enforcement of its subrogation and recovery rights under this provision.

CLAIMS INFORMATION

PROCEDURE FOR FILING A CLAIM

Claims for services provided by a preferred provider will be submitted by the provider. Other claims may be submitted either by the provider or by the participant. Procedures for filing a non-preferred provider claim are as follows:

1. complete a claim form, which may be obtained from the Employer;

2. attach an itemized bill from the provider, which must include the following:

   a) patient's name;
   b) patient's date of birth;
   c) name of employee;
   d) relationship to the employee;
   e) address of employee;
   f) name of the employer;
   g) name, address and tax identification number of provider;
   h) date of service;
   i) type of service rendered; and
   j) nature of the accident or illness being treated.

3. send the completed claim form and itemized bill to the address stated on the identification card.

PENDING A CLAIM

A claim that has been filed with the Third Party Administrator may be pended under circumstances that include, but are not limited to:

1. when there is not enough information to process the claim;

2. when coordination of benefits information is needed; or

3. when the claim is being subrogated.

Once a claim has been pended, the claimant and provider (if applicable) shall receive a letter from the Third Party Administrator requesting the information needed to process the claim. If necessary, three additional letters will be sent, one every thirty (30) days, for a total of ninety (90) days. If the required information is not provided within that time period, the claim will be denied. The claimant has the right to appeal any denial within 180 days of the date of the denial.

TYPES OF CLAIMS

Under the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims.

   A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the covered personor the covered person's ability to

regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan does not require the Covered Person to obtain approval of a specific medical service prior to getting treatment, then there is no Pre-service Claim. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a) The Plan Administrator determines that the course of treatment should be reduced or terminated; or

   b) The Covered Person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

   If the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims: A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

WHEN HEALTH CLAIMS MUST BE FILED

Post-service health claimsmust be filed with the Claims Administrator within twelve (12) months of the date charges for the service was incurred. Failure to file a claim within this time limit will not invalidate the claim provided that the Covered Person submits evidence satisfactory to the Plan Administrator that it was not reasonably possible to file the claim within the time limit. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within forty-five (45) days from receipt by the Covered Person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

TIMING OF CLAIMS DECISIONS

The Plan Administrator shall notify the Covered Person, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service Claimsand Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

1. If the Covered Person has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim.

2. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than seventy-two (72) hours after receipt of the claim. The Covered Person will be notified of a determination of benefits as soon as possible, but not later than seventy-two (72) hours, taking into account the medical exigencies, after the earliest of:

   a) The Plan's receipt of the specified information; or

   b) The end of the period afforded the Covered Person to provide the information.

Pre-service Non-urgent Care Claims:

1. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.

2. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

Concurrent Claims:

1. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

2. Request by Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim, as long as the Covered Person makes the request at least seventy-two (72) hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person submits the request with less than seventy-two (72) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

3. Request by Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service non-urgent Claim or a Post-service Claim).

Post-service Claims:

1. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.

2. If the Covered Personhas not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

When a claim is denied, in whole or in part, the Third Party Administrator shall provide a participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice), containing the following information:

1. Information sufficient to identify the denial in question;

2. A reference to the specific portion(s) of the Plan Document or other criteria upon which the denial is based;

3. Specific reason(s) for the denial;

4. A description of any additional information necessary for the participant to appeal the denial and an explanation of why such information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to the procedures.

6. A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the denial;

7. The identity of any medical or vocational experts consulted in connection with the denial, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the participant, free of charge, upon request);

9. In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or a statement that such explanation will be provided to the participant, free of charge, upon request;

10. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may offer assistance ; and

11. In a denial involving urgent care, a description of the Plan's expedited review process.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

The Plan requires that the participant be provided a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. A participant who believes his claim has been wrongly denied, in whole or in part, should first call customer service at the number listed on his identification card. A customer service representative will try to resolve the complaint informally.

If the participant is not satisfied with the resolution of his complaint, he has the right to file an internal appeal. This right applies to either a pre-service claim (precertification) or post-service claim (denial, in part or in whole, of payment for services already provided), pursuant to the following guidelines:

1. The participant has one hundred eighty (180) days following notice of an initial adverse benefit determination within which to appeal the determination.

2. The participant or his representative has the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.

3. Written appeals should be sent to:

   Anthem Blue Cross and Blue Shield
   ATTN: Appeals, P.O. Box 105568
   Atlanta, Georgia 30348

   The participant's Member Identification Number must be included with an appeal.

4. For appeals involving urgent or concurrent care, the Plan provides an expedited appeal process. The participant or his representative may request an expedited appeal orally or in writing by contacting customer service at the number on the participant's insurance identification card. If the expedited appeal is approved, all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the participant or his representative by telephone, facsimile or other available similarly expeditious method.

5. The appeal will be conducted by an appropriate reviewer who will not rely on the initial benefits determination, who did not make the initial determination and who does not work for the person who made the initial determination.

6. Upon request and free of charge, the participant will be provided reasonable access to, and copies of, all documents, records and other information relevant to the participant's claim for benefits in possession of the Plan Administrator or the Third Party Administrator, including documents records and other information that:

   a) were submitted, considered or produced in the course of making the benefit determination;
   b) were relied on in making the benefit determination;
   c) state a policy, rule, guideline, protocol or other similar criterion relied upon in making the benefit determination; and/or
   d) demonstrate compliance with processes and safeguards, to ensure the terms of the plan are applied consistently for similarly-situated claimants.

   The participant will also be given a rationale for the decision, including an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances.

7. The decision on an appeal will be made within the following time frames:

   a) If the appeal involves a claim for urgent/concurrent care, the participant will be notified of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of the appeal.
   b) If the appeal involves any other pre-service claim, the participant will be notified of the outcome of the appeal within 30 days after receipt of the appeal.
   c) If the appeal involves a post-service claim, the participant will be notified of the outcome of the appeal within 60 days after receipt of the appeal.

If the participant is dissatisfied with the first-level appeal decision, he may request a second-level appeal, which will follow the procedures above, except for the following:

1. A second-level appeal is voluntary; a participant is not required to submit a second-level appeal before requesting an independent external review (see below).

2. The secondary appeal must be submitted in writing within sixty (60) calendar days following denial of the first-level appeal.

3. The second-level appeal will be conducted by an appropriate reviewer who was not involved with the adverse benefits determination or the initial appeal and who does not work for those persons.

If either a first level or secondary internal appeal results in another adverse benefit determination, the participant may request an independent external review, pursuant to the following guidelines:

1. The participant has four (4) months following notice of the final internal adverse benefit determination within which to request the external review.

2. There is no cost to the participant for an independent external review.

3. A request for an external review should be submitted in writing, to the address listed above for the internal appeal process.

4. The external review will take into account all comments, documents, records and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination. The participant is not required to submit additional information, but may do so.

5. In deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who was not consulted in connection with the adverse benefit determination that is the subject of the appeal and who does not work for any such individual.

6. The Plan will also identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.

FOREIGN CLAIMS

When services are rendered by a provider who is located outside the United States or its territories, the Plan will require the participant to obtain and submit, at his own expense, copies of any and all medical records that will support and/or substantiate the charges. Further, all such records must be in English and all such charges must be in U.S. dollars. If the information is not in English or in U.S. dollars, it is the participant's responsibility to obtain the translations and the currency conversions.

OVERPAYMENTS

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, the Plan will have the right to recover these excess payments from the participant, whether the error was made by the Plan Administrator, the Third Party Administrator or any other person or party.

In the Plan Administrator's sole discretion, incorrect or erroneous payments may be recovered either directly from the participant, or through reduction in future Plan benefits claimed by the participant.

GENERAL PROVISIONS

In all instances of interpretation or application, the Plan shall conform to mandated legislative provisions.

ADMINISTRATION OF THE PLAN

The Plan is administered through the Employer. The Employer has designated the City of Carmel Board of Public Works and Safety as Plan Administrator and Named Fiduciary. The Plan Administrator shall have full charge of the operation and management of the Plan. The Plan Administrator shall have full discretionary power to take all actions necessary or proper to carry out its duties required under applicable laws, including, but not limited to, the power to:

1. employ persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;

2. employ agents to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of this Plan;

3. construe and interpret this Plan;

4. make any and all factual determinations;

5. correct any defect, supply any omission or reconcile any inconsistency in the Plan in such a manner and to such extent as it shall deem expedient to effectuate the plan;

6. adopt such rules and regulations as from time to time it deems advisable or appropriate in the proper administration of this Plan, and to amend or supplement such rules, regulations and procedures;

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

8. decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;

9. authorize, in its discretion, payment of benefits properly payable pursuant to the provisions of this Plan;

10. set the level of employer and employee contributions;

11. prepare and to distribute, in such manner as it deems appropriate, information explaining this Plan;

12. keep and maintain all documents and records pertaining to the Plan;

13. perform all reporting and disclosure obligations prescribed by law; and

14. apply consistently and uniformly all rules, regulations, determinations and decisions to all participants in similar circumstances.

The Plan Administrator may delegate, as appropriate, any or all of the responsibilities specifically required of the Plan Administrator under the terms of the Plan; provided, however, that matters of Plan interpretation shall not be delegated.

Any interpretation or determination made or any action taken by the Plan Administrator under this Plan shall be deemed to be conclusive with respect to any participant or other individual to whom that interpretation, determination or action relates, and any such interpretation, determination or action may be reviewed or reversed by a court of competent jurisdiction only upon a finding by the court that such interpretation, determination or action was arbitrary and capricious or constitutes an abuse of discretion.

AMENDMENT OR TERMINATION OF THE PLAN

The Plan Administrator reserves the right at any time, and in its sole discretion, to modify or amend, in whole or in part, any or all of the provisions of the Plan, which changes shall be binding on all participants, Plan amendments or modifications shall be in writing, shall set forth the modified provisions of the Plan and the effective date of the modifications, and shall be signed by the Plan Administrator. Participants will be notified in writing of all amendments.

The Employer intends to maintain this Plan indefinitely; however, the Employer reserves the right to terminate the Plan established hereby for any reason, at any time, in its sole and final discretion. Upon termination, the rights of the participants to benefits are limited to claims incurred up to the date of termination.

Upon termination of this Plan, all claims incurred prior to termination, but not received by either the Employer or Third Party Administrator within ninety (90) days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

Upon termination of the Plan, any assets remaining after payment of all claims incurred prior to the effective date of termination and all reasonable administrative expenses, will be used to provide, either directly or through the purchase of insurance, life or health benefits to all participants. In no event shall additional contributions be required of the Employer.

ASSIGNMENT

Preferred providers will bill the Plan directly. If services or supplies have been received from a preferred provider, benefits are automatically paid to that provider. The participant's portion of the negotiated rate, after the Plan's payment, will be billed to the participant by the preferred provider.

The Plan will pay benefits for claims from non-preferred providers to the employee.

The Plan will pay benefits for an alternate recipient to the responsible party designated in the Qualified Medical Child Support Order.

CLERICAL ERROR

A clerical error (whether by the Plan Administrator or the Third Party Administrator) in keeping the records of this Plan, or delays in making entries on the records, will not void the coverage of any participant if that coverage would otherwise have been in effect. Such clerical error will not extend the coverage of any participant if that coverage would otherwise have ended or been reduced as provided by this Plan document.

CONFORMITY WITH STATUTE(S)

Any provision of this Plan that is in conflict with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of the said statute(s).

CONFORMITY WITH THE LAW

This Plan will be deemed automatically amended to conform with the minimum requirements of the Americans with Disabilities Act (ADA), Family Medical Leave Act (FMLA), Health Insurance

Portability and Accountability Act (HIPAA), Mental Health Parity Act, Newborns' and Mothers' Health Protection Act, Women's Health and Cancer Rights Act or any other applicable federal or state law, as may be amended from time to time.

CONSTRUCTION

Whenever a personal pronoun in the masculine gender is used herein, it shall include the feminine also, unless the context clearly indicates the contrary.

Words used herein in the singular or plural shall be construed to also include the plural or the singular, where appropriate.

EFFECTIVE TIME

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

ENTIRE PLAN

The Plan and the documents incorporated by reference herein shall constitute the only legally governing documents for the Plan. No oral statement or other communication shall amend or modify any provision of the plan as set forth herein.

FACILITY OF PAYMENT

When another plan makes payment that should have been made under this Plan, the Plan Administrator reserves the right to decide whether or not to reimburse the plan making the payment, and the amount to be paid in order to satisfy the intent of this provision. Any such reimbursement will be considered benefits paid under this Plan and will fulfill the Plan's responsibility to the extent of the amount paid.

Benefits under Medicare after the first thirty (30) months of End Stage Renal Disease will be payable before this Plan's benefits are payable.

In the event that any benefit is payable to a minor or other person under legal disability, the Plan Administrator, in its discretion, may determine that payment will be made or applied for the benefit of that person.

In the event of the death of a participant, any benefit due and unpaid at the time of the participant's death will be paid to or for the benefit of the participant's estate. Payment in good faith will discharge the Plan from its obligation with respect to that payment.

FIDUCIARY OPERATION

Each fiduciary shall discharge its duties with respect to the Plan solely in the interest of the participants and beneficiaries and:

1. for the exclusive purpose of providing benefits to participants and defraying reasonable expenses of administering the Plan;

2. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
3. in accordance with all documents and instruments governing the Plan.

FREE CHOICE OF PHYSICIANS

The participant shall have free choice of any health care provider. In no event will the Plan be responsible for any act or omission of any provider.

INCONTESTABILITY

All statements made by the Plan Administrator or by the participant under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the Plan Administrator or by the participant.

MISREPRESENTATION

Participants are prohibited from submitting false or fraudulent information, or fraudulently omitting information related to eligibility, benefit determination, subrogation, coordination of benefits or any other purpose under this Plan. Coverage may be terminated or benefits may be denied, at the Plan Administrator's option, if it is discovered that the participant's eligibility or any claim for benefits contains any misrepresentation designed to induce the Plan to issue coverage or to provide payment on a claim when the Plan would not ordinarily have done so.

NONDISCRIMINATION

The Plan Administrator shall not discriminate either for or against a participant with respect to the Plan, regardless of that person's level of compensation or position with the Employer.

OBLIGATION TO PROVIDE REQUESTED INFORMATION

Participants shall provide the Plan Administrator with all requested information and shall sign all documents as may be reasonably requested from time to time for the purpose of administration of the Plan. Failure to do so within a reasonable time established by the Plan Administrator may result in denial of all incurred claims related to the information or signed documentation that was requested.

PLAN IS NOT A CONTRACT

This Plan shall not be deemed to constitute a contract between the Employer and any participant or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any participant the right to be retained in service or interfere with the discharge of any participant at any time.

PLAN FUNDING

The Employer has established the City of Carmel Employee Health Benefit Plan as a self-funded employee benefit plan. Revenues are deposited into an escrow account established expressly for this purpose, and benefits are paid from the escrow account. Periodically, the Plan Administrator shall determine the level of contributions required by the Employer and the Plan participants for the funding of benefits under this Plan. The Employer and the participants shall jointly contribute such amount as will be sufficient to fund the actuarially determined cost of providing Plan benefits.

PROTECTION AGAINST CREDITORS

Except as otherwise required pursuant to a Qualified Medical Child Support Order under Section 609 of the Act, no benefit under the Plan prior to actual receipt thereof by a participant, shall be subject to any debt, liability, contract, engagement or tort of any employee or dependent, nor subject to anticipation, sale, assignment (except in the case of medical benefits), transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other

voluntary or involuntary alienation or other legal or equitable process, nor transferable by operation of law except as may be provided in the Plan.

RIGHT OF RECOVERY

In the event benefits are paid under this Plan that were not properly payable under any provision of the Plan, the Plan will have the right to recover those benefits from the person to or for whom the benefits were paid or the plan or entity properly liable for the benefits. The right of recovery will include the right to offset future benefit payments.

SEVERABILITY

If any provision of this Plan is held to be invalid, illegal or unenforceable by a court of competent jurisdiction, the provision shall be stricken, and all other provisions of this Plan that can operate independently of such stricken provision shall continue in full force and effect.

TAX CONSEQUENCES

Neither the Employer nor the Plan Administrator nor the Third Party Administrator make any commitment or guarantee that any amounts paid to or for the benefit of a participant under this Plan will be excludable from that person's gross income for federal or state income tax purposes.

WORKER'S COMPENSATION

This Plan and the benefits provided herein are not in lieu of, nor shall affect any requirements for coverage under any worker's compensation law or other similar law.

DEFINITIONS

Accident

A sudden and unforeseen event that:

1. causes injury to the physical structure of the body;
2. results from an external agent or trauma;
3. is definite as to time and place; and
4. occurs involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.

Actively at Work

Performing for a full normal work day the regular duties of the employee's occupation and employment at the Employer's place of business, or at another location to which the employee is required to travel in the performance of the duties of his occupation. An employee whose coverage is continued under the Family and Medical Leave Act (FMLA) or the Consolidated Omnibus Budget Reconciliation Act (COBRA) will be deemed actively at work. An employee will be deemed actively at work if his absence from work is due to a health condition of the employee. If the employee is not actively at work, as defined herein on the date the employee would otherwise become covered, the employee (and the employee's eligible dependents) will not be covered until the employee qualifies as being actively at work.

Allowable Expense

An expense incurred by a participant that is reasonable, necessary and eligible in full or in part for benefits under this Plan.

Alternate Recipient

Any child of an employee or his spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) that has been issued by any court judgment, decree or order as being entitled to enrollment for coverage under this Plan.

Amendment

A formal document that changes the provisions of the Plan Document, duly signed by the Plan Administrator.

Birthing Center

A medical facility that is primarily a setting for labor, delivery and immediate post-partum care for low risk patients, and that meets all the following criteria:

1. complies with licensing and other legal requirements of the jurisdiction in which it is located;
2. has comprehensive and organized facilities for birth services on its premises;
3. provides birth services performed by a physician specializing in obstetrics and gynecology or, at his direction, by a certified nurse midwife;
4. has 24-hour a day registered nursing services; and

5. provides for the discharge of mother and infant within 24 hours after birth.

Child

A participant's child under twenty-six (26) years of age(coverage ends the last day of the month in which the 26th birthday occurs). The term "child" shall include a biological child, a legally adopted child, a step-child, a child of a registered domestic partner, a child related to the employee by blood or marriage and for whom the employee has assumed legal guardianship, or a child whom the employee must cover due to a Qualified Medical Child Support Order (QMCSO), subject to the conditions and limits of the law.

Close Relative

The spouse, mother, father, sister, brother, child, grandparent or grandchild of a participant, or of his spouse.

COBRA

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, as now embodied in Section 4980B of the Internal Revenue Code.

Coinsurance

The percentage of eligible expenses the Plan will pay after the participant meets his calendar year deductible. The coinsurance is stated in the Schedule of Benefits.

Copay

The amount payable by the participant for certain services and supplies rendered, as stated in the Schedule of Benefits. The copay must be paid each time the service or supply is rendered, unless otherwise noted. The copay will not be applied toward the calendar year deductible, but will be applied toward the out-of-pocket maximum.

Cosmetic Surgery

Any surgery performed primarily to improve or change bodily appearance; cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma or birth defect, and is not medically necessary.

Covered Employee

An eligible employee who has elected coverage under this Plan.

Covered Dependent

An eligible dependent who is covered under this Plan.

Custodial Care

Care that is not a medically necessary part of treatment for recovery, but comprises services and supplies provided primarily to assist an individual in the activities of daily living.

Deductible

The individual deductible applies to a participant with employee-only coverage; that is, a participant with no dependents enrolled in the Plan. The individual deductible is the amount of eligible

expenses the participant must incur and pay each calendar year before the Plan pays applicable benefits. The amount of the individual deductible is stated in the Schedule of Benefits.

The family deductible applies to a participant who also has one or more dependents enrolled in the Plan. The family deductible is the aggregate amount of eligible expenses that a family of participants must incur and pay each calendar year before the Plan pays applicable benefits. Any number of family members may help to meet the family deductible amount. In Plan A, the entire deductible amount may be applied toward the expenses of one participant or any combination of participants. In Plan B, no one participant will be required to meet more than half of the family deductible. The amount of the family deductible is stated in the Schedule of Benefits.

Dentist

A person licensed to practice dentistry by the appropriate authority in the state where the dental service is given, including an oral surgeon or a physician providing dental services within the scope of his license.

Dental Hygienist

A person who has been trained in an accredited school, who is licensed by the state in which he is practicing the art of dental prophylaxis, and who is practicing under the direction and supervision of a dentist.

Dependent

An eligible participant's spouse, domestic partner, child under the age of twenty-six (26) and/or an eligible disabled dependent child age twenty-six (26) or over.

Disabled Dependent Child

A child who is physically or mentally incapable of self-support upon attaining age twenty-six (26). The covered employee is required to provide periodic medical proof of the child's incapacity.

Durable Medical Equipment

Medical equipment that:

1. is primarily and customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of an illness or injury;
2. is prescribed by a physician only when medically necessary;
3. can withstand repeated use; and
4. is appropriate for use in the home.

Eligible Expense

Reasonable and customary expense required and incurred for the diagnosis and treatment of an injury or illness covered by this Plan, including hospital, surgical or medical care. Unless otherwise noted herein, an eligible expense must be medically necessary and recommended and approved by the attending physician.

Emergency

The sudden and unexpected acute onset of a condition requiring immediate treatment to avoid severe impairment to health and/or possible death.

Employee Health Clinic

Primary healthcare facility owned and operated by the City for the exclusive benefit of Plan participants.

Employer

The City of Carmel, Indiana, or any successor entity that adopts and maintains this Plan.

Enrollment Date

The first day of coverage or of the waiting period, if there is a waiting period.

Experimental or Investigative

Any procedure, treatment, facility, equipment, drug, device or supply that is not approved or accepted as standard medical treatment of the condition being treated, or any such item requiring American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, U.S. Food and Drug Administration, National Institute of Health, American Dental Association or American Osteopathic Association or other government approval, if it is not granted at the time services are rendered. In determining whether any treatment, procedure, facility, equipment, drug, device or supply is experimental or investigative, the Plan Administrator may consider the views of the state or national medical communities and the views and practices of Medicare, Medicaid and other government financed programs. Although a physician may have prescribed treatment, such treatment may still be considered experimental or investigative within this definition.

FMLA

The Family and Medical Leave Act of 1993 (FMLA), as may be amended from time to time.

Family

A participant and his eligible dependents who are covered under this Plan.

Fiduciary

The Employer or the Plan Administrator, but only with respect to the specific responsibilities of each regarding the administration of the Plan.

Full-Time Employee

An employee who works an average of 30 hours per week or more, and who is not a seasonal employee.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as may be amended from time to time.

Home Health Care Agency

A health care agency that provides a health care delivery system to individuals confined by illness or injury to their home, and that meets all the following criteria:

1. complies with licensing and other legal requirements of the jurisdiction in which it is located;
2. is approved by Medicare;

3. has a full-time administrator;

4. has at least one licensed physician on staff;

5. has a staff that includes at least one graduate registered nurse (R.N.), or has nursing care by a graduate registered nurse (R.N.) available; and

6. has employees that are bonded, and provides malpractice and malplacement insurance.

Hospice

An interdisciplinary health care provider engaged in alleviating the physical, emotional, social and spiritual discomforts of terminally ill patients and their families. A hospice must meet all the following criteria:

1. comply with licensing and other legal requirements of the jurisdiction in which it is located;

2. be approved by Medicare;

3. have a full-time administrator;

4. be under the direct supervision of a licensed physician;

5. have a coordinator who is a graduate registered nurse (R.N.) with four (4) years of full-time clinical experience, two of which involve caring for the terminally ill;

6. have a social service coordinator who is licensed in the area in which the agency is located;

7. have employees that are bonded, and provide malpractice and malplacement insurance; and

8. provide twenty-four (24) hour-a-day service, seven (7) days a week.

Hospital

An accredited institution that is approved as a hospital by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria:

1. is primarily engaged in providing on an inpatient basis diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians; and

2. continuously provides twenty-four (24) hour-a-day nursing service by or under the supervision of graduate registered nurses (R.N.s).

With respect to the treatment of mental and nervous disorders and substance abuse, the term hospital will include an institution that would qualify under the above definition except that it lacks surgical facilities, and that is licensed as a psychiatric hospital by the appropriate authority.
With respect to a hospital outside the United States, the facility must be properly licensed in its own jurisdiction.

In no event will the term hospital include an institution or any part thereof that is a convalescent hospital, or any institution that is used primarily as a rest facility, nursing facility, rehabilitation facility, facility for the aged or facility for custodial care.

Illness

Any physical or mental condition or disease (including pregnancy) that requires treatment by a physician. When used in connection with a newborn child, the term illness will include congenital defects and birth abnormalities, including premature birth.

Injury

Any physical condition caused by accidental means from an external force that results in bodily damage and requires treatment by a physician.

Incurred Date

The date on which a medical service or supply is rendered or furnished.

Maximum Benefit

The highest calendar year and/or lifetime benefit payable under this Plan as, described in the Schedule of Benefits.

Wherever the word "lifetime" appears in this Plan in reference to benefit maximums and limitations, it is understood to include both this Plan and any previous plans of the Employer.

Medically Necessary

A treatment, service or supply that is:

1. recommended, authorized, ordered or prescribed by a physician;
2. essential to and consistent with the diagnosis and treatment of the condition, illness, disease, injury or bodily malfunction for which the treatment, service or supply is rendered;
3. consistent with currently accepted health care practices;
4. not provided primarily for the convenience of the participant, physician or other supplier;
5. the most economical level of service or supplies that is appropriate for the safe and effective treatment of the participant (when applied to hospitalization, this further means that the participant requires acute care as a bed patient due to his condition or due to the nature of the services rendered); and
6. not experimental in nature at the time services or supplies are provided.

In determining medical necessity, the Plan Administrator may consider the views of the state or national medical communities and the view and practices of Medicare, Medicaid and other government financed programs. The fact that a physician may have prescribed, recommended, ordered or approved a treatment, service or supply does not, in itself, constitute medical necessity.

Medicare

The program established by Title I of Public Law 89-98 (79 Stature 291), as amended, entitled Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act of 1965, as amended, which includes Parts A (Hospital Insurance Benefits for the Aged) and B (Supplementary Medical Insurance Benefits for the Aged).

Negotiated Rate

The reduced rate for services rendered to participants of a preferred provider organization.

Non-Preferred Provider

A health care provider that is not a member of the preferred provider organization utilized by the Plan.

Nurse

An individual who has received specialized training, is authorized to use the designation Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and is duly licensed in the state in which the individual performs the nursing services.

Out-of-Pocket Expenses

Expenses not covered by the Plan, for which the covered employee is responsible. After the participant or family has incurred an amount equal to the out-of-pocket maximum during a calendar year as stated in the Schedule of Benefits, the Plan will begin to pay additional eligible expenses at one hundred percent (100%) for the remainder of that calendar year. Expenses that do not apply toward satisfaction of the calendar year out-of-pocket limitation are listed in the Schedule of Medical Benefits.

Outpatient Services

Services provided during confinement to a hospital or outpatient surgical facility for which no room and board charge is made.

Outpatient Surgical Facility

A medical center that is engaged primarily in performing surgical procedures, and that meets all the following criteria:

1. complies with licensing and other legal requirements of the jurisdiction in which it is located;
2. has permanent operating room(s), recovery rooms(s) and equipment for emergency care;
3. maintains a written agreement with at least one (1) hospital for immediate acceptance of patients who develop complications or require post-operative confinement;
4. has an organized medical staff that includes licensed physicians and graduate registered nurses (R.N.s) and/or licensed nurses (L.P.N.s); and
5. does not provide accommodations for patients to remain overnight.

An outpatient surgical facility may or may not be part of a hospital. For surgery benefits eligible under this Plan, the term "hospital" shall include freestanding outpatient surgical centers.

Participant

An employee or a qualified beneficiary and his spouse and/or dependent child who are eligible and covered under this Plan.

Physician

A legally qualified medical professional who is practicing within the scope of his license and holding a degree of Doctor of Medicine (M.D.), Doctor of Psychology (Ph.D.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Osteopathic Medicine (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Optometry (O.D.), or Doctor of Chiropractic (D.C.). The term "physician" shall also be extended to include Physician's Assistant (P.A.), Nurse Practitioner (N.P.), Nurse-Midwife, Clinical Nurse Specialist (C.N.S.), Licensed Clinical Social Worker (L.C.S.W.), Orthoptic Technician, Registered Occupational Therapist, Registered Physical Therapist, Licensed Speech Therapist or Licensed Behavioral Analyst, provided they are licensed in the political jurisdiction where practicing, and practicing within the scope of their license.

Plan

The City of Carmel Employee Health Benefit Plan, as may be amended from time to time. The Plan is a group health plan that offers medical, prescription drug and dental benefits as outlined in the Plan Document and those documents incorporated in or related thereto.

Plan Administrator

The City of Carmel Board of Public Works and Safety, which is responsible for the day-to-day function and management of this Plan. The Plan Administrator may appoint or employ other persons or firms to process claims and perform other Plan services. The Plan Administrator is also the Named Fiduciary.

Plan Document

The only legally governing document for the provisions of the Plan. All statements made by the Employer, Plan Administrator or Third Party Administrator shall be deemed representations and not warranties. No such statement shall void, increase or reduce coverage under the Plan or be used in defense to a claim unless it is in writing and signed by the Plan Administrator or Third Party Administrator.

Plan Sponsor

The City of Carmel, Indiana, or any successor entity that adopts and maintains this Plan.

Plan Year

The calendar year.beginning on January 1 and ending on December 31 each year.

Precertification

The process of evaluating in advance whether services, treatment and supplies are medically necessary, and of giving approval for such services, treatments and supplies to be provided under the Plan. The purpose of precertification is to ensure medically appropriate and cost-effective care. Precertification of in-network services, treatment and supplies is the responsibility of the provider. Out-of-network precertification is the responsibility of the participant.

Predetermination of Benefits

Submission by health care provider to the Third Party Administrator of services to be performed or supplies to be provided in the future, to determine if and to what extent such services and supplies will be covered by the Plan.

Preferred Provider

A physician, hospital or ancillary service provider that has an agreement in effect with the preferred provider organization to accept a reduced rate for services rendered to participants.

Preferred Provider Organization (PPO)

The contracting organization responsible for negotiating reduced rates for services rendered by providers in the organization. Benefits for PPO services are paid as stated in the Schedule of Medical Benefits.

Pregnancy

That physical state that results in childbirth, abortion or miscarriage. This definition includes medical complications of the physical state of pregnancy.

Preventive

Services provided for preventive purposes, when there is no diagnosis of illness or injury.

Psychologist

A certified practitioner who:

1. is listed in the National Register of Health Service Providers in psychology; or
2. is a Diplomat in Clinical Psychology through the American Board of Professional Psychologists.

An associate psychologist will be considered a psychologist if he meets all the requirements for the above qualifications except for completion of a doctoral degree.

Qualified Beneficiary

An employee and his dependents who, on the date before a qualifying event occurred, were covered under the Plan.

A dependent, other than a newborn or adopted child, acquired and enrolled after the original qualifying event is not a qualified beneficiary if a subsequent event results in loss of coverage.

Qualified Medical Child Support Order (QMCSO)

A child support order that requires an employee benefit plan to provide coverage for a dependent child of a covered employee or his spouse if the Plan normally provides coverage for dependent children. A QMCSO is typically generated as a part of a divorce proceeding or a paternity action.

Qualifying Event

A specific type of event that, except for continuation of coverage provisions included in the Plan, would cause an individual to lose health care coverage.

Reasonable and Customary Charge

The charge customarily made for the same or similar treatment, services or supplies provided to individuals of similar medical condition in the locality concerned.

Registered Domestic Partner

A person in a committed non-marital relationship with an employee that meets all the criteria established by the City. To register as domestic partners, an employee and his partner must swear under oath that they:

1. Are in a relationship that has existed for twelve (12) or more consecutive months;
2. Have shared a residence for twelve (12) or more consecutive months;
3. Are not related by blood closer than permitted under marriage laws of the State of Indiana;
4. Are not legally married to anyone, according to the laws of the State of Indiana;
5. Have no other domestic partner; and
6. Are both at least 18 years of age and have the capacity to enter into a contract.

They must also attest that their relationship is an exclusive mutual commitment that is the functional equivalent of marriage. That is, that they are jointly responsible for each other's financial, emotional and physical wellbeing, including each other's debt, and; they intend to remain in the relationship indefinitely, and; they have agreed that in event of the dissolution of their domestic partner relationship, they will make a substantially equal division of any earnings acquired during the domestic partnership and of any property acquired with those earnings.

Documentation of an interdependent financial relationship is required.

Employees should be aware that registration as domestic partners may create substantial financial and legal obligations under federal and state law, and are advised to consult a tax advisor and/or attorney before applying for domestic partner status.

Retail Health Clinic

A walk-in health clinic located in a retail setting, through which a Nurse Practitioner or Physician's Assistant provides treatment for a limited number of common ailments.

Room and Board

The room, meals, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by a hospital as a condition of occupancy of the class of accommodations occupied. Room and board does not include professional services of physicians or special nursing services rendered outside of an intensive care unit by whatever name called.

Second Surgical Opinion

An evaluation of the need for surgery by a second physician (or third physician if the opinions of the physician recommending surgery and the second physician are in conflict), including the physician's exam of the patient and related diagnostic testing.

Skilled Nursing Facility

An institution or part thereof that operates as a skilled nursing facility, convalescent hospital, extended care facility or intermediate or long-term care facility and that meets all the following criteria:

1. complies with licensing and other legal requirements of the jurisdiction in which it is located;

2. provides twenty-four (24) hour skilled nursing services under the full-time supervision of a licensed physician or graduate registered nurse (R.N.); and

3. has a written agreement with at least one hospital providing for the transfer of patients and medical information.

Skilled nursing facility does not include an institution or any part thereof that is primarily a place for the aged, alcoholics or drug addicts, the blind or deaf, the mentally ill or disabled, or that is primarily a rest home or a custodial care facility. Nor does it include any institution that is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals or approved by Medicare as a hospital.

Third Party Administrator (TPA)

Anthem Blue Cross and Blue Shield for medical and prescription drug benefits; Benefit Administrative Systems for dental benefits and COBRA administration. These organizations have been engaged by the Plan Administrator to pay benefits on its behalf, in accordance with the terms and conditions of the Plan, and to perform other administrative services on behalf of the Employer.

Utilization Review

The process of evaluating whether services, supplies or treatment are medically necessary, to help ensure medically appropriate and cost-effective care. Utilization review may involve communication with the patient and the provider, as well as suggestions for alternate courses of treatment.