BOARD OF PUBLIC WORKS AND SAFETY

RESOLUTION NO. 15-03

A RESOLUTION OF THE BOARD OF PUBLIC WORKS AND SAFETY OF THE CITY OF GREENWOOD ADOPTING EMPLOYEE HEALTH INSURANCE BENEFIT PLAN AND RELATED CONTRACTS FOR THE 2015-2016 POLICY YEAR

WHEREAS, the Board of Public Works and Safety of the City of Greenwood, Indiana (the "Board") recognizes that health insurance is an important benefit to the City's employees;

WHEREAS, health insurance represents a significant expenditure to the City's budget;

WHEREAS, the City's health insurance plan is renewed annual on April 1; and

WHEREAS, certain revisions and amendments are necessary to the City's Employee Health Insurance Benefit Plan due to changes in federal laws and regulations, market conditions, and budgetary reasons.

NOW THEREFORE, BE IT RESOLVED BY THE BOARD OF PUBLIC WORKS AND SAFETY OF THE CITY OF GREENWOOD, INDIANA THAT:

1. Pierre Fox of Regions Insurance, Inc. shall serve as broker of record for the City for its health insurance benefit plan for the 2015-2016 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

2. HCC Life Insurance Company shall serve as the medical stop loss provider for the City for its health insurance benefit plan for the 2015-2016 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

3. Advantage Care Solutions, Inc. shall serve as the third party administrator for the City for its health insurance benefit plan for the 2015-2016 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

4. Premiums for the 2015-2016 policy year shall be established as follows:

Category	Monthly Rate
Single	$68.50
Employee plus Spouse/Employee plus Children	$128.00
Family	$159.00

Additionally, a $20 monthly surcharge shall be applied to Employee plus Spouse accounts and Family accounts where the employee's spouse is employed full time at an employer who offers health insurance benefits.

5. The City's Employee Health Benefits Plan is hereby approved in the form attached hereto as **Exhibit A**.

6. Delta Dental of Indiana shall serve as the provider for the City for its dental insurance benefit plan for the 2015-2016 policy year. The Board authorizes and delegates authority to the Mayor to sign all documents and contracts necessary to effectuate said relationship subject to approval of form by the City's Legal Department.

PASSED BY THE BOARD OF PUBLIC WORKS AND SAFETY OF GREENWOOD, INDIANA this 16th day of March, 2015, by a vote of 3 ayes, 0 nays.

BOARD OF PUBLIC WORKS AND SAFETY

Kevin Hoover

Michael Newbold

Shan Rutherford

ATTEST:

Amanda Leach, Board Clerk

REGIONS
INSURANCE, INC.

ADVISOR AGREEMENT

This Advisor Agreement ("Agreement") is entered into as of 4/1/2015 by and between City of Greenwood and all of its subsidiaries and related entities enrolled through the employee benefit programs and having a place of business at 300 S. Madison Ave, Greenwood, IN and Regions Insurance, Inc., having its principal place of business in Birmingham, Alabama with an agency location at 630 3rd Ave SW, Suite 200, Carmel, IN 46032 ("Advisor").

WHEREAS, Client wishes to obtain the services and assistance of Advisor with strategic benefit planning, benefit design, data analysis, optimal funding, management and communication with respect to its employee benefit programs;

WHEREAS, Advisor has knowledge and experience in assisting employers with designing, managing, analyzing and communicating employee benefit plans; and

WHEREAS, Client and Advisor desire to set forth in this Agreement their respective expectations relating to the services to be provided by Advisor to Client.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby mutually acknowledged, the parties hereby agree as set forth in this Agreement.

1. Services. Advisor will provide Client services for Client's core employee benefit programs which includes group medical, group prescription drugs, group life & disability benefits, dental, vision, and non-core programs which includes employee paid voluntary benefits programs.

a. Strategic Benefit Planning. Advisor will provide assistance in developing overall employee benefit program benchmarks and targets to ensure that the employee benefit programs meet the objectives of Client.

b. Benefit Design. Advisor will help to ensure that benefit designs are consistent with the strategic benchmarks and targets set forth in the strategic benefit planning process.

c. Administration. Advisor will review and assess vendor performance and conduct claims reviews with Client.

d. Funding. Advisor will review and recommend funding alternatives, including reviewing fee proposals and monitoring employee benefit program costs against expectations.

e. Employee Communications. Advisor will assist Client in drafting employee communications regarding employee benefit programs performance and changes.

f. Compliance Tools & Legislative Information. Advisor will provide informational materials on legislative developments impacting employee benefit plans, including access to online reference tools on topics such as FMLA, COBRA, HIPAA, HIPAA Privacy, FLSA, and other topics for Client's review.

g. Meetings with Client and Vendors. Advisor will attend and facilitate meetings with Client and vendors as needed to facilitate program management and planning employee benefit program changes.

h. Other Services Not Included. Actuarial services from third parties, on-line enrollment services specifically required by Client, legal advice, and deferred compensation plans are not offered nor included as part of the services provided by Advisor to Client.

i. Outline of Services. The services to be provided Client are further described on Exhibit A to this Agreement.

2. Authorization. Client authorizes Advisor to act as an Insurance producer on its behalf and to represent and assist Client in all discussions with Insurers and/or intermediaries.

3. Approval. Upon request of Client, Advisor, acting as an insurance producer, will place the selected insurance coverages for Client. Client has the right to approve of, and Advisor will obtain Client's approval prior to, the placement of any insurance coverage by Advisor acting as an insurance producer with a specific insurance company or other risk bearing entity ("Insurer") or the utilization of any intermediaries. Client is not required to use Advisor to place any specific insurance coverage during the term of this Agreement.

4. Compensation. Client shall pay Advisor a fee of $1,666 payable in equal monthly installments except as otherwise provided in this Agreement.

5. Term. This Agreement will commence on 4/1/2015 and end on 3/31/2015 regardless of the policy period of any insurance coverage ("Initial Term"). After the Initial Term, this Agreement will remain in effect until terminated as provided for in this Agreement.

6. Termination. This Agreement may be terminated by either party for any reason upon sixty (60) days written notice to the other party.

7. Commissions Received for the Sale of Insurance. Upon the receipt of a request by Client, Advisor acting as an insurance producer will attempt to place the requested core program insurance coverage without commissions being included in the premium. However, this may not be possible and Advisor may receive compensation from insurance companies, or their affiliates, in the form of commissions for the sale of insurance. Commissions are typically calculated as a percentage of the premium paid to the insurance company. Some insurance companies offer additional compensation based on incentive or contingent criteria such as the amount of the total premium collected by an insurance company, underwriting profitability, or

other factors. The total amount of compensation that may be received from an insurance company is not generally known until the completion of the underwriting year.

8. Non-Core Programs. Since commissions are typically included in employee paid voluntary benefits, Advisor may receive commissions from an Insurer.

9. Client Information. Advisor will limit the use of any and all information it receives from the Client, Client's employee, and/or plan sponsor relating to the Client's employees and will execute a Business Associate Agreement in the form attached hereto as Exhibit B.

10. Records. Advisor will retain its records in accordance with the Regions Document Retention and Destruction policy. Unless otherwise required by law, records will not be retained for more than seven (7) years and noncritical documents may be destroyed earlier in accordance with Advisor's normal course of business practice. Client must maintain such documents or other information delivered by Advisor or an Insurer which Client deems to be critical business records.

11. Designated Professionals. Advisor will designate appropriate professionals to assist Client according to the needs of Client and according to the disciplines required to complete the appointed task in a professional manner. Advisor retains the right to substitute personnel with reasonable cause. Advisor agrees to replace designated professionals as reasonably requested by Client.

12. Client Responsibilities. Client will make available such reasonable information as requested by Advisor that is necessary for Advisor to provide its services recognizing that the Client has limited resources. The requested information will be made available to Advisor as promptly as possible. Each party will endeavor to make judicious use of the other party's time. Client will meet regularly with Advisor for the purposes of completing certain mutually agreed upon tasks. Client agrees to notify Advisor as soon as possible, but at least thirty (30) days prior to the effective date, of any proposed amendments to the employee benefit plans if the amendments would affect Advisor in the performance of its obligations under this Agreement.

13. Independent. Advisor does not speak for any Insurer, is not bound to utilize any particular Insurer, and does not have the authority to make binding commitments on behalf of any Insurer.

14. Fiduciary Responsibility. Client acknowledges that: (a) Advisor will have no discretionary authority or discretionary control respecting the management of any of the employee benefit plans; (b) Advisor will exercise no authority or control with respect to management or disposition of the assets of Client's employee benefit plans; and (c) Advisor will perform services pursuant to this Agreement in a non-fiduciary capacity. While the Advisor is not a fiduciary, Advisor will perform its services in good faith under this Agreement.

15. Miscellaneous. This Agreement sets forth the entire understandings and agreements between the parties. Any prior understandings or agreements relating to the subject matter of this Agreement are terminated. All advisory services are deemed to have been performed in the Advisor's agency location. The state law of the agency location governs the construction, interpretation, and effectiveness of this Agreement without regard to its conflict of laws provision. Any amendment to this Agreement must be in writing and signed by the parties. Course of dealings between the parties may not alter the provisions of this Agreement. This Agreement may be executed in counterparts and each such document will deemed to be an original. This Agreement may be executed by the parties and submitted electronically to the other party with the signature of each party binding on each party to the fullest extent allowed by applicable law.

IN WITNESS WHEREOF, the parties have executed this Agreement by and through their respective duly authorized officers or agents as of the date set forth hereinabove.

Regions Insurance, Inc.

By: _____

Print Name: _____

Title: _____

Date: _____

CITY OF GREENWOOD, by and through its Board of Public Works & Safety,

By: Mark W Myers

Print Name: Mark W. Myers

Title: Mayor

Date: March 16, 2015

15. Miscellaneous. This Agreement sets forth the entire understandings and agreements between the parties. Any prior understandings or agreements relating to the subject matter of this Agreement are terminated. All advisory services are deemed to have been performed in the Advisor's agency location. The state law of the agency location governs the construction, interpretation, and effectiveness of this Agreement without regard to its conflict of laws provision. Any amendment to this Agreement must be in writing and signed by the parties. Course of dealings between the parties may not alter the provisions of this Agreement. This Agreement may be executed in counterparts and each such document will deemed to be an original. This Agreement may be executed by the parties and submitted electronically to the other party with the signature of each party binding on each party to the fullest extent allowed by applicable law.

IN WITNESS WHEREOF, the parties have executed this Agreement by and through their respective duly authorized officers or agents as of the date set forth hereinabove.

Regions Insurance, Inc.

By: _____

Print Name: Jon Pierce Fox

Title: V.P. Regions Insurance

Date: 5/4/2015

CITY OF GREENWOOD, by and through its Board of Public Works & Safety,

By: _____

Print Name: _____

Title: _____

Date: _____

ADVISOR AGREEMENT

Exhibit A

Strategic Planning	Data Analysis	Recommendation and Implementation	Management	Performance Measurement
Define employee benefit objectives with focus on immediate opportunities	Conduct plan design review and integration into insurance program options	Recommend customized benefit solutions that also provide for strategic enhancements.	Create value statement for employee communication and education	Prepare stewardship report
Define strategy to integrate future enhancements to manage trend and promote employee health and productivity	Conduct core program claims and analyze data	Conduct vendor relationship negotiations and assistance with management of services provided by vendor	Conduct network utilization analysis	Evaluate year-over-year performance
Assess health care reform impact	Project impact of plan design changes	Develop employee communication strategy	Engage in plan utilization review	
Plan for health care reform implementation		Assist in program implementation		
		Develop employee education and communication plans		

Exhibit B

BUSINESS ASSOCIATE AGREEMENT

The **City of Greenwood Group Health Plan** ("Payor") and **Regions Insurance, Inc** ("Business Associate") (jointly "the Parties") enter into this agreement to comply with the requirements of 45 C.F.R. Parts 160, 162, and 164 for the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH") applicable to business associates, and the final modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules as issued on January 25, 2013 and effective March 26, 2013 (75 Fed. Reg. 5566 (Jan. 25, 2013)) ("the Final Regulations"). HIPAA, HITECH, and the Final Regulations are collectively referred to in this Agreement as "HIPAA Requirements."

Payor and Business Associate agree to incorporate into this Agreement any regulations issued by the U.S. Department of Health and Human Services ("DHHS") with respect to the HIPAA Requirements that relate to the obligations of business associates and that are required to be (or should be) reflected in a business associate agreement. Business Associate recognizes and agrees that it is obligated by law to meet the applicable provisions of the HIPAA Requirements and that it has direct liability for any violations of the HIPAA Requirements.

WHEREAS, the Payor has engaged Business Associate to perform services or provide goods, or both;

WHEREAS, Payor possesses PHI (as hereinafter defined) that is protected under the HIPAA Requirements and is permitted to use and disclose such information only in accordance with such laws and regulations;

WHEREAS, Business Associate may receive such information from Payor, or create and receive such information on behalf of Payor, in order to perform certain of the services or provide certain of the goods, or both; and

WHEREAS, Payor wishes to ensure that Business Associate will appropriately safeguard the privacy, confidentiality, integrity, and availability of PHI;

NOW THEREFORE, Payor and Business Associate agree as follows:

ARTICLE 1 DEFINITIONS

For purposes of this Agreement, the following terms shall have the following prescribed meanings.

"Breach" means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under the HIPAA Requirements unless there is a low probability the PHI has been compromised based on a risk assessment, as defined in 45 C.F.R. § 164.402.

"Business Associate Subcontractor" means an entity or agent that creates, receives, maintains or transmits Protected Health Information on behalf of Business Associate, as defined in 45 C.F.R. § 160.103.

"Data Aggregation Services" means, with respect to Protected Health Information created or received by Business Associate, the combining of such Protected Health Information by Business Associate with protected health information (as defined in HIPAA) received by Business Associate in its capacity as a business associate (as defined in HIPAA) of another Covered Entity (as defined in HIPAA), to permit data analyses that relate to the health care operations of the respective covered entities, including Payor.

"Electronic Media" means the mode of electronic transmission and includes the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media.

"Electronic Protected Health Information" or "ePHI" means Protected Health Information that is (i) transmitted by Electronic Media, or (ii) maintained in any medium described as Electronic Media, as defined in 45 C.F.R. § 160.103.

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

"HITECH" means the Health Information Technology for Economic and Clinical Health Act of 2009 as reflected in 42 U.S.C. § 17921 *et. seq.* and such regulations as may be promulgated thereunder from time to time.

"Limited Data Set" means Protected Health Information excluding direct identifiers of an individual or of relatives, employers, or household members of the individual, as defined in 45 C.F.R. § 164.514.

"Principal Agreement" means the contract or agreement, whether in writing or otherwise, between Payor and Business Associate, pursuant to which Business Associate provides services to Payor of the type that require the Parties to enter into this Agreement pursuant to HIPAA.

"Protected Health Information" or "PHI" means individually identifiable health information of Payor that is (i) transmitted by Electronic Media, (ii) maintained in any medium described as Electronic Media, or (iii) transmitted or maintained in any other form or medium, as defined in 45 C.F.R. § 160.103. "Protected Health Information" does not include individually identifiable health information in: (i) education records covered by the Family Educational Right and Privacy Act (20 U.S.C. § 1232g(a)(4)(B)(iv)), or (ii) records described at 20 U.S.C. § 1232g(a)(4)(B)(iv). The use of "Protected Health Information" or "PHI" in this Agreement shall mean both Electronic PHI and non-Electronic PHI, unless another meaning is clearly specified.

"Security Incident" means the attempted or successful unauthorized access, destruction, disclosure, modification, or use of information or interference with system operations in an information system, as defined in 45 C.F.R. § 164.304.

"Unsecured Protected Health Information" or "Unsecured PHI" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services in the guidance issued under section 13402(h)(2) of HITECH, as defined in 45 C.F.R. § 164.402.

"Unsuccessful Security Incident" means any Security Incident that does not result in unauthorized access, destruction, disclosure, modification, or use of Protected Health Information. Examples include, but are not limited to, pings on Business Associate's firewall, port scans, attempts to long onto a system or enter a database with an invalid username or password, denial of service attacks not resulting in the system being taken off-line, or malware such as worms or viruses.

All other terms in this agreement shall have the meanings set forth in the applicable divisions under the HIPAA Requirements.

II. STATUS OF PARTIES

Business Associate hereby acknowledges and agrees that Payor is a Covered Entity and that Business Associate is a Business Associate as that term is defined in HIPAA Requirements of the Payor.

III. PERMITTED AND REQUIRED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Business Associate shall be permitted and required to create, receive, disclose, maintain, transmit or use PHI only as provided in the Principal Agreement and this Agreement. Business Associate shall not use or further disclose PHI in any manner that: (a) would violate the terms of this Agreement; or (b) if done by Payor, would violate HIPAA, except that (i) Business Associate may use and disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, and (ii) Business Associate may provide Data Aggregation Services relating to the health care operations of Payor. Business Associate may disclose PHI for the purposes described in item (b)(i) of this Section III only if the disclosure is required by law or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person and that the person will notify Business Associate of any instance where the confidentiality of the PHI has been breached. Business Associate agrees that it shall comply with the requirements of the Privacy Rule that apply to Payor in the performance of carrying out one or more of Payor's obligations under the Privacy Rule (Subpart E of 45 C.F.R. Part 164).

Business Associate shall report any use or disclosure of PHI that is not provided for in this Agreement to Payor, including Breaches of Unsecured PHI as required by 45 C.F.R. § 164.410 and required by this Agreement in Section VI below.

Business Associate shall establish, implement, and maintain appropriate safeguards, and comply with the Security Standards (Subpart C of 45 C.F.R. Part 164) with respect to ePHI, as necessary to prevent any use or disclosure of PHI other than as provided for in this Agreement.

In conducting functions and/or activities under this Agreement that involve the use and/or disclosure of PHI, Busienss Associate shall limit the use and/or disclosure of PHI to the minimum amount of information necessary as determined by Payor to accomplish the intended purpose of the use or disclosure, as required by 45 C.F.R. § 164.502(b).

RESTRICTIONS ON THE USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Notwithstanding anything in the Principal Agreement to the contrary, Business Associate shall:

1.1 Not use or further disclose PHI other than permitted or required by this Agreement or required by law;

1.2 Business Associate shall not, without prior written consent of Payor, disclose any PHI on the basis that such disclosure is required by law without notifying Payor so that Payor shall have the opportunity to object to the disclosure and to seek appropriate relief. If the Payor objects to the disclosure, Business Associate shall refrain from disclosing the PHI until Payor has exhausted all alternatives for relief. Business Associate shall require reasonable assurances from persons receiving PHI that such persons will provide Payor with similar notice and opportunity to object before disclosing PHI on the basis that such disclosure is required by law;

1.3 If Payor notifies Business Associate that Payor has agreed to be bound by additional restrictions on the uses or disclosures of PHI pursuant to HIPAA Requirements, Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions in accordance with 45 C.F.R. § 164.522;

1.4 Use appropriate safeguards to prevent use or disclosure of the PHI other than provided for by this Agreement and represent and warrant that it complies with each of the Standards and Implementation Specifications of 45 CFR §§ 164.308 (Administrative Safeguards), 164.310 (Physical Safeguards), 164.312 (Technical Safeguards), 164.314 (Organizational Requirements), and 164.31 (Policies and Procedures and Documentation Requirements) with respect to ePHI. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of Payor as required by HIPAA;

1.5 Business Associate shall utilize a Limited Data Set wherever possible in the use, disclosure or request of PHI. In the event that a Limited Data Set is not possible, Business Associate agrees to use, disclose, or request only the minimum necessary PHI to accomplish the intended purpose of the use, disclosure, or request;

1.6 Report to Payor any use or disclosure of the PHI not provided for by this Agreement, or any security incident, of which it becomes aware;

1.7 Ensure that any agents, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of, Payor agrees to the same restrictions and conditions that apply to Business Associate with respect to such PHI (and, in the case of ePHI, that such agents and subcontractors agree to implement reasonable and appropriate safeguards to protect it) provided, however, that Business Associate shall not disclose or provide access to PHI to any subcontractor or agent without the prior written consent of the Payor;

1.8 Make available to Payor (or as directed by Payor, to an individual who is the subject of the PHI (or their designees)) PHI about that individual to the extent required by, and in accordance with, 45 C.F.R § 164.524 of the HIPAA Requirements. When requested, Business Associate shall make such information available in an electronic format;

1.9 Make available an individual's PHI in a Designated Record Set for amendment by that individual and incorporate any amendments to that individual's PHI to the extent required by, and in accordance with, 45 C.F.R. § 164.526 of the HIPAA Requirements;

1.10 Make available PHI required to provide an accounting of disclosures of an individual's PHI to the extent such accounting is required by, and in accordance with, 45 C.F.R. § 164.528 to Payor or, at the direction of Payor, directly to the individual;

1.11 Make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Payor available to the Secretary of Health and Human Services (or its delegate) for purposes of determining Payor's compliance with HIPAA; and

1.12 At termination or expiration of this Agreement, if feasible, return or destroy (at Payor's option) all PHI received from, or created or received by Business Associate on behalf of, Payor that Business Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, extend the protections of this Agreement and of the HIPAA requirements to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

ARTICLE 2NOTICE

Business Associate shall immediately report to Payor any unauthorized access, use, disclosure, modification, or destruction of PHI not permitted by this Agreement, by applicable law, or permitted in writing by Payor upon discovery, whether it is by or at Business Associate or Business Associate Subcontractor. Business Associate shall also report any Breach of Unsecured PHI or Non-Compliance with the Agreement, any Security Incident, or any Breach consistent with the HIPAA Breach Notification Regulations known or reasonably believed by Business Associate or Business Associate Subcontractor. Notice shall be in writing and provided to Payor immediately.

Such notice will include, to the extent possible, the identification of each individual whose PHI has been or is reasonably believed by Business Associate to have been accessed, acquired, used, or disclosed during the Breach. Such notice shall also include the following information: (i) a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known; (ii) a description of the types of Unsecured PHI that were involved in the Breach (such as full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information); (iii) any steps individuals should take to protect themselves from potential harm resulting from the Breach; (iv) a brief description of what Business Associate or Business Associate Subcontractor is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further breaches; (iv) any other information, including a written report, as Payor might reasonably request; and (v) contact procedures for obtaining additional information.

Business Associate shall assist Payor in performing a risk assessment to determine if there is a low probability of compromised PHI and cooperate with Payor in meeting all of Payor's obligations under the HIPAA Requirements and any other security breach notification law.

Business Associate agrees to fully cooperate, coordinate with, and assist Payor in gathering information necessary to notify the affected individuals and agrees that it shall be solely responsible for all costs and expenses incurred as a result of the Breach, including costs associated with mitigation, preparation, and delivery of the notices. In the event that Business

Associate creates, receives maintains, or transmits PHI on behalf of other covered entities in addition to Payor, Business Associate agrees that it has the capability to identify the covered entity to which the breached information relates.

In the event of any use or disclosure of PHI in violation of this Agreement by Business Associate or by a third party to which Business Associate disclosed PHI that arises from the acts or omissions or Business Associate or its employees, subcontractors, agents, or representatives, and that requires notification of governmental agencies and individuals, Business Associate will cooperate fully with Payor and will carry out the notification requirements subject to Payor's prior approval of any written reports, unless Payor elects to carry out the notifications.

For Unsuccessful Security Incidents, Business Associate shall provide Payor, upon written request, a report that identifies the categories of Unsuccessful Security Incidents, indicates whether Business Associate believes its or its Business Associate Subcontractor's current security measures are adequate given the scope and nature of such attempts, and, if the security measures are not adequate, the measures Business Associate or Business Associate Subcontractor will implement to address the security inadequacies.

Business Associate shall have procedures in place to mitigate, to the maximum extent practicable, any deleterious effect from any use or disclosure of PHI in violation of this Agreement or applicable law.

Business Associate shall have and apply appropriate sanctions against any employee, subcontractor, or agent who uses or discloses PHI in violation of this Agreement or applicable law.

ARTICLE 3OBLIGATIONS OF BUSINESS ASSOCIATE SUBCONTRACTORS

Business Associate agrees to enter into a written agreement with all Business Associate Subcontractors, as required by the HIPAA Requirements. The Business Associate Subcontractor Agreement will (i) require them to comply with the Privacy and Security Rule provisions of this Agreement in the same manner as required of Business Associate and (ii) notifies such Business Associate Subcontractors that they will incur liability under HIPAA Requirements for non-compliance with such provisions. Business Associate shall ensure that all Business Associate Subcontractors agree in writing to the same privacy and security restrictions, conditions, and requirements that apply to Business Associate with respect to PHI.

ARTICLE 4BUSINESS ASSOCIATE COMPLIANCE WITH HIPAA

Business Associate represents and warrants that effective February 17, 2010, it shall be in compliance with HIPAA, including, but not limited to 45 CFR § 164.308, 45 CFR § 164.310, 45 CFR § 164.312, 45 CFR § 164.316 and 45 CFR § 504(e).

ARTICLE 5SECURITY STANDARDS

In order to preserve the integrity, confidentiality, and availability of , and to prevent non-permitted use or disclosure of ePHI created or received for or from Payor, Business Associate agrees to develop, document, implement, maintain, and use appropriate Administrative, Technical, and Physical Safeguards. At a minimum these standards shall meet the requirements of the HIPAA Security Standards applicable to Business Associate.

To comply with HIPAA Security Standards, Business Associate agrees that it shall:

5.1 Develop and implement Administrative, Technical, and Physical Safeguards as required by the HIPAA Security Standards that reasonably protect the confidentiality, integrity and availability of ePHI that Business Associate creates, receives, maintains, or transmits on behalf of Payor. Policies and procedures that meet the documentation standards of the HIPAA Requirements shall also be developed and implemented;

5.2 Ensure that any Business Associate Subcontractor agrees to implement reasonable safeguards to protect ePHI;

5.3 Report any unauthorized access, use, disclosure, modification, or destruction of PHI or ePHI not permitted by this Agreement, applicable law, or permitted by Payor in writing of which Business Associate becomes aware to Payor in accordance with the reporting requirements;

5.4 For Unsuccessful Security Incidents, aggregate the data and, upon written request by Payor, report to Payor in accordance with the reporting requirements;

5.5 Take all practical and reasonable steps to mitigate any harmful effects known to Business Associate resulting from any unauthorized access, use, disclosure, modification, or destruction of PHI;

5.6 If Payor determines Business Associate has violated a material term of the Agreement concerning Business Associate's security obligations and Business Associate is unable to cure, permit termination of the Agreement; and

5.7 Provide Payor, upon request, with access to and copies of documentation regarding Business Associate's safeguards for PHI.

ARTICLE 6PAYMENT OF BREACH EXPENSES

Business Associate shall reimburse Payor for all reasonable costs and expenses incurred by Payor to satisfy Payor's obligation under HITECH and the regulations promulgated thereunder to notify individuals and other entities in the event of a Breach of Unsecured PHI by Business Associate or any subcontractor, agent, employee, director, member, or other representative of Business Associate. Payor will submit an invoice to Business Associate detailing the costs and expenses incurred by Payor and Business Associate shall make full payment to Payor within ten (10) business days of receipt of the invoice.

ARTICLE 7OBLIGATIONS OF PAYOR

Payor shall notify Business Associate of any limitation(s) in Payor's notice of privacy practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

Payor shall notify Business Associate of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

Payor shall notify Business Associate of any restriction to the use or disclosure of PHI that Payor has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

Payor shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA Requirements if done by Payor. Notwithstanding the foregoing language, Business Associate may use or disclose PHI for Data Aggregation Services to Payor as permitted by 42 CFR § 164.504(e)(2)(i)(B) or the management and administrative activities of Business Associate in accordance with this Agreement.

ARTICLE 8AMENDMENT

This Agreement may be amended only in writing and only by the mutual consent of the Parties. Notwithstanding the foregoing, this Agreement shall automatically be amended to the extent minimally necessary to comply with any changes to HIPAA, including any changes as a result of HITECH.

ARTICLE 9TERM AND TERMINATION

This Agreement shall become effective as of the later of (i) the date set forth below or (ii) the date the HIPAA Requirements become effective with respect to the relationship between Payor and Business Associate. This Agreement shall remain in effect until the earlier of: (i) the date the Parties mutually agree in writing to terminate this Agreement, or (ii) the date the Principal Agreement is terminated. No separate notice shall be required to terminate this Agreement upon termination of the Principal Agreement.

Notwithstanding anything in the Principal Agreement to the contrary, Payor may terminate this Agreement and the Principal Agreement or seek other remedies upon written notice to Business Associate if Payor determines that Business Associate has violated a material provision of this Agreement; if Business Associate is named a defendant in a criminal proceeding for violation of HIPAA Requirements, or if a finding or stipulation that Business Associate has violated any HIPAA Requirement or other security or privacy laws is made in any administrative or civil proceeding in which Business Associate has been joined

Upon termination of this Agreement, Business Associate and Payor shall have a continued obligation to protect the privacy and security of PHI created, received, maintained, or transmitted in connection with services provided under the Agreement. This obligation shall be continuous and survive termination, expiration, cancellation, or other conclusion of this Agreement.

Upon termination of this Agreement for any reason, Business Associate shall return or destroy, as specified by Payor, all PHI that Business Associate still maintains in any form, and shall retian no copies of such PHI. If Payor, in its sole discretion, requires that Business Associate destroy any or all PHI, Business Associate shall certify to Payor that the PHI has been destroyed. If return or destruction is not feasible, Business Associate shall inform Payor of the reason it is not feasible and shall continue to extend the protections of this Agreement to such information and limit further use and disclosure of such PHI to those purposes that make the return or destruction of such PHI infeasible.

Payor and Business Associate agree that any violation of the provisions of this Agreement may cause irreparable harm to Payor. Accordingly, in addition to any other remedies available to Payor at law, in equity, or under this Agreement, in the event of any violation by Business Associate of any of the provisions of this Agreement, or any explicit threat thereof, Payor shall

be entitled to an injunction or other decree of specific performance with respect to such violation or explicit threat thereof, without bond or other security being required and without the necessity of demonstrating actual damages.

Business Associate shall indemnify, hold harmless, and defend Payor from and against any and all claims, losses, liabilities, costs, and other expenses resulting from, or relating to, the acts or omissions of Business Associate in connection with the representations, duties, and obligations of Business Associate under this Agreement.

ARTICLE 10RELATIONSHIP TO PRINCIPAL AGREEMENT

It is the intent of the Parties that the terms of this Agreement be interpreted so as to cause the Principal Agreement to comply with the privacy and security requirements of HIPAA and the requirements of HITECH. Accordingly, this Agreement shall amend the Principal Agreement to the extent provided herein regardless of whether this Agreement formally satisfies the requirements of the Principal Agreement for amendment of the Principal Agreement. To the extent any provisions of this Agreement conflict with the terms of the Principal Agreement, this Agreement shall govern.

ARTICLE 11MISCELLANEOUS

Inconsistencies. In the event an inconsistency arises between the provisions of this Agreement and a mandatory term of the HIPAA Requirements, which may be expressly amended from time to time by the DHHS or as a result of interpretations by DHHS, a court, or other regulatory agency with authority over the Parties), the interpretation of DHHS, such court or regulatory agency shall prevail. In the event of a conflict in interpretation between these entities, the conflict shall be resolved in accordance with rules of precedence. Where provisions of this Agreement conflict with mandated HIPAA Requirements but are nonetheless permitted by the HIPAA Requirements, the provisions of this Agreement shall control.

Assignment. This Agreement may not be assigned by either party without the prior written consent of the other party, which consent shall not be unreasonably withheld. This Agreement shall be binding upon and inure to the benefit of the successors and permitted assigns hereof.

Further Assurances. Each party will cooperate with the other and execute and deliver to the other party such other instruments and documents and take such other actions as may be reasonably requested from time to time by the other party to carry out, evidence and confirm the intended purposes of this Agreement.

Survival. Notwithstanding any contrary provision in this Agreement, the provisions of this Agreement shall continue in force beyond the term of this Agreement to the extent necessary or appropriate to give such provisions their intended effect, unless and until the Parties specifically agree in writing to the contrary.

Waiver. The rights and remedies of the Parties are cumulative and not alternative. Neither the failure nor any delay on the part of any party in exercising any right, power, or privilege under this Agreement shall operate as a waiver thereof, nor shall any single or partial exercise of any

such right, power or privilege preclude any other or further exercise thereof or exercise of any other right, power or privilege.

Governing Law. This Agreement shall be governed by the laws of the jurisdiction provided in the Principal Agreement. If the Principal Agreement does not specify such a jurisdiction, this Agreement shall be governed by the laws of the State of Indiana.

Force Majeure. Neither party shall be liable or deemed to be in default for any delay or failure in performance under this Agreement or other interruption of services deemed resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, or strikes, or similar cause beyond the reasonably control of either party.

Relationship of Parties. None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the Parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement.

No Third Party Beneficiaries. Nothing herein is intended to give nor shall have the effect of giving, any enforceable rights to any third parties who are not parties hereto or successors or permitted assigns of the parties hereto, whether such claims are asserted as third party beneficiary rights or otherwise.

Counterparts. This Agreement may be executed in one or more counterparts each of which shall be deemed to be an original and all of which together shall constitute one and the same instrument.

Notice. Notices required under this Agreement shall be sent by regular mail to the address of each party set forth below or such other address as that party may designate in a notice properly delivered to the other parties.

IN WITNESS WHEREOF, Payor and Business Associate, each by their duly authorized representatives, have caused this Agreement to be executed and delivered as of the last date written below.

CITY OF GREENWOOD, by and through its
Board of Public Works & Safety,

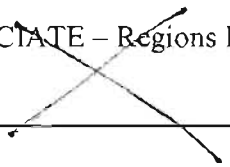
Mark W Nye — March 17, 2015

Signature — Date

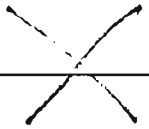
Plan Name:
Address: 300 S. Madison Avenue

City, State, Zip: Greenwood, IN 46142

BUSINESS ASSOCIATE – Regions Insurance



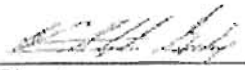
Signature



Date

Business Associate Name:	Regions Insurance, Inc.
Address:	630 3rd Ave SW
	Suite 200
City, State, Zip:	Carmel IN 46032

BUSINESS ASSOCIATE – Regions Insurance



Signature

April 30, 2015

Date

Business Associate Name: Regions Insurance, Inc.
Address: 630 3rd Ave SW
Suite 200
City, State, Zip: Carmel IN 46032

March 20, 2015

Jon P Fox
Regions Insurance, Inc.
630 3rd Avenue, Suite 200
Carmel, IN 46032

Policyholder: City of Greenwood
Policy Effective Date: 03/01/2015
Policy Number: HCL19565

Dear Jon,

Thank you for your sincere cooperation in sending the documentation necessary for policy issuance.

Attached please find a copy of the Stop Loss Policy including the following documents:

- Fully Executed Application
- Endorsements # 1-6

If we can be of further assistance with this group, please do not hesitate to contact either your Sales Administrator or myself.

Sincerely,

Ivy Jones

Ivy Jones
Policy Issuance Assistant III

INDIANA NOTICE

Under a Group Policy issued by HCC Life Insurance Company, Kennesaw Georgia 30144

NOTICE CONCERNING INSURANCE COMPLAINTS

Should You have any questions regarding the Insurance, You may contact Us at the following addresses:

Complaints other than claims:

225 Town Park Drive, Suite 350
Kennesaw, Georgia 30144

Tel: 800/447-0460

Complaints regarding claims:

Same as above

If further assistance is needed in appealing a claim, contact the Indiana Insurance Department at the address listed below.

Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787

Consumer Hotline: 1-800 622-4461
In the Indianapolis Area: 1-317 232-2395

HCC LIFE INSURANCE COMPANY

STOP LOSS POLICY

Independent Review Organization Coverage Endorsement

Policy Number: HCL19565

Endorsement Number: 6

Policyholder: City of Greenwood

Effective Date: 03/01/2015

You and We agree that this Policy is amended as follows:

In the event Covered Expenses are Paid by You for a Covered Person based on an Independent Review Organization's reversal of previously denied claims, and such Covered Expenses are Paid after the last paid date provided in the Contract Basis of this Policy, the Paid Covered Expenses shall be deemed to have been Paid during this Policy's Contract Period, provided that:

1. Such Covered Expenses are not eligible for reimbursement under any other coverage; and
2. Such Plan Benefits are otherwise eligible for reimbursement under the terms of this stop loss policy.

You (or You through your Plan Supervisor) agree to provide notice to Us that an appeal has been sent to an Independent Review Organization on a claim that could or is expected to exceed the specific stop loss deductible under this policy within 30 days of the referral to the Independent Review Organization. We will not reimburse any stop loss claim under this Endorsement if we do not receive such notice within the 30-day time frame.

When filing a reimbursement claim under this Endorsement, You agree to provide us all documentation related to the Independent Review Organization's reversal of the previously denied Covered Expenses. We will not reimburse any stop loss claim where the Independent Review Organization's reversal documentation, along with any other information necessary to process the claim, is not received within 90 days from the last date a claim is eligible for payment under the Contract Period or within 90 days of the date the claim was Paid if Paid after the Contract Period has lapsed.

For purposes of this Endorsement, Independent Review Organization means the organization for external review as required under the external review process of the Patient Protection and Affordable Care Act.

Fees, or any similar expenses, paid to the Independent Review Organization for their services are not reimbursable under this Endorsement. Coverage under this endorsement does not modify any other terms, conditions, deductibles or split funded retentions of this policy. If coverage is available under a subsequent policy issued by Us, coverage shall be provided under this endorsed policy and not the subsequent policy.

HCC LIFE INSURANCE COMPANY

STOP LOSS POLICY

Independent Review Organization Coverage Endorsement

THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN STATED ABOVE.

HCC LIFE INSURANCE COMPANY

President

Corporate Secretary

Dated: March 20, 2015

HCC LIFE INSURANCE COMPANY

STOP LOSS POLICY
QUALIFIED CLINICAL TRIALS ENDORSEMENT

Policy Number: HCL19565

Endorsement Number: 5

Policyholder: City of Greenwood

Effective: 03/01/2015

YOU and WE agree that this Policy is amended as follows:

ARTICLE I. DEFINITIONS is hereby amended to add the following:

PATIENT CARE SERVICES. Health care items or services that are furnished to an individual enrolled in a Qualified Clinical Trial, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial.

Patient Care Services must be determined to be eligible under the Policyholder's Employee Benefit Plan.

Patient Care Services do not include any of the following:

1. An FDA approved drug or device shall be a Patient Care Service only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug of device, or
2. Non-health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial, or
3. Costs associated with managing the research associated with the Qualified Clinical Trial, or
4. Costs that would not be covered for non-investigational treatments, or
5. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial, or
6. The costs of services, which are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly, intended guidelines.

QUALIFIED CLINICAL TRIAL. A Qualified Clinical Trial is a clinical trial that meets all of the following conditions:

1. The clinical trial is intended to treat cancer or another life threatening condition in a patient who has been so diagnosed, and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
   a. A federally funded or approved Trial; or
   b. A clinical trial conducted under an FDA investigation new drug application; or
   c. A drug trial that is exempt from the requirement of an FDA investigational new drug application.
3. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.

Article VI, EXCLUSIONS. Item C is amended to include the following:

If your Employee Benefit Plan is compliant with Section 10103(c) of the Affordable Care Act, Covered Expenses for Patient Care Services furnished in connection with participation in Qualified Clinical Trials, as defined herein, will not be considered Experimental or Investigative.

HCC LIFE INSURANCE COMPANY

STOP LOSS POLICY
QUALIFIED CLINICAL TRIALS ENDORSEMENT

ADDITIONAL QUALIFIED CLINICAL TRIALS PROVISIONS

WE may require a copy of the Qualified Clinical Trial's study protocol before determining if any benefits are payable under this Endorsement.

We shall rely on the Employee Benefit Plan in terms of the definition of Life Threatening. Should the Employee Benefit Plan fail to provide a definition of Life Threatening, We will define Life Threatening as a condition that is expected to cause death within 6 months. Such definition will be used solely for the purposes of this policy and adjudication of any claims under this Endorsement.

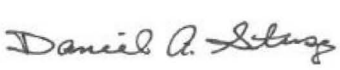
Stop Loss Policy benefits paid under this Endorsement will be included in the Specific Contract Period Reimbursement Maximum, if applicable.

Stop Loss Policy benefits paid under this Endorsement shall not create any legal presumption that HCC Life Insurance Company has recommended, directed, endorsed or required any Covered Person's participation in the Qualified Clinical Trial.

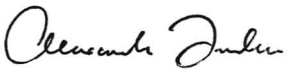
Stop Loss Policy benefits paid under this Endorsement shall be subject to all terms and conditions of the Policyholder's Employee Benefit Plan.

THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN STATED ABOVE.

HCC LIFE INSURANCE COMPANY



President



Corporate Secretary

Dated: March 20, 2015

HCC LIFE INSURANCE COMPANY

STOP LOSS POLICY
ENDORSEMENT TO A POLICY ISSUED IN THE STATE OF INDIANA

Policy Number: HCL19565

Endorsement Number: 4

Policyholder: City of Greenwood

Effective Date of Endorsement: 03/01/2015

You and We agree that above policy is amended as follows:

Article VII – General Provisions is amended as follows:

Paragraph N is amended to read as follows:

N. LEGAL ACTION: No legal action can be brought to recover under this Policy:

1. Until 60 days after the date proof of claim is submitted, or

2. Three years after the date a reimbursement claim is required to be furnished. You shall notify Us in writing within 10 days after receipt of any objection, notice of legal action or complaint regarding Your handling of a claim.

THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN STATED ABOVE.

HCC LIFE INSURANCE COMPANY

Daniel A. Strong — President

Alexander Jubelirer — Corporate Secretary

Dated: March 20, 2015

HCC LIFE INSURANCE COMPANY

STOP LOSS POLICY
ENDORSEMENT

Policy Number: HCL19565

Endorsement Number: 3

Policyholder: City of Greenwood

Effective Date of Endorsement: 03/01/2015

You and We agree that above policy is amended as follows:

Subject to the terms and conditions of the Policy and only in the event the identified Covered Person receives after the Original Effective Date of this Policy and prior to the termination date of this Policy or any renewal Policy, the Separate Individual Specific Deductible for will be $175,000 . The Separate Individual Specific Deductible shall apply for the entire Contract Period in which the occurs.

If We reimburse any Plan Benefits for the identified Covered Person(s) subject to the Separate Individual Specific Deductible during the Contract Period but prior to the occurring, we reserve the right to a) invoke the Policy's Offset provision to recover the reimbursements We have paid above Your Specific Deductible and below the Separate Individual Specific Deductible for the identified Covered Person(s), or b) request a refund from You to recover the reimbursements We have paid above Your Specific Deductible and below the Separate Individual Specific Deductible for the identified Covered Person(s).

THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN STATED ABOVE.

City of Greenwood
Full Legal Name of Applicant / Policyholder

Officer / Partner Signature Mark W Myers (print name)

Greenwood, IN
Signed At / Date Signed

Licensed Agent Signature Jon Pierre Fox (print name)

FOR HCC LIFE INSURANCE COMPANY OFFICE USE ONLY:

ACCEPTANCE

Accepted on behalf of the Company, this 20th day of March, 2015

By

Title: Senior Vice President

HCC LIFE INSURANCE COMPANY
STOP LOSS POLICY
ENDORSEMENT

Policy Number: HCL19565

Endorsement Number: 2

Policyholder: City of Greenwood

Effective Date of Endorsement: 03/01/2015

You and We agree that above policy is amended as follows:

Subject to the terms and conditions of the Policy and only in the event the identified Covered Person receives after the Original Effective Date of this Policy and prior to the termination date of this Policy or any renewal Policy, the Separate Individual Specific Deductible for will be $150,000 . The Separate Individual Specific Deductible shall apply for the entire Contract Period in which the .

If We reimburse any Plan Benefits for the identified Covered Person(s) subject to the Separate Individual Specific Deductible during the Contract Period but prior to the identified occurring, we reserve the right to a) invoke the Policy's Offset provision to recover the reimbursements We have paid above Your Specific Deductible and below the Separate Individual Specific Deductible for the identified Covered Person(s), or b) request a refund from You to recover the reimbursements We have paid above Your Specific Deductible and below the Separate Individual Specific Deductible for the identified Covered Person(s).

THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN STATED ABOVE.

City of Greenwood
Full Legal Name of Applicant / Policyholder

Greenwood, IN 2/18/2015
Signed At / Date Signed

Officer / Partner Signature (print name) Matthew Myers

Licensed Agent Signature (print name) Jon Pierre Fox

FOR HCC LIFE INSURANCE COMPANY OFFICE USE ONLY:

ACCEPTANCE

Accepted on behalf of the Company, this 20th day of March, 2015

By

Title: Senior Vice President

HCC LIFE INSURANCE COMPANY
STOP LOSS POLICY
SPLIT FUNDED ENDORSEMENT

Policy Number: HCL19565

Endorsement Number: 1

Policyholder: City of Greenwood

Effective Date of Endorsement: 03/01/2015

SPLIT FUNDED ARRANGEMENT - FIXED

Notwithstanding any other provisions of the Stop Loss Policy, the provisions of this Endorsement shall be used to determine the amount of Individual Stop Loss Insurance benefits payable by Us.

You and We agree that this Policy is amended as follows:

1. You shall pay for all Covered Expenses:

   A. Which are used to satisfy the Specific Deductible shown on Your Application for each Covered Person, and
   B. Which exceed the Specific Deductible up to an amount (hereinafter called Split Funded Liability) as set forth in this Endorsement.

2. Your Split Funded Liability, for the purposes of this Endorsement is $25,000.

3. We will not be responsible for paying any Specific Stop Loss Insurance Benefits under this Policy until You have paid the Split Funded Liability as set forth in this Endorsement.

4. If the Specific Stop Loss Insurance is terminated before the end of the Policy Year, the added Split Funded Liability will not be eliminated or reduced in any way. Such terminations will take effect pursuant to Article VII. of the Policy.

5. To the extent that there is any conflict between the terms of this Endorsement and the Policy, the terms of this Endorsement will control.

6. This Endorsement will terminate on the first to occur of:

   A. The end of the Policy Year, or
   B. Your failure to comply with any provision of this Endorsement, or
   C. Termination of the Policy pursuant to Article VII of the Policy.

You understand that it is Your responsibility to pay the Split Funded Liability amount of $25,000 over and above the amounts used to satisfy the Specific Deductible shown on Your Application. Our responsibility for reimbursement begins with those Covered Expenses that are in excess of the Specific Deductible plus the Split Funded Liability.

HCC LIFE INSURANCE COMPANY
STOP LOSS POLICY
SPLIT FUNDED ENDORSEMENT

THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN STATED ABOVE.

City of Greenwood
Full Legal Name of Applicant / Policyholder

Greenwood, IN 2/18/2015
Signed At / Date Signed

Officer / Partner Signature (print name) Marcus W. Meyer

Licensed Agent Signature

FOR HCC LIFE INSURANCE COMPANY OFFICE USE ONLY:

ACCEPTANCE

Accepted on behalf of the Company, this 20th day of March, 2015

By

Title: Senior Vice President

HCC LIFE INSURANCE COMPANY
225 Town Park Drive, Suite 350
Kennesaw, Georgia 30144
1-800 447-0460

STOP LOSS POLICY

THIS IS A LEGAL CONTRACT - PLEASE READ IT CAREFULLY

Policy Number: HCL19565

Policyholder: City of Greenwood

Principal Address: 300 S. Main Street
Greenwood IN 46143

Designated Third Party Administrator (TPA): Advantage Health Solutions, Inc.
9045 River Road, Suite 200
Indianapolis IN 46240

This Policy is issued in consideration of Your Application, Your Plan Document, Your Disclosure Statement and the payment of premiums. The aforementioned documents combine to form this Policy.

The effective date of this Policy is 12:01 a.m., at Your address and the expiration date of this Policy is 11:59 p.m., as shown below at Your principal address.

Effective Date: 03/01/2015

Expiration Date: 02/29/2016

This Policy is issued by Us as of the Effective Date, but is not valid unless countersigned by Our duly authorized representative.

Jurisdiction of Issue: Indiana

This policy is governed by the laws of the jurisdiction of issue.

Daniel A. Sitarz

President

Alexander Jurkus

Corporate Secretary

NON-PARTICIPATING INSURANCE

This is a reimbursement policy. You, or Your Plan Supervisor, are responsible for making benefit determinations under Your Employee Benefit Plan. We have no duty or authority to administer, settle, adjust, or provide advice regarding claims filed under Your Employee Benefit Plan.

TABLE OF CONTENTS

ARTICLE I. DEFINITIONS

When used in this Policy, the following terms will have the meanings as indicated below:

ANNUAL AGGREGATE DEDUCTIBLE. For any one Contract Period, (or any fraction thereof, if the Contract terminates during the Contract Period) the total of the number of Covered Single or Family units multiplied by its corresponding Monthly Aggregate Factor, applied each month that the Contract is in-force. In no instance shall the Annual Aggregate Deductible be less than the Minimum Annual Aggregate Deductible.

AGGREGATE CONTRACT PERIOD REIMBURSEMENT MAXIMUM. The maximum amount We will reimburse the Policyholder for Covered Expenses during each Contract Period under the terms of the Aggregate Stop Loss Insurance as shown on the Application.

AGGREGATE PERCENTAGE REIMBURSABLE. The percentage of Covered Expenses to be reimbursed that were Paid under the Employee Benefit Plan in excess of the Annual Aggregate Deductible.

COBRA BENEFICIARY. Any former Covered Person of the Employee Benefit Plan continuing participation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

COMPANY. Company, We, Our, and Us refers to HCC Life Insurance Company.

COMPLETE CLAIMS HISTORY. All of the following for a minimum of 12 consecutive months immediately preceding the Policy Year:

1. Participant census, and
2. Eligibility information, and
3. Claims Experience, and
4. Large Claim Disclosures, and
5. Details of any condition shown on the Trigger Diagnosis List in the Disclosure Statement.

CONTRACT. All of the following:

1. The Application, and
2. This Policy and any endorsements to it, and
3. The Policyholder's Plan Document.

CONTRACT BASIS. The form of coverage shown on the Application that was selected by the Policyholder. The Contract Basis shall be considered in determining what Covered Expenses will be reimbursed by Us.

CONTRACT MONTH. A period of one-month that begins on:

1. The effective date of the Policy, or
2. The same day of each following month during the Contract Period.

CONTRACT PERIOD. The period of time shown on the Application during which the Policyholder is covered for Aggregate and / or Specific Stop Loss Insurance.

COST CONTAINMENT PROGRAM. A program designed to reduce or control the cost of providing Plan Benefits to participants of the Employee Benefit Plan.

COVERED EXPENSES. Plan Benefits incurred by a Covered Person (or Covered Family):

1. For which benefits are Paid by the Policyholder under the Employee Benefit Plan, and
2. Which are not in excess of the Reasonable and Customary Charge for those services, and
3. Which are Medically Necessary for the treatment of an illness or injury or for any preventative care covered by the Employee Benefit Plan, and
4. Which are reimbursable under this policy subject to its terms, deductible(s), limitations and exclusions.

Plan Benefits provided by the Employee Benefit Plan that are specifically excluded by this Policy are not considered Covered Expenses. Covered Expenses shall not include any expenses which are not reimbursable under this Policy, such as:

1. The expenses related to processing claim payment, or
2. PPO discounts, network or negotiated discounts, and other reductions from billed charges, whether or not they were actually deducted from Plan Benefits, or
3. Salaries paid to any individual, or
4. Plan Supervisor's fees, or
5. Litigation expenses, or
6. Premiums paid for coverage under this Policy.

COVERED FAMILY. The Covered Person and his or her dependents covered under the Employee Benefit Plan.

COVERED PERSON. If so indicated on the Application, an individual covered under the Employee Benefit Plan. This includes:

1. Legally employed covered employees, and
2. Covered dependents, and
3. Participating COBRA Beneficiaries, and
4. Retirees.

COVERED UNITS. A Covered Person, a Covered Family, or such other defined unit as agreed upon between You and Us in writing.

DEDUCTIBLE. The amount of Covered Expenses You must pay before Aggregate Stop Loss Insurance and / or Specific Stop Loss Insurance benefits become reimbursable. The Deductible(s) is / are shown on the Application issued to You. See also:

1. Annual Aggregate Deductible, and
2. Specific Deductible, and
3. Specific Family Deductible.

ELIGIBLE. Eligible under the Employee Benefit Plan.

EMPLOYEE BENEFIT PLAN. The medical benefits You have agreed to provide under a plan of benefits for Your Eligible employees and their Eligible dependents, whether or not it is subject to the Employee Retirement Income Security Act of 1974, as is or as may be amended.

EXPERIMENTAL AND INVESTIGATIVE. A drug, device or medical treatment or procedure is Experimental or Investigative:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, or
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to determine its:
   a. Maximum tolerated dose, or
   b. Toxicity, or
   c. Safety, or
   d. Efficacy, or
   e. Efficacy as compared with the standard means of treatment or diagnosis, or
3. If reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a. Maximum tolerated dose, or
   b. Toxicity, or
   c. Safety, or
   d. Efficacy, or
   e. Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative peer reviewed medical and scientific literature, or
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure, or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

INCURRED. The date on which medical care or a service or supply is provided to a Covered Person for Plan Benefits under the Employee Benefit Plan for which a charge results.

LARGE CLAIM DISCLOSURE. You, with the assistance of Your Plan Supervisor, agree to disclose to us any known or potential shock losses. Shock Losses are:

1. Injuries, and
2. Illnesses, and
3. Diseases, and
4. Diagnoses, and
5. Any condition listed on the Trigger Diagnosis list, and
6. Other losses of the type, which are reasonably expected or are likely to result in significant medical expense or liability.

LOSS LIMIT. The maximum amount of Covered Expenses Incurred by each Covered Person (or Covered Family), which can be used to satisfy the Annual Aggregate Deductible. This amount is shown in the Application. The maximum allowable amount of Covered Expenses by a Covered Person who has been assigned a Separate Individual Specific Deductible will be the specified amount as shown under the Loss Limit on the Application, regardless of that Covered Person's Separate Individual Specific Deductible.

MEDICALLY NECESSARY. A procedure, treatment, service, supply, equipment, drug or medicine that is:

1. Deemed appropriate, essential and is recommended for the diagnosis or treatment of the Covered Person's symptoms by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license and specialty or primary area of practice, and
2. Within the scope, duration and intensity of that level of care which is required to provide safe, adequate and appropriate diagnosis or treatment, and
3. Prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental or Investigative.

MINIMUM ANNUAL AGGREGATE DEDUCTIBLE. For each Contract Period, the number of Contract Months times the Monthly Aggregate Factor times the number of Covered Units. Covered Units shall be based on the first month's enrollment or the quoted enrollment whichever is greater. The Minimum Annual Aggregate Deductible as shown on the Application is based on the quoted enrollment and it is subject to change if the first month's enrollment is greater.

MONTHLY AGGREGATE DEDUCTIBLE. The Monthly Aggregate Deductible is determined for each Contract Month by multiplying the number of Covered Units for that month by the applicable Monthly Aggregate Factor(s) shown on the Application.

MONTHLY AGGREGATE FACTOR. The amount specified in the Application.

MONTHLY SPECIFIC PREMIUM RATES. The amounts specified in the Application.

NET PAID CLAIMS. The sum of Covered Expenses Paid during the Policy Year by You less the sum of all amounts paid by You that exceeds the Loss Limit of any Covered Person(s).

ORIGINAL EFFECTIVE DATE. The first day of the Contract Period of Your initial Stop Loss Policy with Us subject to any Run-In Period as shown on the Application. If coverage has not been continuous with Us, then the Original Effective Date shall be the first day of the most recent continuous coverage.

PAY, PAID, PAYMENT. Charges that, as of the dates shown in the Contract Basis, are:

1. Covered and payable under your Employee Benefit Plan, and
2. Have been adjudicated and approved, and
3. A check or draft for remuneration is issued and deposited in the U.S. Mail, or other similar conveyance or is otherwise delivered to the payee, and
4. Sufficient funds are on deposit the date the check or draft is issued.

Our reimbursements will not be made until all of these conditions are satisfied. Checks or drafts that are returned to the payor unpaid for any reason will not be considered Paid.

PLAN BENEFITS. The medical expense benefits to which Covered Persons become entitled under the Employee Benefit Plan during the Policy Year which are:

1. Incurred after the effective date of this Policy or the first date of the Run-In Period, and
2. Incurred while this Policy is in-force, and
3. Paid during the Policy Year or before the end of the Run-Out Period.

Plan Benefits do not include:

1. Deductibles, or
2. Co-insurance amounts, or
3. Interest, or

4. Expenses, or
5. The amounts of any PPO discounts, network or negotiated discounts, or any other reductions to billed charges, whether or not they were actually deducted, and
6. Claims paid under an Employee Benefit Plan's discretionary clause or similar provision that would not otherwise be payable under the terms and conditions of the Employee Benefit Plan, and
7. Claims that are not covered under the terms and conditions of the Employee Benefit Plan or that are reimbursable from any other source.

An Employee Benefit Plan expense is incurred at the time the service is rendered or the supply is provided.

PLAN DOCUMENT. The written document evidencing Your Employee Benefit Plan including any amendments. You will provide Us with a copy of Your Plan Document that is in effect as of the Policy effective date. Amendments are subject to Article VI, Item A and Article VII, Item A.3.a and B of this Policy. We will provide written confirmation of receipt of this Plan Document. The Plan Document does not waive of any provisions of this Policy.

PLAN SUPERVISOR (TPA). The person or entity selected by the Plan Sponsor and approved by Us to perform administrative services for the Employee Benefit Plan, including payment of claims.

POLICY YEAR. The period beginning on the effective date and ending on the expiration date as shown on the face page of this Policy, or the actual period of time during which the Policy is in force if the Policy terminates prior to the expiration date.

POLICYHOLDER. Employer, Insured, You, Your or Plan Sponsor.

REASONABLE AND CUSTOMARY CHARGE. Charges for medical expenses, including but not limited to, physician services, hospital supplies, hospital bed rates, drugs, ancillary services and durable medical equipment usually made by such providers in the same geographical area using nationally and regionally adjusted data.

RUN-IN PERIOD. The period of time as defined under the Contract Basis on the Application during which claims for Plan Benefits may be Incurred provided they are Paid during the Contract Period.

RUN-OUT PERIOD. The period of time as defined under the Contract Basis on the Application during which claims for Plan Benefits may be Paid provided they were Incurred during the Contract Period.

SPECIFIC CONTRACT PERIOD REIMBURSEMENT MAXIMUM. The maximum amount of Covered Expenses We will reimburse You in each Contract Period for any one Covered Person (or Covered Family). This amount shall not exceed the amount shown as the Specific Contract Period Reimbursement Maximum on Your Application, or any maximum benefit amount or limit defined in Your Employee Benefit Plan, whichever is less.

SPECIFIC DEDUCTIBLE. If a Specific Deductible is shown on the Application, this is the amount of Covered Expenses that must be Paid by the Employee Benefit Plan for any Covered Person before Specific Stop Loss Insurance benefits are reimbursable under the Policy. It applies separately for each Policy Year and will be determined annually by Us.

SPECIFIC FAMILY DEDUCTIBLE. If a Specific Deductible is shown on the Application per a Covered Family, this is the amount of Covered Expenses which must be Paid by the Employee Benefit Plan for any Covered Family member or combination of Covered Family members before Specific Stop Loss Insurance benefits are reimbursable under the Policy. It applies separately for each Policy Year and will be determined annually by Us.

SPECIFIC PERCENTAGE REIMBURSABLE. The percentage of Covered Expenses to be reimbursed that were Paid under the Employee Benefit Plan in excess of the Specific Deductible.

ARTICLE II. SPECIFIC STOP LOSS INSURANCE

A. Subject to the terms, conditions and limitations of this Policy, We will reimburse You for Covered Expenses Paid in excess of the Specific Deductible (or Specific Family Deductible).

B. We will not reimburse you for any amounts after the Specific Contract Period Reimbursement Maximum has been reached.

C. We will not reimburse You for Plan Benefits Incurred after the Policy's expiration date.

D. If the Policy terminates before the expiration date, Plan Benefits paid after the date of termination will not be eligible for reimbursement.

E. Plan Benefits Paid by You which have been reimbursed by Us under Your Aggregate Stop Loss Insurance or by another insurance company or reinsurance company will not be used to:

1. Satisfy the Specific Deductible (or the Specific Family Deductible), or
2. Compute Specific Stop Loss Insurance benefits payable to You.

F. The Monthly Specific Premium Rates shown on the Application apply only to the Policy Year shown therein. New Monthly Specific Premium Rates will be furnished for each new Policy Year and will be shown on a new Application provided for each Policy Year.

ARTICLE III. AGGREGATE STOP LOSS INSURANCE

A. Subject to the terms, conditions and limitations of this Policy, We will reimburse You for Eligible Covered Expenses Paid, less:

1. The Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible, whichever is greater, and
2. Specific Stop Loss reimbursements due or paid to You, and
3. Any amounts paid by you that exceeds the Loss Limit for any Covered Person (or Covered Family).

B. We will not reimburse you for any amounts after the Aggregate Contract Period Reimbursement Maximum has been reached.

C. We will not reimburse You for Plan Benefits Incurred after the Policy's expiration date.

D. If the Policy terminates before the expiration date, any Plan Benefits paid after the date of termination will not be eligible for reimbursement.

E. Plan Benefits Paid by You which have been reimbursed by Us under Your Specific Stop Loss Insurance, by another insurance company or reinsurance company will not be used to:

1. Satisfy the Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible, or
2. Compute the Aggregate Stop Loss Insurance benefits payable to You.

F. Plan Benefits Paid by You which exceed the Specific Contract Period Reimbursement Maximum for Specific Stop Loss Insurance as shown on the Application will not be used to:

1. Satisfy the Annual Aggregate Deductible or Minimum Annual Aggregate Deductible, or
2. Compute the Aggregate Stop Loss Insurance benefits payable to You.

G. Reimbursement for Aggregate Stop Loss Insurance for any Covered Person (or Covered Family) will be limited to an amount not to exceed the Specific Deductible (or Specific Family Deductible) or the Loss Limit, whichever is less, as set forth in the Application.

H. The Monthly Aggregate Factor(s) shown on the Application apply only to the Policy Year shown therein. New Monthly Aggregate Factors will be furnished for each new Policy Year and will be shown on a new Application provided for each Policy Year.

I. The Monthly Aggregate Deductible cannot be reduced by more than 10% per month if the number of Covered Persons decreases for any reason. If any Covered Persons are absent from work due to a strike, lockout, or work stoppage during any Contract Month, the number of Covered Persons will remain at the same level as for the Contract Month preceding the disruption.

ARTICLE IV. CLAIMS UNDER THE POLICY

A. Specific Claims

1. We will reimburse You for Specific Stop Loss Insurance, subject to the terms, conditions and limitations of this Policy, only after We receive a request for reimbursement with complete claim information.

2. The following documentation is required to file a Specific Stop Loss claim:

   a. *Specific Claim Notification / Initial Filing form*, and
   b. A copy of the employee's enrollment card, including the employee's hire date and the original effective date, and
   c. A copy of the Plan Supervisor's claim form if the claim is for a dependent, and
   d. Complete details regarding eligibility, and if applicable, information regarding work status, pre-existing / HIPAA documentation, subrogation, Coordination of Benefits, provider discounts and COBRA, including a copy of the COBRA election form and COBRA payment verification for all months, and
   e. Copies of *Explanations of Benefits* attached to the corresponding itemized bills, and
   f. Check copies, if not part of an *Explanation of Benefits*, and
   g. Completion of the *Specific Supplemental Claim Request* portion of the claim form if applicable, and
   h. Miscellaneous information as applicable, including but not limited to:
      i. Complete accident details, including how, when and where an accident may have occurred, and
      ii. Police reports for motor vehicle accidents or for services for which a law enforcement agency is involved, and
      iii. A *Subrogation and Right of Recovery Reimbursement Agreement* if charges were Incurred as a result of a third party liability, and
      iv. Coordination of benefits documentation, and
      v. PPO discount / repricing sheets, and
      vi. *Large Case Management Reports*, and
   i. Other documentation We may request.

3. LATE CLAIMS: Any claim that is either submitted, or that remains incomplete, more than 90 days after the last date for which Plan Benefits can be reimbursed under the terms of

the Policy will be denied, whether or not the delay has prejudiced Us. Your or Your Plan Supervisor's failure to file a complete claim in a timely manner may result in an adjustment of Our reimbursement to You to reflect any savings We could have obtained had a timely claim filing taken place pursuant to this provision.

4. 50% NOTIFICATION: You or Your Plan Supervisor must give notice to Us when the total amount of Plan Benefits Paid by You on a Covered Person equals or exceeds 50% of the Specific Deductible, or has the potential to exceed 50% of the Specific Deductible. Your failure to give prompt notice may result in an adjustment of Our reimbursement to You, if any, to reflect any savings We could have obtained had a prompt 50% Notification been given.

B. Aggregate Claims

1. We will reimburse You for Aggregate Stop Loss Insurance, subject to the terms, conditions and limitations of this Policy, only after We receive a request for reimbursement with Complete Claim History.

2. The following documentation is required to file an Aggregate Stop Loss claim:

   a. Completed *Year End Aggregate Claim Form*, and
   b. *Paid Claims Analysis report* indicating claimant's name, Incurred date, charged amount, Paid amount and Paid date, and
   c. Eligibility listing which identifies birth date, effective date, termination date and coverage type, and
   d. Proof of funding to include bank statements and/or deposit slips, and
   e. *Void & Refund report*, and
   f. *Benefit / Service Code report*, and
   g. *Aggregate Report* (Monthly Loss Summary Reports), and
   h. *Specific Report* showing which claimants have exceeded the Specific Deductible or Loss Limit, and
   i. Listing of payments made outside the Aggregate Stop Loss Insurance (i.e. Dental, Weekly Income, Vision, PPO fees capitated and, PCS Administrative Fees), and
   j. Check Register, and
   k. Outstanding overpayment and subrogation log, and
   l. Prescription invoices if Prescriptions are covered under the Aggregate Stop Loss Insurance, and
   m. Other documentation We may request.

   We may also request this information the month following the expiration date of the Policy to review for retroactive adjustments.

3. Any reimbursement payable by Us to You, under this article, will be paid after the end of the Contract Period, unless otherwise endorsed.

4. CLAIM FILING: You must file a request for reimbursement with Us on Our customary Notice / Proof of Loss form within 90 days after the end of the time specified for payment of claims under this Policy. Your failure to file a claim within 90 days will result in claim denial, whether or not the delay has prejudiced Us.

5. DETERMINATION OF THE ULTIMATE AGGREGATE CLAIM: You must submit a Proof of Loss within 90 days of the end of the Policy Year or Run-Out Period, whichever is later, showing the amount of all Plan Benefits Eligible under the Employee Benefit Plan and this Policy which You have Paid. These shall be compared to the greater of the Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible. If the amount of Net Paid Claims eligible under this policy is greater than the appropriate Annual Aggregate Deductible, We will reimburse You for the amount of the excess.

C. All Claims

1. REIMBURSEMENT OF CLAIMS: Prior to making any reimbursement, We have the right to review each claim submitted to Us to determine if You are entitled to any reimbursement under this Policy. This review may include, but is not limited to, an on-site audit or requests for additional documentation. You warrant that You have Paid the providers of Plan Benefits for which reimbursement is sought.

2. SETTLEMENT OF PLAN CLAIMS: We have no duty or obligation to settle or adjust any claims for Plan Benefits filed under Your Employee Benefit Plan.

3. RIGHT OF RECOVERY. If You are entitled to recover from any party Plan Benefits Paid under the Employee Benefit Plan, such amounts cannot be used to satisfy either the Specific and / or Aggregate Deductibles. We also will not reimburse You for any Plan Benefit recovered from any party. If We have reimbursed You for all or part of a Plan Benefit and You recover any part of the Plan Benefit from any party, You must repay Us to the extent of Our reimbursement regardless of whether the policy is still in-force on the date of the recovery. You must reimburse Us first, and in full, before You receive any benefit of the recovery. We retain the right to employ our own independent counsel and You assign to us Your rights and the Employee Benefit Plan's rights to the extent of Our reimbursement(s) to You.

   In the event that You reimburse Us in the matter where Our designated counsel is not involved, Your repayment may be reduced by the reasonable and necessary expenses incurred in recovering from the third party.

   If You fail to reimburse Us for a valid claim for a Covered Expense against a third party, and We are required to reimburse You for such a Covered Expense, We shall be subrogated to Your rights to pursue the claim.

   Any amount We recover shall first be used to pay Our expenses of collection and then apply towards any amount that We reimbursed You under the policy. Any remaining amount will be paid to You.

   You are required to provide Us with such information as We request in order to protect Our right to reimbursement.

4. CLAIMS ELIGIBLE UNDER TWO CONTRACTS. If a claim for reimbursement can be filed under two different policy years, it must be filed under the earlier policy year.

ARTICLE V. LIMITATIONS OF COVERAGE

A. This Policy is between You and Us. No other party has any rights under this Policy.

B. Coverage for Plan Benefits Incurred for an employee who is not actively at work as a result of sickness, accidental bodily injury, maternity, military service, personal reasons, lay-off, strike, or any other leave of absence (either before or after the effective date of the Policy), or the employee's covered dependent(s), unless the employee or dependent(s) are receiving continuation benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall be limited to the length of time specified in the Plan Document.

C. All Plan Benefits Incurred outside the United States of America will be excluded from coverage unless:

1. The service(s) would have been a Covered Expense if the service(s) had been provided in the United States, and
2. The Covered Person is not covered by any other country's national health care program or any employer's foreign voluntary compensation coverage.

ARTICLE VI. EXCLUSIONS

WE will not reimburse YOU for:

A. Plan Benefits covered by amendments to the Employee Benefit Plan that were incurred prior to Our written approval of such amendments.

B. Plan Benefits that are covered under any Coordination of Benefits provision. We may elect to reduce or deny any reimbursement which may be payable to You, to the extent that a payment may be made by another insurer, another Employee Benefit Plan or any other party, to either the Employee Benefit Plan or Covered Person. This provision is applicable irrespective of how such payment is characterized and whether or not payment has actually been made for any or all of the Covered Person's losses.

C. Plan Benefits paid for any surgery, prescription drugs, device, or procedure, which is defined as Experimental or Investigative and any complications or other expenses arising thereto.

D. Plan Benefits Incurred by or on behalf of an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application, unless added by Policy endorsement.

ARTICLE VII. GENERAL PROVISIONS

A. CHANGES AND TERMINATIONS OF THE POLICY

1. Your Policy may be changed at any time with Our written consent.

2. Only an officer of The Company has the authority to alter this Policy, or to waive any of Our rights or requirements, and then only by written endorsement.

3. We reserve the right to change any Specific or Aggregate Premium Rates and Monthly Aggregate Factors with written notice to You as to the extent and effective date of the change at any time during Your Policy Year if:

a. Your Employee Benefit Plan is changed, or
b. The number of Covered Units Eligible under Your Policy:
    i. Drops below 15, or
    ii. Increases or decreases by 15% from the number of Covered Units on the first day of the Contract Period, or
    iii. Increases or decreases by 10% in any Contract Month from the prior Contract Month.
c. If we have agreed to reduce the Monthly Aggregate Factors, the Minimum Annual Aggregate Deductible and / or the Monthly Specific Premium Rates in consideration of Your agreement to implement a Cost Containment Program, we may recalculate in accordance with Our normal practice, the Monthly Aggregate Factors, the Minimum Annual Aggregate Deductible and / or the Monthly Specific Premium Rates if you have not followed the procedures relating to the Cost Containment Program as defined in Our agreement.
d. Upon the enactment of any law, regulation or amendment thereto, by any state or jurisdiction, which affects our liability under this Policy, and in Our judgment, requires such a change.

4. You may terminate the Policy by giving Us not less than 31 days written notice.

5. We may terminate this Policy prior to the end of a Contract Period by giving you 31 days written notice if You fail to comply with any provision of the Policy.

6. We may terminate this Policy at the end of the Contract Period by giving You 31 days written notice of such termination.

7. All insurance provided hereunder to You will automatically terminate:

    a. At the beginning of any Contract Month for which any premium for either Specific or Aggregate Stop Loss Insurance has not been paid in full by the end of the grace period, or
    b. On the date You fail to Pay claims promptly or make funds available to Pay claims promptly as required by this Policy, or
    c. On the date Your agreement with Your Plan Supervisor is terminated, or
    d. On the date You change Your Plan Supervisor before obtaining Our written consent for a successor Plan Supervisor, or
    e. On the date Your Employee Benefit Plan terminates or ceases to accept newly Incurred claims, whichever is earlier, or on the date You obtain other coverage for Your Employee Benefit Plan participants, or
    f. On the date You terminate the Policy for any reason prior to the end of the Contract Period. In this event, We will not be liable for any Plan Benefits Paid after the termination date, or
    g. At the end of the Contract Period unless You accept in writing Our terms for renewal of the Stop Loss Insurance before the end of the Contract Period, or
    h. On the expiration date of this Policy.

B. AMENDMENTS TO THE PLAN: You must give Us at least 31 days written notice of any proposed amendments to Your Employee Benefit Plan. No amendment to Your Employee Benefit Plan will be binding on Us until We have approved the amendment in writing.

C. ARBITRATION: Any controversy or dispute, involving Us that arises out of or relates to this Policy, shall be settled by arbitration in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision shall survive the termination of this Policy.

D. ASSIGNMENT: You may not assign any of Your rights under this Policy without Our prior written consent.

E. CLERICAL ERROR: Our obligations under this Policy will not be expanded by any clerical error whether by You or Us in creating or maintaining records or calculating rates, factors, premiums, deductibles or claims pertaining to this Policy. A clerical error is a mistake in performing a clerical function, such as typing, but does not include intentional acts or the failure to comply with the provisions of the Employee Benefit Plan or Policy.

F. CONCEALMENT OR MISREPRESENTATION: This Policy is issued based upon Our understanding that You, Your Plan Supervisor and your agent or broker have provided to Us a Complete Claims History. The Policy will be void if We find that You, your Plan Supervisor and your agent or broker have concealed or misrepresented any material fact or circumstance concerning this coverage or the Employee Benefit Plan's Complete Claims History, whether intentional or not. Our liability will be limited to return of the premium paid by You after deducting the amount of the reimbursements made by Us to You prior to the date of termination. If the amount of reimbursements paid to You exceeds the premium paid to Us, You will pay Us the difference. If We find that You, Your Plan Supervisor, your agent or broker have not provided to Us a Complete Claims History, We may, at Our option, either rescind the policy or re-underwrite coverages under this Policy, using all claims data available to Us.

G. CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of this Policy, which, on its effective date, is in conflict with the laws of the state of jurisdiction or which is mandated by Federal law, is hereby amended to conform to the minimum requirements of said laws.

H. COST CONTAINMENT PROGRAM: We have the right to participate, at Our option and expense, in any savings or Cost Containment Program that You have in place. If no such program exists, We have the right to retain the services of a third party to implement a Cost Containment Program.

I. DISCLAIMER: We act only as an insurer to You. We are not a fiduciary or a party in interest to the Employee Benefit Plan or any participant. We do not assume any duty to perform any of the functions of, or to provide any of the reports required by, You by the Employee Retirement Income Security Act of 1974, as amended or any other applicable state or federal law. We assume no responsibility or obligation for the administration of Your Employee Benefit Plan or Your acts. We reserve the right to determine amounts payable under this Policy without regards to such acts.

J. ENDORSEMENTS: Any endorsements attached or subsequently issued by us shall become a part of this Policy.

K. ENTIRE AGREEMENT: This Policy and any attached endorsements, Your attached Application and your Plan Document are the entire agreement between You and Us. We have relied upon the underwriting information (including Complete Claims History and the Plan Document) provided by You in issuing this Policy and You represent such information is complete and accurate. Should We later learn such information was incomplete or incorrect, We have the right to modify the Policy as of the effective date to reflect the complete or correct information or to terminate the Policy.

L. INDEMNIFICATION, DEFENSE AND HOLD HARMLESS: You agree to indemnify, defend and hold Us harmless from any liability, including but not limited to, interest, penalties, attorney fees, extra contractual, exemplary or punitive damages ("expenses") arising from or relating to:

1. Any negligence, error, omission, defalcation or intentional acts by your Plan Supervisor, or

2. Any dispute involving Covered Person(s), former Covered Person(s), or any person(s) claiming entitlement to benefits under the Employee Benefit Plan, or

3. Any taxes We are assessed with respect to funds paid to or by You under Your Employee Benefit Plan, except any taxes or amounts paid to Us as premiums for this Policy.

We will promptly notify You upon discovery of matters to which Your obligations under this provision apply. We have the right to participate in the defense at Our expense. Without limiting the foregoing, if You fail to defend timely, We have the right, but not the duty, to defend and to compromise or settle the claim or other matters on Your behalf, for Your account and at Your risk.

M. INSOLVENCY: In the event of Your insolvency or bankruptcy, subject to the terms, conditions and limitations of this policy, We may pay to Your receiver, trustee, liquidator or legal successor amounts otherwise payable under this Policy. We will make such payments only if You have Paid all required premiums and have complied with Your obligations under this Policy. Nothing in this section shall increase Our liability beyond that which would have existed had You not become insolvent or bankrupt.

N. LEGAL ACTION: No legal action can be brought to recover under this Policy:

1. Until 60 days after the date a reimbursement claim is submitted, or

2. Two years after the date a reimbursement claim is required to be furnished. You shall notify Us in writing within 10 days after receipt of any objection, notice of legal action or complaint regarding Your handling of a claim.

O. NOTICE: Notice under this Policy will be given to You through Your Plan Supervisor and will be deemed to have been received by You.

P. OFFSET: We may offset payments due to You under this Policy against claims overpayments, cost containment charges and premiums due and unpaid.

Q. PAYMENT OF PREMIUMS:

1. Each premium is payable to HCC Life Insurance Company, P.O. Box 402032, Atlanta, GA 30384-2032 or such other place as We designate in writing.

2. Specific Stop Loss Insurance premiums are due on the first day of each calendar month, regardless of the effective date of the Policy. If the effective date is other than the first day of a calendar month, the first month's premium will be pro-rated.

3. Aggregate Stop Loss Premium(s) are due monthly or are payable in advance for the Policy Year, as stated in Your Application.

4. A grace period of thirty-one (31) days is allowed for the payment of each premium after the first premium. If the premium is not paid during the grace period, the Policy will terminate without further notice as of the premium due date.

5. If we terminate this Policy for non-payment of premium, application may be made for reinstatement.

   All outstanding premiums, including the current month's premium, must be remitted within 10 days of the end of the grace period.

   Payment of premiums shall not guarantee reinstatement of the Policy. We reserve the right to conduct a diligent review of the Complete Claims History and re-underwrite the Policy as We deem necessary as part of the terms for reinstatement.

   If the Policy is terminated more than one time during a Policy Year for non-payment, no requests for reinstatement will be granted.

6. In no event, will more than three (3) months of retroactive credit be granted for any clerical error(s) in the remittance of any premium.

R. POLICY NON-PARTICIPATING: This Policy is non-participating and does not entitle You to share in Our earnings.

S. RECORDS: You and / or Your Plan Supervisor will maintain such records as may be required by Us for this Policy and will make them available to us upon Our request. These records may include, but are not limited to, the Complete Claims History. We may audit Your records relating to this Policy and the claims filed under the Employee Benefit Plan at any time during the Policy Year and for two years after the expiration date of such Policy. Your records will include records held by You or by Your Plan Supervisor. As a result of any audit, We may readjust your Monthly Specific Premium Rates, Monthly Aggregate Factors, premiums, deductibles or expenses as may be necessary to reflect Our original intent in underwriting this Policy.

T. RENEWAL: Unless terminated for any of the reason(s) described in this Policy, Your insurance will be renewed for another Policy Year if You accept Our renewal terms. We will not change rates more than once in any Policy Year, except as allowed under the Changes and Termination Provisions in Article VII.

   We reserve the right to change the renewal premium rates and Monthly Aggregate Factors for the new Contract Period if the average monthly payments made by You for Plan Benefits during the last two months of the current Policy Year vary by more than 30% from the average of the monthly payments made for Plan Benefits during the previous ten (10) Contract Months.

   We will not offer a renewal if We are no longer doing business with Your Plan Supervisor.

U. SUBSIDIARIES AND AFFILIATED COMPANIES: You must notify Us in the event You acquire a subsidiary or affiliated company that will be included under Your Employee Benefit Plan. If You do acquire a subsidiary or affiliated company that will be included under Your Employee Benefit Plan, You must disclose certain claims information on the acquired subsidiary as a whole and / or on persons whose coverage You will be assuming under Your Employee Benefit Plan. Failure to do so will subject benefits under this Policy to certain limitations, as described under the ENTIRE AGREEMENT provision of this Article.

   Acquisition of a subsidiary or affiliated company that will be included under Your Employee Benefit Plan may affect Your Monthly Specific Premium Rates and/or Monthly Aggregate Factors, as described in the CHANGES AND TERMINATIONS provision of this Article.

You must notify Us in the event You cede or dissolve a subsidiary or affiliated company that was included under your Employee Benefit Plan. Failure to do so may subject this Policy to termination or may affect Your Monthly Specific Premium Rates and/or Monthly Aggregate Factors as described in the CHANGES AND TERMINATIONS provision of this Article.

V. TAXES: You shall hold Us harmless from any taxes, which may be assessed against Us with respect to Your Employee Benefit Plan or with respect to claims for Covered Expenses paid under the Policy, and You shall reimburse Us for such taxes, if any, as determined by Us.

W. YOUR DESIGNATED PLAN SUPERVISOR (YOUR TPA). We agree to recognize Your Plan Supervisor as Your agent and attorney-in-fact for the administration of Your Employee Benefit Plan. You agree that:

1. Your Plan Supervisor is Your agent and attorney-in-fact, and is not Our agent. You authorize Your Plan Supervisor to act in Your name, place and stead for purposes of this Policy, to include submission of proofs of loss, certifying the Payment of Plan Benefits, transmitting reports and payments of premiums to Us and receiving reimbursements from Us. Payments sent by Us to Your Plan Supervisor are payments to You. Premium payments by You through Your Plan Supervisor will be payments to Us only to the extent We actually receive them.

2. You or Your Plan Supervisor is responsible for administering Your Employee Benefit Plan, preparing reports as required by Us and keeping and making available to Us such data as We may require.

3. You or Your Plan Supervisor will perform such duties and keep such records as are required for You to comply with this Policy.

4. You will pay Your Plan Supervisor for all administrative functions performed in relation to this Policy.

5. We reserve the right to cease doing business with Your Plan Supervisor.

STOP LOSS INSURANCE

HCC LIFE INSURANCE COMPANY

Three Town Park Commons, 225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144 (800 447-0460)

APPLICATION

1. Full Legal Name of Applicant and Address
   City of Greenwood
   300 S. Main Street
   Greenwood, IN 46143
   Telephone No.:

2. Applicant is a (check one):
   ☐ Corporation ☐ Labor Union ☐ Trust
   ☐ Association ☐ PEO
   ☐ Partnership ☐ MEWA
   Other: **Government**

3. Contract Period: **Effective Date: 03/01/2015** **Expiration Date: 02/29/2016**

4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:

   Address of Affiliates or Subsidiaries: ☐ None ☐ See attached listing

5. Nature of Business of the Applicant to be Insured:
   Government

6. Key Contact Person at Applicant:
   MARILYN ALLEN

7. Enter full name of the Employee Benefit Plan(s): **City of Greenwood Employee Health Benefit Plan**
   A signed copy of such Employee Benefit Plan(s) must be attached and will form part of this contract.

8. Name and Address of Plan Supervisor:
   Advantage Health Solutions, Inc. 9045 River Road, Suite 200 Indianapolis, IN 46240

9. Agent of Record: **Regions Insurance, Inc.**

10. Estimated Initial Enrollment: **Single: 47 Family: 178 Total Covered Units: 225**

11. Retirees Covered: ☒ Yes ☐ No

12. The Utilization Review vendor will be: **Advantage Health Solutions, Inc.**

13. Deposit Premium (Minimum of first month's estimated premium): **$ 20,916.06**
    Please review the deposit premium on the Monthly Premium Accounting Worksheet.

14. **SPECIFIC STOP LOSS INSURANCE:** ☒ Yes ☐ No

    A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked):
    ☒ Medical ☒ Prescription Drug Card ☐ Prescription Drugs Under Medical ☐ Other:

    B. Specific Deductible in each Contract Period per Covered Person: **$125,000**

    C. Contract Basis: **24/12**
    Covered Expenses Incurred from 03/01/2014 through 02/29/2016, and Paid from 03/01/2015 through 02/29/2016.

    D. Unlimited Specific Lifetime Reimbursement Maximum per Covered Person
    Specific Contract Period Reimbursement Maximum per Covered Person **Unlimited**

    E. Separate Individual Specific Deductible: **Zane Davidson ($175,000 - 24/12 Contract Basis)**

    F. Monthly Specific Premium Rates: **(Based on Split Funded Endorsement)**
    Single: $38.69 Family: $96.71

    G. Specific Percentage Reimbursable **100%**

    H. Specific Terminal Liability Option: ☐ Yes ☒ No
    Specific Terminal Liability Option premium per Covered Person per month:

Applicant's Initials: MMA

15. **AGGREGATE STOP LOSS INSURANCE:** ☒ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):
☒ Medical ☐ Dental ☐ Weekly Income ☐ Vision ☒ Prescription Drug Card ☐ Prescription Drugs under Medical ☐ Other:

B. Minimum Annual Aggregate Deductible: **$4,239,542.76**
(Subject to the Definition of Minimum Annual Aggregate Deductible In the Policy)

C. Contract Basis: **24/12**
Covered Expenses Incurred from 03/01/2014 through 02/29/2016, and Paid from 03/01/2015 through 02/29/2016.
Run-in limit: N/A

D. Aggregate Contract Period Reimbursement Maximum: **$1,000,000**

E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Single	**$753.45**					
Family	**$1,785.86**					

F. Aggregate Percentage Reimbursable **100%**

G. Loss Limit: **$125,000**
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person, which can be used to satisfy the Annual Aggregate Deductible.

H. Monthly Deductible Advance Reimbursement Option: ☐ Yes ☒ No

I. Aggregate Terminal Liability Option: ☐ Yes ☒ No

J. Aggregate Premium:
1. ☐ Annual Premium payable in advance for Contract Period:
2. ☒ Monthly Premium rate per Covered Unit: **$ 8.37**
3. ☐ Monthly Deductible Advance Reimbursement premium per Covered Unit per month:
4. ☐ Aggregate Terminal Liability Option premium per Covered Unit per month:

Applicant's Initials: MAA

SPECIAL RISK LIMITATIONS are stated on the Addendum to Application (if applicable).

It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Plan Supervisor retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, and is subject to approval by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application, and all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Employee Benefit Plan(s) attached shall be the basis of any Stop Loss Insurance provided by the Company and such Employee Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant in accordance with the Employee Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Full Legal Name of Applicant: City of Greenwood

Applicant's Federal Tax I.D. Number: 356001050

Dated at Greenwood IN this 18 day of February, 2015.

Mark W. Myers
Officer / Partner Signature (print name)

Jon Pierre Fox
Licensed Agent Signature (print name)

For HCC Life Insurance Company Office Use Only: ACCEPTANCE

Accepted on behalf of the Company, this 20th day of March, 2015.

By: _____ Title: Senior Vice President

Policy No.: HCL19565

STOP LOSS INSURANCE
HCC LIFE INSURANCE COMPANY
ADDENDUM TO APPLICATION

Full Legal Name of Applicant: City of Greenwood

Effective Date: 03/01/2015

SPECIAL RISK LIMITATIONS:

The maximum amount of Covered Expenses that are eligible to satisfy the Annual Aggregate deductible for an individual who has been assigned a higher Separate Individual Specific Deductible will be the amount as shown under Loss Limit on the Application.

Officer/Partner Signature

Licensed Agent Signature

ADVANTAGE Health Solutions, Inc.[SM]

THIRD PARTY ADMINISTRATION AGREEMENT

This Third Party Administration Agreement (this "Agreement") is made between the City of Greenwood (the "Plan Sponsor"), City of Greenwood Employee Health Benefit Plan (the "Plan") and ADVANTAGE Health Solutions, Inc.[SM], an Indiana corporation ("ADVANTAGE") and shall be effective as of the first of April, 2012 (the "Effective Date"). The Plan Sponsor, the Plan and ADVANTAGE are each individually referred to herein as a "Party" and, collectively, as the "Parties."

RECITALS

WHEREAS, ADVANTAGE is an Indiana corporation licensed in Indiana as a health maintenance organization ("HMO") and as such is exempt from registration as a third party administrator pursuant to Indiana Code Section 27-1-25-1; and

WHEREAS, the Plan Sponsor has adopted and implemented the Plan, a self-insured employee welfare benefit group health plan that provides a means by which eligible employees of the Plan Sponsor and their eligible dependents may obtain benefits provided by the Plan as set forth in the Plan Documents (as defined below); and

WHEREAS, the Plan is a government plan and is not bound by the requirements of the Employee Retirement Income Security Act of 1974, as amended from time to time ("ERISA"); and

WHEREAS, ADVANTAGE, under the terms of this Agreement, shall assist the Plan Sponsor in the implementation and administration of the Plan.

AGREEMENT

NOW THEREFORE, in consideration of the mutual covenants and obligations contained herein, the Parties agree as follows:

For the purposes of this Agreement, the following words and phrases have the meanings set forth below:

ARTICLE I: DEFINITIONS

1.1 **ACH Transfer:** Refers to the electronic transfer of funds, including direct deposit and electronic payments.

1.2 **ADVANTAGE Proprietary Network:** A separately contracted integrated delivery system of participating providers that have agreed to provide Covered Services and a fee schedule for Claims pricing.

1.3 **Applicable Laws:** all applicable laws and regulations.

1.4 ***Care*-ADVANTAGE Program:** The ADVANTAGE patient-centric integrated population management services conducted by ADVANTAGE health professional resources to avoid unnecessary utilization, ensure utilization of Covered Services at the right place and right time, encourage Participants engagement, and reward providers to promote outreach and health preventions as more fully described in Exhibit A (*Care*-ADVANTAGE Program Description Summary).

1.5 **Claim:** A request by Claimant for payment or reimbursement.

1.6 **Claimant:** Any person or entity submitting a Claim.

1.7 **Claims Account:** means a segregated account established on behalf of Plan Sponsor by ADVANTAGE and funded by Plan Sponsor for payment or reimbursement of Covered Services.

1.8 **COBRA:** The Consolidated Omnibus Budget Reconciliation Act of 1986, as amended which may or may not apply to Plan Sponsor.

1.9 **Covered Services:** The care, treatments, services or supplies described in the Plan Document(s) as eligible for payment or reimbursement under the terms of the Plan.

1.10 **Data Processing Program:** The population management analytics and reporting services included in the *Care*-ADVANTAGE Program provided to Plan Sponsor by ADVANTAGE utilizing the reported paid medical and pharmacy claims associated with Participants under the Plan administered by Plan Administrator.

1.11 **Explanation of Benefits ("EOB"):** the explanation of benefits is a worksheet that provides details regarding how a medical claim was processed.

1.12 **Fees:** These monetary amounts and charges specifically listed and incorporated herein by reference as "Schedule B".

1.14 **HIPAA:** The Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder, as amended.

1.15 **Local Financial Manager:** Means the Plan Sponsor's assigned representative, for each of Plan Sponsor's locations, authorized, provided to ADVANTAGE in writing, by Plan Sponsor to exercise discretionary authority on Plan Sponsor's behalf regarding Claims Account and Premium Payment funding and payment.

1.16 **Participant(s):** Means any person who is eligible, properly enrolled and entitled to benefits under the terms of the Plan.

1.17 **Plan:** The self-insured employee welfare benefit plan which the Plan Sponsor has established pursuant to the Plan Document and which is made the subject of this Agreement, [Name of Plan].

1.18 **Plan Administrator:** Means the Plan Sponsor, as indicated in the Plan Documents and Summary Plan Description, responsible for the day to day functions, operations and management of the Plan.

1.19 **Plan Document:** Means the instrument or instruments, including Summary Plan Description that set forth and govern the duties of the Plan Sponsor, as the designated Plan administrator, as well as the eligibility and benefit provisions of the Plan which provide for the payment or reimbursement of Covered Services.

1.20 **Plan Sponsor:** Means the employer, City of Greenwood, Greenwood Indiana, who established the City of Greenwood Employee Health Benefit Plan as indicated in the Plan's Plan Document(s).

1.21 **Premium Payment:** Payment to ADVANTAGE by Plan Sponsor for the payment of Stop-Loss Reinsurance Premiums to be remitted by ADVANTAGE to the Stop-Loss Reinsurance carrier on behalf of Plan Sponsor.

1.22 **Protected Health Information (PHI):** Has the same meaning as the term "Protected Health Information" in HIPAA, limited to information created or received by one Party from or on behalf of the other Party. For the purpose of this Agreement, PHI includes Electronic Protected Health Information (EPHI) as defined in the Security Standards under HIPAA.

1.23 **Ministerial Functions:** Functions performed by ADVANTAGE with respect to this Agreement, within a framework of Plan Documents, policies, interpretations, rules, practices and procedures made or approved by or within the discretionary authority of the Named Fiduciary.

1.24 **Named Fiduciary:** Means the Plan Sponsor.

1.25 **Stop Loss Reinsurance:** A form of reinsurance purchased by the Plan Sponsor that limits the amount the Plan Sponsor will have to pay for each Participant's health care (individual limit) or for the total expenses of the Plan Sponsor (group limit).

1.26 **Summary Plan Description:** If the Plan Sponsor maintains a summary of the Plan Document, which is provided to Plan participants to summarize the terms of the Plan, such document shall be known as the Summary Plan Description

1.27 **Termination Package:** The reporting package described in Schedule A provided to Plan Sponsor upon termination, at Plan Sponsor's request and at an additional cost to Plan Sponsor.

1.28 **TPA:** A third party administrator, ADVANTAGE, contracted by Plan Sponsor to perform certain administrative functions and other services as more fully described herein.

ARTICLE II: TERM AND TERMINATION

Section 2.1 The term of this Agreement shall begin as of the Effective Date as set forth above and shall continue to and including March 31, 2013 (the "Term"), unless sooner terminated pursuant to the provisions of this Agreement. Unless either Party provides the other with at least sixty (60) days written notice prior to the end of the then current Term, the Term of this Agreement shall automatically renew for an additional one (1) year term, provided that ADVANTAGE reserves the right to increase the Fees payable by Plan Sponsor for such renewal Term to a mutually agreed upon rate. Any proposed increase of fees by ADVANTAGE must be provided in writing to Plan Sponsor at least ninety (90) days prior to the expiration of the current Term.

Section 2.2 ADVANTAGE's obligations under this Agreement apply only to Claims for Plan benefits that are incurred on or after the Effective Date and prior to the date this Agreement terminates or expires in accordance with its terms.

Section 2.3 In addition to the expiration or non-renewal provisions of this Agreement, this Agreement may terminate:

(A) At the discretion of ADVANTAGE after expiration of ten (10) business days' notice to Plan Sponsor for Plan Sponsor's failure to pay Fees or amounts due under this Agreement;

(B) At the discretion of ADVANTAGE, upon written notice from ADVANTAGE based upon Plan Sponsor's failure to provide funds necessary or required to adequately and timely fund the Claims Account; pay for benefits or Covered Services under the Plan; or produce checks for the payments of Claims with insufficient funds;

(C) At the discretion of ADVANTAGE, after expiration of ten (10) business days written notice, from ADVANTAGE based upon Plan Sponsor's failure to disclose any information or data necessary for ADVANTAGE's performance of services under this Agreement; or

(D) In the event either Party materially breaches a term, provision or warranty of this Agreement or defaults (other than for the foregoing reasons and those set forth in Section 2.4 below), and does not correct the breach to the non-breaching Party's reasonable satisfaction within thirty (30) days after receipt of written notice of breach form the non-breaching Party.

Section 2.4 In addition to the above, the occurrence of any one of the following events shall constitute a default under this Agreement, and the Party not in default may, at its option, immediately terminate this Agreement upon written notice to the other Party.

Section 2.4.1 If Plan Sponsor fails to pay any monies to ADVANTAGE pursuant to this Agreement within the applicable grace period;

Section 2.4.2 Thirty (30) days after either Party: (a) becomes insolvent, (b) is unable to pay its debts as they become due, (c) states in writing that it is not able to pay its debts as they become due, (d) makes an assignment for the benefit of its creditors, (e) files or has filed against it any proceeding in the United States Bankruptcy Court, (f) is subject to a levy, seizure, or sale of a substantial part of its property or assets on behalf of creditors, or (g) is subject to the appointment of a receiver for a period equal to greater than thirty (30) days;

Section 2.4.3 Upon either Party being dissolved, terminated, or ceasing to exist according to Applicable Law (hereafter defined); or

Section 2.4.4 Upon notice to the other Party if the other Party engages in fraud, misappropriation of funds, material misrepresentation or willful misconduct of any kind.

Section 2.5 In addition, either Party may terminate this Agreement, without cause, by providing the other Party at least sixty (60) days' written notice prior to the expiration of the term.

Section 2.5.1 If Plan Sponsor terminates this Agreement pursuant to Section 2.5 within six (6) months of the Effective Date, Plan Sponsor shall pay ADVANTAGE the implementation costs incurred by ADVANTAGE as well as any outstanding balances due ADVANTAGE for services performed under this Agreement up to and including the date of termination.

Section 2.6 Upon expiration or termination of this Agreement:

(A) **Claims Records.** Because the services provided by ADVANTAGE include access to the ADVANTAGE Proprietary Network, owned by ADVANTAGE, Plan Sponsor agrees to engage ADVANTAGE for a period of six (6) months following the date of expiration or termination of this Agreement to: administer all Claims incurred prior to such date and Plan Sponsor agrees to tender to ADVANTAGE immediately available funds in an amount equal to: (i) one-hundred percent (100%) of three (3) months of the

then current administration fees due ADVANTAGE pursuant to this Agreement based upon enrollment at the time of termination, to be paid to ADVANTAGE on or before the termination date of this Agreement, plus (ii) an additional three (3) months or run-out Fees at the rate of fifty percent (50%) of administration Fees as of the termination of this Agreement, to be paid to ADVANTAGE by the end of the second month after expiration or termination of this Agreement; and

(B) Unless within sixty (60) days of the expiration or termination period the Plan Sponsor sends ADVANTAGE a written request to receive all cases in the ADVANTAGE subrogation process, ADVANTAGE shall continue subrogation and recovery efforts on all such cases and agrees to remit to Plan Sponsor all proceeds it receives, minus the subrogation Fees set forth herein. In the event Plan Sponsor requests to receive subrogation cases from ADVANTAGE, it agrees to release ADVANTAGE and its subrogation vendor from and against any and all suits, claims, losses, fees, and expenses related to the subrogation cases and to reimburse ADVANTAGE for all out- of- pocket costs and expenses.

(C) At the time the standard termination reports are provided subsequent to expiration or termination of this Agreement and any applicable Claims run-out period, ADVANTAGE and the Plan Sponsor or Plan Administrator, as applicable, shall be relieved of further responsibility for performing any of the services enumerated in this Agreement.

Section 2.6.1 Outstanding Fees. Upon termination, the Plan Sponsor agrees to remit to ADVANTAGE any outstanding balances due as described in Article VII. ADVANTAGE shall have the right to retain all records as specified in Section 2.6 above until receipt of all outstanding monies due and in accordance with Section 2.8 below.

Section 2.6.2 Return of Funds. As soon as reasonably possible after the termination of this Agreement, ADVANTAGE shall deliver any funds of the Plan Sponsor or Plan in ADVANTAGE's possession to the Plan Sponsor or Plan, as applicable, or to any designated successor to ADVANTAGE.

Notwithstanding the expiration or termination date of this Agreement, this Section 2.6 shall be deemed to survive for the purpose of effectuating this Section.

Section 2.7 Any Party not in breach of this Agreement shall be entitled to exercise any remedy to which it is entitled at law or in equity and to enforce its rights under this Agreement, including without limitation, enforcement through specific performance, injunctive relief and the recovery of all costs arising from any litigation or mediation including, but not limited to, reasonable attorneys' fees.

Section 2.8 Retention of Books and Records. Each Party shall retain this Agreement as part of its official records for a minimum of six (6) years following the termination of this Agreement. In addition, notwithstanding anything to the contrary herein, ADVANTAGE may retain books and records related to this Agreement, as necessary to comply with its business operations and to meet its business requirements, for a minimum of six (6) years following the creation of such books and records, provided, that ADVANTAGE may transfer a copy of such books and records to a new administrator in the event this Agreement terminates and the Plan Sponsor and ADVANTAGE enter into a written agreement that provides for such transfer.

ARTICLE III: RESPONSIBILITIES OF ADVANTAGE

The Plan Sponsor and ADVANTAGE agree that ADVANTAGE is authorized to perform certain functions on behalf of Plan Sponsor as described in this Agreement (including the duties specifically described in this Article III) with respect to the Plan and in accordance with the Plan Documents.

Section 3.1 The Plan Sponsor is solely responsible for determining the terms, conditions, features and benefits of the Plan. At Plan Sponsor's request ADVANTAGE has provided a sample plan document template. ADVANTAGE makes no representations or warranties as to the adequacy or sufficiency of any Plan Documents, or as to any Plan Documents' compliance with any federal or state laws. The Plan Sponsor shall review and finalize the plan document(s) template with its own legal counsel to determine their adequacy and sufficiency prior to adopting such documents. The Plan Sponsor shall provide to ADVANTAGE a copy of the final, current and adopted Plan Document and Summary Plan Description (collectively, the "Plan Documents"), for the Plan, which ADVANTAGE shall use in performing its services under this Agreement.

Section 3.2 Receive on behalf of Plan Sponsor claims data and documentation from Participants and providers.

Section 3.3 Process Claims submitted by Participants and providers according to the Plan Documents and Summary Plan Description, as construed by the Plan Sponsor and in accordance with ADVANTAGE's standard Claims service described below:

(A) adjudicate (exercising ordinary care and reasonable diligence) benefit Claims and in connection therewith:
   1. maintain the eligibility of Participants and the status of Claims on ADVANTAGE's computer systems; and
   2. review Claims submitted and evaluate whether such Claims have been properly submitted;

(B) provide a notice of benefit determination to Participants and providers as appropriate;

(C) prepare standard Claims activity reports, check registers, identification cards, enrollment forms and fund reports;

(D) respond to inquiries from Participants and providers regarding benefits available or status of Claims; and

(E) on a weekly basis, notify the Plan Sponsor of the amount of funds necessary to pay the adjudicated benefit Claims and any plan expenses (which Plan Sponsor shall pay in accordance with Article IV in its entirety).

The Parties acknowledge and agree that ADVANTAGE shall perform these services as a non-fiduciary claims administrator. The Plan Sponsor (or other entity identified in the Plan Documents) is the Plan Administrator of the Plan and is and shall remain responsible for any and all Claims decisions under the Plan, including the exercise of any discretion in deciding Claims or construing the terms of the Plan. ADVANTAGE shall refer to Plan Sponsor (or other entity identified in the Plan Documents), for its exclusive and final resolution, of any questions concerning the meaning of any part of the Plan Documents and Summary Plan Description, or the validity of any questionable or disputed Claims.

Section 3.4 Process appeals in accordance with Plan Sponsor's Plan Documents and Summary Plan Description and refer to Plan Sponsor (or other entity identified in the Plan Documents), for its exclusive and final resolution, of any appeals from any denial of any of Claims.

Section 3.5 Process, print and remit checks from the Claims Account as instructed by the Plan Sponsor, to Participants, providers or others as may be applicable in accordance with Plan Documents, and the applicable ADVANTAGE Self-Funded Financial Policies and Procedures which shall be included as an attachment to this Agreement and referred to and incorporated herein by reference as ADVANTAGE Self-Funded Financial Policies and Procedures for Claims Account, upon Plan Sponsor's agreement and available to Plan Sponsor upon request.

Section 3.6 Deliver to the Plan Sponsor via secured e-mail (or such other delivery method mutually agreed to by the Parties) an accounting of the transactions performed by ADVANTAGE pursuant to this Agreement and affecting the Claims Account and Premium Payment (if applicable.)

Section 3.7 Deliver to the Plan Sponsor copies of ADVANTAGE's electronic files with respect to the Claims within ninety (90) days of the termination of this Agreement subject to the payment by Plan Sponsor of all monies due ADVANTAGE.

Section 3.8 Provide a HIPAA compliant Certificate of Creditable Coverage whenever a Participant terminates coverage under the Plan and a HIPAA Certificate of Creditable Coverage file to Plan Sponsor upon termination of this Agreement. The document will provide the period of coverage beginning on the Participant's date of enrollment (if provided by the Plan Sponsor) and ending on the Participant's date of termination as verified by eligibility records provided by Plan Sponsor.

> **Section 3.8.1** Notwithstanding the above, Plan Sponsor is responsible for all aspects of COBRA compliance under the Plan, including providing timely and proper notification of COBRA rights to Participants and qualified beneficiaries. ADVANTAGE shall not be responsible for any COBRA duties under this Agreement unless specifically stated herein.

Section 3.9 *Care*-ADVANTAGE. ADVANTAGE shall provide *Care*-ADVANTAGE Program services to the Plan. *Care*-ADVANTAGE Program services shall include: prior authorization of services in accordance with the Plan Document, utilization management review, concurrent review, disease management, discharge planning, continuity and transition of care management, and complex case management.

Section 3.10 Stop-Loss Reinsurance. Subject to the terms of Article IV, Section 4.8 hereof, and as requested by Plan Sponsor, use commercially reasonable efforts to procure Stop Loss Reinsurance proposals (specific and/or aggregate) for the Plan Sponsor's consideration, which reinsurance shall be an asset of the Plan Sponsor and not of the Plan (the "Stop-Loss Reinsurance"), and prepare and file reinsurance claims, on behalf of Plan Sponsor, associated with Stop-Loss Reinsurance.

> **Section 3.10.1 Duties Related to Stop- Loss Reinsurance.** The Plan Sponsor shall have final authority to decide whether to purchase Stop- Loss Reinsurance, the type and level of coverage and with which insurer such coverage shall be placed. The Plan Sponsor shall remain solely responsible for timely payment of Premium Payments under the Stop-Loss Reinsurance policy. Subsequent to Plan Sponsor's securing of such coverage, ADVANTAGE shall provide reporting and Claim filing services to the relevant Stop- Loss Reinsurance carrier.
>
> Additionally, for any benefit Claim that is received by ADVANTAGE during the last thirty (30) days of any Stop Loss Reinsurance year, ADVANTAGE may, but shall in no event be under any obligation to, discharge its duties in such a manner as may be required to cause the applicable reimbursement to the Plan Sponsor or the Plan, as applicable, to occur as part of the same Stop Loss Reinsurance year.

Section 3.11 To the extent maintained by ADVANTAGE and as applicable to Plan Sponsor, provides the Plan Sponsor with the information ERISA requires, within the time frame required by ERISA, to enable the Plan Sponsor to file the annual report (IRS Form 5500) for the Plan.

Section 3.12 Provide access to the ADVANTAGE Proprietary Network. Such access will be subject to each participating network's terms and conditions and the right of the network to grant access to the Plan Sponsor for the Plan. Plan Sponsor understands that each participating network shall have the right to determine the level of discount to be offered to Plan Sponsor and that ADVANTAGE does not control nor shall be held liable for participating network's discount.

Section 3.13 ADVANTAGE shall provide the *Care*-ADVANTAGE Program as indicated in Article III, Section 3.9, which may be modified and updated from time to time, and which will govern functions including Data Processing Program's reporting, administrative responsibilities, requirements for cooperation and participation between the Plan and ADVANTAGE to support the population management strategies, and other Data Processing Program requirements. The *Care*-ADVANTAGE Program Description Summary is attached and incorporated herein as Exhibit A.

(A) ADVANTAGE shall use its best efforts to perform all services, program interventions, reporting and outreach activities related to the *Care*-ADVANTAGE Program in a manner that promotes the highest degree of Participant's engagement, improved outcomes, and cost avoidance. These services shall include those services listed in Exhibit A.

Section 3.14 ADVANTAGE shall comply with the HIPAA Business Associate Agreement attached hereto as Exhibit B.

Section 3.15 If elected by Plan Sponsor and the Plan meets ADVANTAGE's requirements for a dedicated line; provide Plan Participants with a toll free telephone number for servicing for a fee as indicated in Article VII.

Section 3.16 Maintain adequate records of Claims made and benefits paid in such form and format as may be convenient for ADVANTAGE for a period of six (6) years or longer if required by Applicable Law.

Section 3.17 If it is subsequently determined that any Claims or Premium payment was incorrect, ADVANTAGE will use reasonable efforts to promptly correct the error. In no event shall ADVANTAGE be required to initiate court proceedings for any such recovery.

Section 3.18 Provide additional services not specified in this Agreement but incorporated in writing by way of an amendment to this Agreement, as mutually agreed upon in writing by the Plan Sponsor and ADVANTAGE for additional Fees.

Section 3.19 Provide reasonable assistance to Plan Sponsor in pursuing rights of recovery arising from: coordination of benefits, bill negotiation, discount programs, cost management, subrogation and fraud detection. Such services are subject to those Fees set forth in Article VII.

Section 3.20 Renewal. ADVANTAGE will present a renewal proposal at least ninety (90) days prior to expiration of the term.

ARTICLE IV: RESPONSIBILITIES OF PLAN SPONSOR

The Plan Sponsor shall perform the following responsibilities during the Term:

Section 4.1 Preparation of Eligibility List and Plan Information. The Plan Sponsor shall prepare an initial complete and accurate set of enrollment records for all Participants and deliver such records to ADVANTAGE no less than thirty (30) days prior to the Effective Date of this Agreement. Thereafter, the Plan Sponsor shall notify ADVANTAGE, in writing of any and all changes in Participant status (including, without limitation, the addition of new Participants, termination or layoff, changes in dependent status or any other changes that may affect the eligibility of a Participant) within fifteen (15) days of the date Plan Sponsor becomes aware of such change by promptly updating such records in writing or by any other medium acceptable to ADVANTAGE, in ADVANTAGE's sole discretion and shall include the following with respect to each Participant: name and address, social security number, date of birth, type of coverage, sex, relationship to employee, changes in coverage, date coverage begins or ends, and any other information necessary to determine eligibility and coverage levels under the Plan. If the Plan Sponsor submits a termination record to ADVANTAGE, which is retroactive in accordance with federal regulations and all Applicable Laws, ADVANTAGE will not be obligated to adjust administrative Fees, premiums, or vendor costs retroactively for more than sixty (60) days.

> **Section 4.1.1** Resolve or cause to be resolved by an authorized entity identified in Plan Documents, all ambiguities and disputes relating to the Plan eligibility of Participant, Plan Coverage, denial of Claims and decisions regarding appeals of denials of Claims, as well as any other Plan interpretation questions.

Section 4.2 Establish, maintain and fund a bank account to be designated as the Claims Account, and execute and deliver to ADVANTAGE any and all documents necessary to empower ADVANTAGE to release funds by issuing checks with Plan Sponsor's name, if and as requested and authorized by Plan Sponsor and/or Plan as specifically described in the ADVANTAGE Self-Funded Financial Policies and Procedures applicable to the Claims Account which shall be included , upon Plan Sponsor's approval, and available to Plan Sponsor upon request.

Section 4.3 Section 4.3 Claims Funding.

(A) The Plan Sponsor shall be solely responsible for funding the payment of benefits and expenses under the Plan, either through:

1. collection of premiums or contributions from Participants;
2. need insert here
3. purchase of reinsurance; or
4. a combination of the foregoing.

(B) On a weekly basis, ADVANTAGE shall notify the Plan Sponsor's Local Financial Manager of the funds required to satisfy the Plan's expense and benefit obligations, including the adjudicated benefit Claims under Article IV above. Within forty-eight (48) hours of receiving such notice, the Plan Sponsor's Local Financial Managers must notify ADVANTAGE if they want to remove any payment from the funding. If notification is not received by ADVANTAGE within forty-eight (48) hours, ADVANTAGE will deem its notice to the Local Financial Manager as accepted and authorized and will initiate an ACH transfer to deposit funds into the Claims Account, from accounts specified by the Local Financial Manager. The ACH transfer of funds shall be in an amount sufficient to satisfy all expense and benefit obligations as specified by ADVANTAGE in such notice. If a Local Financial Manager notifies ADVANTAGE within forty-eight (48) hours of its desire to remove a payment from funding, the specific check will be withheld by ADVANTAGE until the Local Fund Manager notifies ADVANTAGE to release the check or such Claim is reversed. ADVANTAGE will not be responsible for any consequences resulting from Plan

Sponsor's untimely funding of Claims, Plan Sponsor's Local Financial Manager's delay in providing any notification to ADVANTAGE or the non-release or reversal of any Claim per Plan Sponsor Local Financial Manager's instructions.

(C) The Plan Sponsor recognizes its responsibility to fund all benefits payable under the Plan, and all expenses of the Plan, including the benefit Claims liability as stated above in this Section 4.3. If the Plan Sponsor does not provide funding within fifteen (15) calendar days of ADVANTAGE's notice regarding funding, ADVANTAGE has the right, but not a duty, to notify Participants and health care providers of the delinquency of funding. ADVANTAGE shall earn any applicable service Fees set forth in Article VII attached hereto in connection with providing such notice. In the event of such delinquency, ADVANTAGE may also suspend the processing of all Claims and the issuance of checks and EOBs to Participants.

(D) The Plan Sponsor acknowledges that in the event the Plan is discontinued or canceled or this Agreement terminates, the Plan Sponsor is responsible for funding payment of all Claims incurred prior to the date of such discontinuance, cancellation or termination. This Section 4.3 (D) shall survive the discontinuation of the Plan, the cancellation or termination of this Agreement.

Section 4.4 ACH to ADVANTAGE, within twenty (20) days of Plan Sponsor's receipt of funding of ADVANTAGE's invoice, all monies that ADVANTAGE requests for reimbursement of monies expended to obtain medical records or to investigate Claims, which expenses shall be borne solely by Plan Sponsor.

Section 4.5 ACH payment to ADVANTAGE, by the due date, of all monies that ADVANTAGE requests for pre-approved expenses incurred for professional services rendered to or on behalf of the Plan Sponsor or in connection with ADVANTAGE's obligations under this Agreement.

Section 4.6 ACH payments to ADVANTAGE, by the due date, of all monies that ADVANTAGE requests for expenses incurred to print materials for Plan Sponsor, which expenses shall be borne solely by Plan Sponsor.

Section 4.7 Forward payment to ADVANTAGE, by the due date, of those Fees for services rendered under this Agreement as set forth in Article VII hereof.

Section 4.8 In the event that Plan Sponsor desires to engage ADVANTAGE to assist, at Plan Sponsor's request, in securing and placing Stop- Loss Reinsurance for the Plan Sponsor, and the Plan Sponsor requests ADVANTAGE to remit, on Plan Sponsor's behalf, premiums due and owed to the Stop-Loss Reinsurer in connection with such coverage, Plan Sponsor shall issue a Premium Payment check payable to ADVANTAGE. ADVANTAGE shall deposit Premium Payment in its account and promptly transfer such Premium Payment to Stop-Loss Reinsurer via ACH Transfer.

Section 4.8.1 If Plan Sponsor requests ADVANTAGE to remit payment, on Plan Sponsor's behalf to Stop-Loss Reinsurer, Plan Sponsor shall execute and deliver to ADVANTAGE and to the chosen depository, any and all documents necessary to empower ADVANTAGE to accept such Premium Payment and remit payment to Stop-Loss Reinsurer. Plan Sponsor must remit Premium Payment to ADVANTAGE within forty-eight (48) hours of receipt of invoice from ADVANTAGE. In the event Plan Sponsor fails to abide by the forty-eight (48) hours requirement, Plan Sponsor shall be solely responsible in the event of ADVANTAGE's untimely remittance of Premium Payments to Stop-Loss Reinsurer.

Section 4.9 Promptly notify ADVANTAGE of any termination, expiration, lapse or modification of Stop-Loss Reinsurance.

Section 4.10 Hold confidential such information respecting ADVANTAGE which is obtained by or disclosed to the Plan Sponsor, and which is proprietary to ADVANTAGE. Such information includes, but is not limited to, provider contracting arrangements, ADVANTAGE's fee schedules, Claims administration guidelines, and ADVANTAGE's practices and procedures.

Section 4.11 Pay any and all taxes, licenses and fees levied, if any, by any local, state or federal authority in connection with the Plan.

Section 4.12 Maintain and operate the Plan in accordance with all Applicable Laws and regulations. Plan Sponsor shall provide and timely distribute all applicable notices, information, materials and documents required to be given to Participants under Applicable Laws, and maintain all recordkeeping, and file all forms relative to the Plan, as required under Applicable Laws. In addition, Plan Sponsor shall timely prepare or cause to be prepared, and timely execute, any documents, forms or contracts respecting the Plan that are required by Applicable Laws.

Section 4.13 Plan Documentation. The Plan Sponsor shall provide ADVANTAGE with a final and current copy of the Plan Documents and Summary Plan Description which ADVANTAGE will follow and rely upon to provide the services described under this Agreement. Plan Sponsor shall also provide ADVANTAGE with copies of any and all revisions or changes to the Plan at least thirty (30) days prior to the effective date of such change.

Section 4.14 The Plan Sponsor shall notify ADVANTAGE in writing upon:

(A) acquisition of any new or different contract relating to the Plan, or upon any change in the Plan Sponsor's organization which might affect the legal status of the Plan; and

(B) any change in the Plan benefits at least thirty (30) days prior to the effective date of such change. Any change requiring an adjustment of Claims shall be performed by ADVANTAGE only for an additional fee mutually agreeable to the Parties.

Section 4.15 Plan Administrator and Named Fiduciary. The Plan Sponsor shall serve as the Plan Administrator and the Named Fiduciary of the Plan. The Plan Sponsor shall remain ultimately responsible with respect to all fiduciary duties relating to the management of the Plan or disposition of plan assets having discretionary authority or responsibility respecting the administration of the Plan, including but not limited to, processing, adjudication and payment of Claims and Claims appeals and shall be the named fiduciary for such purposes. ADVANTAGE is a non-fiduciary claims administrator under the Plan, and does not, and is not authorized to, exercise any discretionary authority or discretionary control over the management of the Plan or the management or disposition of the Plan's assets. The Plan Sponsor shall retain sole full and final authority and responsibility for the Plan and its administration and operation, including the final determination on Claims payable under the Plan.

Section 4.16 Settlement of Claims. The Plan Sponsor shall timely notify ADVANTAGE of any inquiries it receives regarding the activities undertaken by ADVANTAGE and shall assist ADVANTAGE in any reasonable manner with regard to ADVANTAGE's obligations under this Agreement. In addition, the Plan Sponsor shall fully cooperate with ADVANTAGE as and to the extent necessary for ADVANTAGE to effectively respond to such inquiry.

Section 4.17 Regulatory Reporting. If, at any time, a governmental authority requires ADVANTAGE to submit data or information regarding this Agreement or on behalf of the Plan, the Plan Sponsor shall fully cooperate with ADVANTAGE to the extent necessary to respond to the requirement. If the Plan Sponsor fails to cooperate, and as a result, ADVANTAGE incurs a penalty or fine, the Plan Sponsor shall reimburse ADVANTAGE upon written notice and proof of funds due.

Section 4.18 Banking Arrangements. Funding of benefits shall be made by the Plan Sponsor from funds as described in Section 4.3. The checks to pay Claims shall be in a form mutually agreed upon by the Parties. ADVANTAGE shall print and release such checks weekly, as approved by Plan Sponsor, or more frequently as specifically described in the ADVANTAGE Self-Funded Financial Policies and Procedures for Premium Payment which shall be included, upon Plan Sponsor's approval, and available to Plan Sponsor upon request. ADVANTAGE shall be responsible for the costs, if any, and maintenance of the Claims Account. If the Parties have agreed, ADVANTAGE will remit payments to the Stop Loss Reinsurer. ADVANTAGE shall remit payments to the Stop Loss Reinsurer from funds made available by Plan Sponsor to ADVANTAGE by check to ADVANTAGE as more specifically described in the ADVANTAGE Self-Funded Financial Policies and Procedures for Premium Payment. ADVANTAGE will remit the Premium Payment to Stop-Loss Reinsurer on behalf of Plan Sponsor as more specifically described in the ADVANTAGE Self-Funded Financial Policies and Procedures for Premium Payment.

Section 4.19 Plan Information. The Plan Sponsor shall be solely responsible for delivering to Participants all Plan information, including the Plan Documents, any summaries of material modifications or summary annual reports and any other information required by the U.S. Department of Labor or any other applicable federal or state agency. The Plan Sponsor shall also be solely responsible for notifying Participants and beneficiaries if this Agreement is cancelled or terminated for any reason by either Party.

Section 4.20 Safeguard the privacy and confidentiality of PHI regarding Participants. Plan Sponsor warrants that it has obtained a certification by Plan that the Plan Documents have been amended to allow Plan Sponsor to receive certain PHI, to incorporate the following provisions and that the Plan Sponsor agrees to: (A) not use or further disclose the information provided by Plan other than as permitted or required by the Plan Documents or as required by law; (B) ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (C) not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. Plan Sponsor also agrees to adopt and maintain policies and procedures to ensure that it will not use and/or disclose PHI except as permitted or required by regulations promulgated under HIPAA and any applicable State laws and regulations. Plan Sponsor shall establish security measures to ensure that PHI is not used or disclosed by an employee who does not need to access such information for purposes of Plan administration, and to provide ADVANTAGE with a signed certification indicating its compliance with these requirements. Plan Sponsor will not request ADVANTAGE to disclose PHI except as consistent with the HIPAA regulations, the Plan Documents, the Business Associate Agreement, and any applicable state laws or regulations. Plan Sponsor will include in its Notice of Privacy Practice to Plan Participants a statement that the Plan's third party administrators may use and disclose PHI on behalf of the Plan as set forth in the Plan Documents and subject to all Applicable Laws. Plan Sponsor will obtain the proper consents and authorizations for ADVANTAGE to disclose PHI if ADVANTAGE is directed by Plan Sponsor to disclose such information. The Plan and ADVANTAGE have executed the HIPAA Business Associate Agreement, attached hereto as Exhibit B, authorizing ADVANTAGE to act as a business associate of the Plan.

ARTICLE V: RELATIONSHIP OF THE PARTIES

Section 5.1 Relationship of the Parties. In performing services under this Agreement, ADVANTAGE performs all acts as an independent contractor and not as an officer, employee or agent of the Plan Sponsor, Plan Administrator (if other than the Plan Sponsor) or Plan. Nothing in this Agreement shall be construed to mean that the Plan Sponsor retains any control over the manner and means of how ADVANTAGE performs the services provided for herein, but only a right to review the results of the work performed except to the extent ADVANTAGE requires Plan Sponsor's authorization. ADVANTAGE does not assume any responsibility for any act, omission or breach by a Plan fiduciary.

ADVANTAGE does not assume liability for the adequacy of funding of the Plan, and ADVANTAGE is not, and shall not be deemed to be, an insurer, underwriter or guarantor with respect to any benefits payable under the Plan. Benefits under the Plan are not insured by an insurance company, health maintenance organization, or other entity regulated by a state insurance regulatory body. The Plan Sponsor retains ultimate responsibility for payment of any and all benefits under the Plan and all expenses incident to the Plan.

Section 5.2 Business Associate Agreement. ADVANTAGE is a "business associate" with respect to the Plan, pursuant to HIPAA, and the Health Information Technology For Economic and Clinical Health Act, Division A of Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act"). The Parties agree to enter into an agreement setting out the applicable commitments and obligations under the HIPAA and HITECH Act privacy and security rules (the "Business Associate Agreement"), the terms of which are incorporated herein by reference and attached to this Agreement as Exhibit B.

ARTICLE VI : ACKNOWLEDGEMENTS AND REPRESENTATIONS

Each of the Parties expressly acknowledges and represents to the other Party as follows:

Section 6.1 By entering into this Agreement, the Plan Sponsor is delegating to ADVANTAGE only those powers and responsibilities with respect to the Plan which are specifically enumerated herein. Any function not specifically delegated to and assumed by ADVANTAGE pursuant to this Agreement shall remain the sole responsibility of the Plan Sponsor.

Section 6.2 The Parties mutually represent and warrant to one another that: (a) no further corporate approval from either of the Parties is necessary for this Agreement to be effective; (b) each of the Parties has the legal power, authority and right to enter into, and perform its respective obligations under, this Agreement, and (c) each Party's execution of, delivery of and performance under this Agreement shall not constitute a violation of any oral or written agreement to which it is a Party or by which it is bound.

Section 6.3 With respect to the satisfaction of Claims or other obligations arising under the Plan, ADVANTAGE shall not be obligated to disburse more than the amount made available by the Plan Sponsor for disbursement from the Claims Account.

Section 6.4 ADVANTAGE shall not, under any circumstance, be responsible to use its corporate assets to satisfy any Claim or expense that is the responsibility of the Plan Sponsor, the Plan or any Participant.

Section 6.5 This Agreement shall not be deemed a contract of insurance under any Applicable Laws. ADVANTAGE does not insure, guarantee or underwrite the liability of the Plan Sponsor under the Plan. The Plan Sponsor, and not ADVANTAGE, shall remain solely liable for the payment of Claims and all other expenses incidental to the Plan.

Section 6.6 ADVANTAGE owes a duty of care only to the Plan Sponsor, which duty is one of reasonable care under the attendant circumstances. ADVANTAGE is not liable for any mistake of judgment or for any action taken in good faith.

Section 6.7 The Plan Sponsor acknowledges that it is the Plan Sponsor, Plan Administrator and Named Fiduciary with respect to the Plan, as such terms are defined herein and by the Plan's Plan Documents and Summary Plan Description. As such, the Plan Sponsor shall at all times retain full discretionary control, authority and responsibility with respect to the operation and administration of the Plan and Plan assets. The Plan Sponsor agrees that ADVANTAGE's role will be limited to that of a provider of the non-fiduciary services specified under this Agreement, that the services rendered by ADVANTAGE under this

Agreement will not include the power to exercise discretionary authority over Plan operations or plan assets (if any), and that ADVANTAGE will not for any purpose, under ERISA or otherwise, be deemed to be the Plan Administrator of the Plan or a Fiduciary with respect to the Plan. ADVANTAGE's services under this Agreement are intended to and will consist only of those Ministerial Functions and will be performed within the framework of policies and interpretations established by the Plan Sponsor. The Plan's benefit and coverage design has been selected by the Plan Sponsor and the Plan Sponsor is solely responsible for that design. The Plan Sponsor retains all discretionary authority with respect to the Plan and the administration of the Plan.

Section 6.8 ADVANTAGE shall administer and adjudicate Claims in accordance with Article III, hereof if the Plan Document and Summary Plan Description are clear and unambiguous as to the validity of Claims and the Participants' eligibility for coverage under the Plan. ADVANTAGE shall have no discretionary authority to interpret the Plan or to adjudicate Claims. If adjudication of a Claim requires interpretation of ambiguous Plan language, and the Plan Sponsor has not previously indicated to ADVANTAGE the proper interpretation of such language, then the Plan Sponsor shall be responsible for resolving the ambiguity or any other dispute arising therefrom. In any event, the Plan Sponsor's decision as to any Claim (whether or not it involves a Plan ambiguity or other dispute) shall be final, subject only to appeals allowed by Applicable Law.

Section 6.9 The Plan Sponsor represents and warrants to ADVANTAGE that the Plan is in full compliance with, and shall at all times during the Term remain in full compliance with, all Applicable Laws.

Section 6.10 The work to be performed by ADVANTAGE under this Agreement may, at ADVANTAGE's discretion be performed directly by it or wholly or in part through a subsidiary or affiliate of ADVANTAGE, or by another organization, agent, advisor or other person(s) with which ADVANTAGE has an arrangement.

Section 6.11 ADVANTAGE shall be entitled to rely, without investigation or inquiry, upon any written (including but not limited to electronic) communication of the Plan Sponsor or its agents.

Section 6.12 In the event that the Centers for Medicare and Medicaid Services ("CMS") determine that the Plan has underpaid a Claim under Medicare Secondary Payer laws the Parties acknowledge that Plan assets will be used to correct such underpayment. Under no circumstances will ADVANTAGE be required to make such payment with ADVANTAGE funds, regardless of when CMS requires such payment, during or after the term of this Agreement, provided that such underpayment is not due to ADVANTAGE's gross negligence, bad faith, or willful misconduct. This provision shall survive the expiration or termination of this Agreement.

Section 6.13 The Plan Sponsor agrees and acknowledges that ADVANTAGE is not liable for any act or omission by any Provider or for a Provider's failure or refusal to provide services or supplies. Care and treatment received by Plan Participants are subject to the rules and regulations of the Providers.

Section 6.14 The Plan Sponsor agrees and acknowledges that ADVANTAGE and its employees shall not be liable, under any circumstances, for the action or lack thereof by any Provider under theories of vicarious liability, agency, ostensible authority, respondent superior, imputed liability, or any other theory of liability.

Section 6.15 The Plan Sponsor agrees and acknowledges that it is solely responsible for selecting the Stop-Loss Reinsurance broker, carrier, and policy coverage that is utilized in securing Stop-Loss Reinsurance for the Plan. Stop-Loss Reinsurance policy coverage includes the Plan Sponsor's

deductible/retention exposures, Claim submission requirements/limitations, and contract exclusions. The Plan Sponsor agrees to provide ADVANTAGE a copy of the insurance binder or policy within thirty (30) days of the effective date of the procurement of Stop-Loss Reinsurance coverage. The Plan Sponsor agrees and acknowledges that ADVANTAGE shall not be liable for any acts or omissions in connection with the placement or administration of the Stop-Loss Reinsurance policy, unless such acts or omissions were solely due to ADVANTAGE's gross negligence, bad faith, or willful misconduct. The Plan Sponsor agrees to promptly notify ADVANTAGE if any information provided to the Stop-Loss Insurance carrier on behalf of the Plan Sponsor is incomplete or inaccurate. ADVANTAGE does not insure or otherwise provide any guarantees with respect to the adequacy of the Stop-Loss Reinsurance selected by the Plan Sponsor, nor does ADVANTAGE make any representations regarding a Stop-Loss Reinsurance carrier's obligation to reimburse the Plan Sponsor for any Plan costs, including state-imposed surcharges, taxes, or assessments. The Plan Sponsor agrees and acknowledges that quotes issued by Stop-Loss Reinsurers are often subject to the insurer's final underwriting guidelines after coverage is placed. Quotes that are subject to final underwriting may allow the insurer to change the terms of the policy, including but not limited to changing the premiums, specific and aggregate retention levels, and excluding or limiting coverage for certain Participants. ADVANTAGE shall, upon Plan Sponsor's request, use commercially reasonable efforts to submit adequate information to the insurer to limit changes the insurer can make in the final underwriting process, but ADVANTAGE shall not be liable for Plan Sponsor's failure to provide full, complete and timely information to secure Stop-Loss Reinsurance coverage, or for changes made by the insurer arising out of final underwriting.

Section 6.16 ADVANTAGE shall not be liable for any payments, underpayments, fines, penalties, interest or other charges assessed by any governmental or regulatory agency, whether state or federal, in connection with the surcharge(s) and/or assessments due with respect to the Plan pursuant to Applicable Laws. The Plan Sponsor shall remain solely liable for any such payments, underpayments, fines, penalties, interest or other charges so assessed, and shall indemnify ADVANTAGE in the event same are assessed against ADVANTAGE.

Section 6.17 ADVANTAGE represents that it is enrolled in the E-Verify Program (the electronic verification of work authorization program of the Illegal Immigration Reform and Immigration Responsibility Act of 1996 (P.L. 104-208), Division C, Title IV, s.401(a), as amended, operated by the United States Department of Homeland Security or a successor work authorization program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work authorization status of newly hired employees under the Immigration Reform and Control Act of 1986 (P.L. 99-603) and that it verifies the work eligibility of its newly hired employees through the E-Verify Program. ADVANTAGE understands that it will not be required to verify the work status of its newly hired employees through the E-Verify Program if such program ceases to exist. ADVANTAGE does not employee any "unauthorized aliens" as that term is defined in 8 U.S.C. § 1324a(h)(3). ADVANTAGE will complete and return an E-Verify Affidavit contemporaneously with the execution of this Agreement in the form attached hereto as Exhibit C.

ARTICLE VII: FEES

Section 7.1 The following services will be provided under this Agreement at the fees and charges indicated below. These fees and charges are collectively referred to in this Agreement as "Fees" and are specifically listed and incorporated herein by reference as "Schedule B". Unless otherwise stated, the monthly Fees are calculated by multiplying the following rates by the applicable number of employees

enrolled in the Plan each month and adding the result to the specific fees stated below or elsewhere in this Agreement.

The Fees set forth in this Article VII are based on information provided to ADVANTAGE by the Plan Sponsor, including without limitation, information regarding the average number of Participants enrolled in the Plan. ADVANTAGE has relied on that information in developing the Fees. Should there be a material change in this information; ADVANTAGE shall be entitled to adjust the Fees consistent with its customary fees. All Fees listed in this Agreement are subject to change in the event the number of Participants increases or decreases by more than twenty-five (25%) during the Term of this Agreement.

The Plan Sponsor agrees to pay the Fees set forth in this Agreement subject to the terms and conditions of this Agreement, as well as other applicable agreements ADVANTAGE may have with any other vendor.

Section 7.2 Terms of Payment of Fees. The Plan Sponsor agrees to pay ADVANTAGE the Fees as indicated in this Agreement within fifteen (15) days of receipt of the monthly invoice provided by ADVANTAGE, via electronic mail (confirmed receipt) on or about the first week of the current month. The Plan Sponsor shall pay each Fee and any other Fees and reimbursable expenses owing to ADVANTAGE by remitting a check to the address on the monthly electronic invoice for receipt of Fees under this Agreement. The Plan Sponsor shall not commingle the payment of Fees due to ADVANTAGE with any other funds or payments. The Plan Sponsor must notify ADVANTAGE in writing within fifteen (15) days of the Plan Sponsor's receipt of each invoice of any discrepancy regarding the Fees charged in such invoice, in which event the Parties shall reasonably cooperate to reach a mutually agreeable solution to such discrepancy; otherwise, ADVANTAGE's Fees shall be as reflected in the invoice presented.

Section 7.3 Prompt Payment Statute. If the Fees are not paid by the fifteenth (15^{th}) day after receipt of the invoice and applicable documentation, the Plan Sponsor shall be subject to a one percent (1%) late charge fee per month, in accordance with Indiana Code §5-17-5-1 et seq., the Prompt Payment Statute. Late charge fee(s) shall be calculated from the first day of the month on all unpaid amounts provided, that such late charge fee shall apply to ADVANTAGE Fees only.

ARTICLE VIII: MISCELLANEOUS

Section 8.1 Audit Rights. Subject to the provisions of this Section, Plan Sponsor may audit ADVANTAGE's records in connection with the administration of this Agreement and ADVANTAGE agrees to provide Plan Sponsor with reasonable access to such records. ADVANTAGE shall only be required to provide access to such information that is in its possession and which is reasonably necessary to administer the Plan, provided that disclosure of such information is not prohibited by ADVANTAGE's agreements with third parties or any requirement of Applicable Law. Plan Sponsor shall give ADVANTAGE reasonable prior written notice which shall include: a) a statement of its intent to perform such an audit; b) a statement explaining its need to perform the audit; c) a description of the type(s) of information within the scope of the audit, including dates; and d) Plan Sponsor's representation that the information to be disclosed by ADVANTAGE is reasonably necessary for the administration of the Plan. All audits and information disclosures shall occur at a reasonable time and place, in a manner that does not unreasonably interfere with ADVANTAGE's ability to conduct its normal business, and at Plan Sponsor's sole cost and expense. Subject to ADVANTAGE's approval, which may be withheld for any reason, Plan Sponsor may designate a third party to conduct an audit or receive information hereunder. Upon receipt of such approval by ADVANTAGE, the Plan Sponsor and such third party shall enter into an agreement with ADVANTAGE which shall provide at a minimum: (i) a representation from Plan Sponsor and such third party that no portion of the audit is based upon a contingency fee arrangement; (ii)

a representation from Plan Sponsor and such third party that each shall only use the minimally necessary amount of audit information solely for purposes of administering the Plan and that each shall protect and maintain such information as confidential and to not disclose the information to any other person or entity other than ADVANTAGE; and (iii) a representation from Plan Sponsor and such third party that each shall provide ADVANTAGE with copies of all reports and summaries compiled as a result of the audit.

Section 8.2 Full Integration. This Agreement, together with all exhibits and schedules that are attached hereto, supersedes any and all prior representations, conditions, warranties, understandings, proposals or other agreements between the Plan Sponsor and ADVANTAGE, whether oral or written, respecting the subject matter hereof. In this regard, the Parties, having read and understood this entire Agreement, acknowledge and agree that there are no other representations, conditions, promises, agreements, understandings or warranties that exist outside this Agreement which have been made by either of the Parties hereto, which have induced either Party or has led to the execution of this Agreement by either Party. Any statements, proposals, representations, conditions, warranties, understandings or agreements which may have been heretofore made by either of the Parties, and which are not expressly contained herein are void and of no force or effect.

Section 8.3 Use of Names. Except as may be required or permitted under the terms of this Agreement, each Party agrees not to use the name, image, promotional material, stationary, letterhead or logotype of the other Party except as expressly authorized in writing by such other Party.

Section 8.4 Counterparts. This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which, together, shall constitute one and the same instrument.

Section 8.5 No Oral Modification. No provision of this Agreement may be amended, augmented or in any way modified except in writing signed by a duly authorized representative of each of the Parties.

Section 8.6 Indemnification. The Plan Sponsor shall indemnify, defend (with counsel mutually agreed upon by the Parties), save and hold ADVANTAGE and its affiliates, and their officers, directors, employees and agents harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages and expenses of any kind (including, but not limited to, reasonable attorneys' fees) which ADVANTAGE may incur by reason of: (i) Plan Sponsor's or its employees' or agents' failure to perform or abide by any of its duties under this Agreement; (ii) Plan Sponsor's failure to administer the Plan in a prudent or proper manner; (iii) any misconduct on the part of the Plan Sponsor or its agents or representatives; (iv) any disputes arising out of partial payment or denial of a Claim by either the Plan Sponsor or the excess risk carrier; (v) any action taken by ADVANTAGE at the direction of the Plan Sponsor; (vi) ADVANTAGE's inability to comply with ADVANTAGE Proprietary Network prompt pay discounts due to circumstances beyond its control and due to the fault or actions of the Plan Sponsor such as, additional information needed from the Plan Sponsor, Participant Stop-Loss Reinsurance provider or Provider, incomplete Claim, eligibility or coverage information, untimely re-pricing from the vendor, or Plan Sponsor's failure to fund Claims in a timely manner (including but not limited to any checks returned for insufficient funds); or (vii) the Plan Sponsor's violation of any of the acknowledgements, warranties or representations made by the Plan Sponsor contained herein. ADVANTAGE shall indemnify, defend (with counsel mutually agreed upon by the Parties), save and hold the Plan Sponsor harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages and expenses of any kind (including, but not limited to, actual attorneys' fees) which Plan Sponsor may incur by reason of: (i) ADVANTAGE's negligence, willful failure to act or willful misconduct in the performance of its duties under the Agreement; (ii) ADVANTAGE's fraud or embezzlement or other financial willful misconduct related to the Agreement; or (iii) ADVANTAGE's violation of any of the express warranties of ADVANTAGE contained herein; provided, however that ADVANTAGE's cumulative liability arising in

connection with the performance of services under this Agreement shall not exceed the total fees payable by Plan Sponsor under this Agreement for the specific services giving rise to the claim. Notwithstanding the foregoing, Plan Sponsor acknowledges and agrees that ADVANTAGE shall not be liable for any mistake of judgment or for any action taken in good faith, and that any clerical error made by ADVANTAGE in the performance of its duties under this Agreement will not be construed as negligence or gross negligence provided that ADVANTAGE makes a good faith attempt to correct any such error once it is discovered.
This Section 8.6 shall survive termination of this Agreement.

Section 8.7 Severability. In the event any provision of this Agreement is held to be invalid, illegal or unenforceable for any reason or in any respect, such invalidity, illegality or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Agreement, which shall be in full force and effect, enforceable in accordance with its terms.

Section 8.8 Applicable Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Indiana, to the extent such laws are not preempted by ERISA, if applicable. Each Party irrevocably agrees that any claim brought by it in any way arising out of the Agreement must be brought solely and exclusively in state or federal courts located in Johnson or Marion County, Indiana, and each Party irrevocably accepts and submits to the sole and exclusive jurisdiction of each of the aforesaid courts in person, generally and unconditionally with respect to any action, suit, or proceeding brought by it or against it by the other Party.

Section 8.9 No Third Party Beneficiaries. Nothing expressed or implied in this Agreement is intended or shall be construed to confer upon, or give to any third party or persons who are not signatories hereto (including without limitation, Plan Participants) any rights or remedies against any Party hereto.

Section 8.10 Force Majeure. ADVANTAGE shall not be liable to the Plan Sponsor for any failure to satisfy an obligation, representation or warranty under this Agreement due to any cause beyond its reasonable control including, but not limited to, inclement weather, acts of God, war, riots, malicious acts of damage, disasters, civil commotion, strike, lockout, industrial dispute, adverse changes in applicable law, actions of Government Representative, power failure or fire. If such a condition prevents ADVANTAGE's performance under this Agreement for a continuous period of ninety (90) days or more, the Plan Sponsor may terminate this Agreement by providing written notice in accordance with the applicable provisions of this Agreement.

Section 8.11 Subsequent Documents. The Parties agree that each shall timely execute or provide any further documents that will be reasonably necessary to effect any term, condition, warranty or other part or aspect of this Agreement.

Section 8.12 Assignment. The Parties to this Agreement may not assign this Agreement, in whole or in part, without the prior written consent of the other Party, which consent shall not be unreasonably withheld. Notwithstanding the above, ADVANTAGE, in its sole discretion, may subcontract a portion of its duties hereunder to a third party.

Section 8.13 Waiver. No waiver of any term or provision of this Agreement, nor consent to any failure to perform under, or breach of this Agreement, shall be binding against either of the Parties unless such Party delivers a writing, signed by a duly authorized representative, expressly stating why it has waived any such term or provision. There shall be no implied waivers or consents. No waiver respecting an expressly identified term or provision, or consent to an expressly identified act or omission, will have any effect on the balance of this Agreement or the balance of a Party's conduct.

Section 8.14 Approval of Agreement: Binding Nature. Plan Sponsor acknowledges and agrees that it has been provided with the opportunity to engage its own counsel to review this Agreement and any Plan Documents or Summary Plan Description on its behalf. This Agreement shall inure to the benefit of and are binding upon the Parties hereto and their respective legal representatives and permitted successors. This Agreement shall be deemed drafted by both Parties.

Section 8.15 Ethical and Religious Directives. ADVANTAGE is an institution operated in accordance with the *Ethical and Religious Directives for Catholic Health Care Services*, as approved by the National Conference of Catholic Bishops. ADVANTAGE shall not be required to provide, and no provision of the Agreement shall be construed to require ADVANTAGE to provide, services that are inconsistent with the medical ethics or precepts of the Catholic Church. Provided, however, that ADVANTAGE has made certain representations to Plan Sponsor that it can and will provide the family planning and reproductive services outlined in the Plan Documents.

Section 8.16 Notices. Unless otherwise indicated by this Agreement, any notice required to be given by one Party to the other shall be in writing and (i) personally delivered, (ii) sent by certified mail (return receipt requested), (iii) sent by a nationally recognized overnight carrier. Notice shall be considered given upon receipt or documented refusal to accept delivery.

Notices to **Plan Sponsor** shall be addressed to:
City of Greenwood
2 North Madison Avenue
Greenwood, IN 46142
Attn: Marilyn Allen

With a copy to:

City of Greenwood
Office of Corporation Counsel
225 S. Emerson Avenue
Suite B
Greenwood, Indiana 46143

Notices to **Plan** shall be addressed to:
City of Greenwood
2 North Madison Avenue
Greenwood, IN 46142
Attn: Marilyn Allen

With a copy to:

City of Greenwood
Office of Corporation Counsel
225 S. Emerson Avenue
Suite B
Greenwood, Indiana 46143

Notices to **ADVANTAGE** shall be addressed to:

ADVANTAGE Health Solutions, Inc.℠
9045 River Road, Ste.200
Indianapolis, IN 46240
Attn: Vicki F. Perry, President & CEO
v.perry@advantageplan.com
With a copy to: Maria Faget, Corporate Counsel
mfaget@advantageplan.com

Section 8.17 Disputes. For purposes of this Section 8.18 "Dispute" means any dispute or claim between ADVANTAGE and Plan Sponsor out of or related to the interpretation of any term or application of this Agreement.

Section 8.17.1 Dispute Resolution. In the event a Dispute, controversy or disagreement between the Parties arises out of or is related to this Agreement or the breach thereof, executive officers and other authorized representatives of both Parties shall make good faith efforts to settle the Dispute by negotiation between the Parties. Resolution of any Dispute shall be subject to good faith negotiation between the Parties. If, after thirty (30) days of good faith negotiations, any such Dispute, or disagreement has not been resolved, it shall be submitted to mediation which shall be conducted in Indianapolis, Indiana in accordance with the American Health Lawyers Association Alternative Dispute Resolution Services Rules of Procedure for Mediation. The complaining Party shall notify the other Party in writing of such Dispute and the Parties shall attempt to resolve the Dispute within forty-five (45) days of the date of such notice, or within such time as it is mutually agreed upon by the Parties in writing. The Parties shall be required to continue to abide by this Agreement during the mediation period which shall last, in its entirety, no longer than forty-five (45) days. If the Parties are unable to reach an agreement during the mediation period, the Parties may proceed with litigation.

Section 8.17.2 Sections 8.17 and 8.17.1 shall not apply to any Disputes arising out of the provisions and obligations included in Exhibit B.

The provisions of this Section 8.17 (in its entirety) shall survive termination of this Agreement.

Section 8.18 Headings. The headings or captions provided throughout this Agreement are for reference purposes only and shall not in any way affect the meaning or interpretation of this Agreement.

Section 8.19 Disclaimer. ADVANTAGE is not engaged in the practice of medicine or the provision of medical care. Health care providers, whether they are providers contracted with ADVANTAGE or not, are solely responsible for the provision of medical care. Only the Participant, or his/her representative, and the attending physician have the right to decide what health care services will be provided. No statement or recommendation made by either Party shall be construed as precluding any health care service, controlling what health care services are provided to a Participant or guaranteeing a particular outcome.

Section 8.20 Records. Each Party shall maintain, during the term of this Agreement, appropriate records regarding Claims submitted and corresponding payments for the maximum period required by federal, state or local law, and provide data that may be reasonably requested or required for regulatory, audit, and/or business purposes.

Section 8.21 Status. The Plan Sponsor agrees and acknowledges that while ADVANTAGE is a licensed HMO in the State of Indiana, ADVANTAGE is not performing as an HMO under this Agreement and is not providing HMO services or benefits to the Plan Sponsor or any Participants.

Section 8.22 Ownership of Records. The Plan Sponsor owns all records that are generated by ADVANTAGE and that pertain to the Plan Sponsor (including, without limitation, Claim files (not containing PHI), even if such records may be in the possession of ADVANTAGE. However, the Plan, as the covered entity (as that term is defined under HIPAA) shall own records containing PHI.

Section 8.23 Unauthorized Practice of Law. It is understood and agreed that ADVANTAGE will not perform, and the Plan Sponsor will not request performance of, any services which may constitute the unauthorized practice of law.

Section 8.24 Prior Claims Administrator. In the event ADVANTAGE replaces Plan Sponsor's prior claims administrator, ADVANTAGE will not accept any responsibility for the work performed by such prior claims administrator, nor does ADVANTAGE agree to reevaluate or readjust Claims or to perform or continue work previously done by such prior claims administrator (including acting as a named fiduciary for any pending Claims appeals) unless otherwise agreed in writing by the Parties for additional compensation.

Section 8.25 Reliance on Instructions. ADVANTAGE may rely upon any written instructions or information relating to ADVANTAGE's performance of services provided by the Plan Sponsor or the Plan Sponsor's designated representatives, which ADVANTAGE reasonably believes to be genuine and authorized by the Plan Sponsor. ADVANTAGE may rely on and is under no obligation to investigate the accuracy of the information, including its completeness, in the Plan Documents provided by the Plan Sponsor to ADVANTAGE pursuant to Section IV. ADVANTAGE shall incur no liability resulting from ADVANTAGE's reasonable reliance on such instructions or information, provided, that ADVANTAGE does not have actual, immediate and uncontested knowledge that any such instruction or information, as the case may be, is incorrect, inaccurate or incomplete when given to ADVANTAGE.

Section 8.26 Taxes and Surcharges. If, at any time, the federal government or any state government or any political subdivision of any instrumentality of either shall assess any tax or surcharge against the Plan, against ADVANTAGE with respect to payments made by or for the Plan related to the Plan in any way and ADVANTAGE is required to pay such tax or surcharge, ADVANTAGE shall report the payment of such tax or surcharge to the Plan Sponsor and at the option of ADVANTAGE make a charge against the Plan Sponsor for reimbursement of such payment or be reimbursed by the Plan Sponsor upon fifteen (15) days' prior written notice.

Section 8.27 Confidentiality. The Parties agree to hold this Agreement and all information provided by one Party to the other and exchanged in contemplation of, or in connection with, duties under this Agreement confidential and not to disclose such information to any third party except as required or permitted under this Agreement or Exhibit B, as required by law or regulation, or with the prior written permission of the non-disclosing Party. The Parties agree that money damages may not be a sufficient remedy for a breach of this Section 8.27, and that in addition to all other available legal or equitable remedies, including, but not limited to, special and consequential damages, the aggrieved Party shall be entitled, but not limited, to injunctive relief and specific performance. ADVANTAGE may disclose confidential information to the Stop-Loss Reinsurance carrier that has an existing relationship with the Plan Sponsor upon written notice by the Plan Sponsor.

Section 8.28 Change in Applicable Laws or Regulations. In the event the laws or regulations of the United States or the State of Indiana are modified or amended in any material way with respect to this Agreement, this Agreement shall not be terminated but rather, to the extent feasible, shall be promptly amended by the Parties to operate in compliance with existing law. The Parties acknowledge that their responsibilities under this Agreement may be affected and governed by the requirements of new laws, to the extent that regulations implementing the new laws become effective during the Term of this Agreement or any renewal thereof. Both Parties agree that, upon the effective date of any such new laws, this Agreement shall be deemed to incorporate, and impose on the Parties, any obligations applicable to each of them under such new laws pursuant to their responsibilities hereunder. To the extent any

amendments to this Agreement shall be necessary to effectuate or clarify the obligations of the Parties pursuant to such new laws; the Parties hereby agree to negotiate such amendments in good faith, subject to the right of either Party to terminate this Agreement in accordance with its terms.

Section 8.29 Survival. Notwithstanding anything herein to the contrary, the following provisions shall be deemed to survive the expiration or termination of this Agreement: Exhibit B, and Sections 2.2, 2.5, 2.7, 3.4, 3.5, 3.8, 3.17, 4.1.1, 4.2, 4.10, 4.11, 4.12, 4.20, 6.1, 6.7, 6.8, 6.9, 6.12, 6.14, 6.15, 6.16, 8.1, 8.2, 8.6, 8.8, 8.17, and 8.28.

Section 8.30 Non-Discrimination. ADVANTAGE and its subcontractors shall not discriminate against any employee or applicant for employment to be employed in the performance of this Agreement, with respect to her or his hire, tenure, terms, conditions, or privileges of employment, or any matter directly or indirectly related to employment, because of her or his race, sex, religion, color, national origin, ancestry, age, disability, or United States military service veteran status. Breach of this section shall be regarded as a material breach of this Agreement.

Section 8.30 Taxpayer Identification Number. Firm shall provide the City with completed Form W-9 Request for Taxpayer Identification Number at the time of execution of this Agreement.

IN WITNESS WHEREOF, ADVANTAGE and the Plan Sponsor have caused this Agreement to be executed in duplicate by their respective officers duly authorized to do so. The undersigned Plan Administrator hereby certifies that he/she (1) is authorized to sign on behalf of the Plan Sponsor and the Plan, (2) has received and read and understands the explanation of services and Fees and (3) approves the purchase of Stop Loss Reinsurance (if applicable) and the payment to ADVANTAGE of such sales commissions, service Fees and other compensation arrangements as listed therein, as applicable.

City of Greenwood (Plan Sponsor)

By: _____

Print: Mark M. Myers

Its: Mayor (as authorized by the Board of Public Works & Safety by Resolution 12-09)

Date: 10-1-12

ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE)

By: _____

Print: Vicki F. Perry

Its: President & CEO

Date: 2/5/2013

City of Greenwood Employee Health Benefit Plan (Plan)

By: _____

Print: Mark W. Myers (as authorized by the Board of Public Works & Safety by Resolution 12-09)

Its: Mayor

Date: _____

APPROVED AS TO FORM:

_____

Krista S. Taggart
City of Greenwood, Corporation Counsel

SCHEDULE A

Termination Package

The Termination Package, which is available to Plan Sponsor for purchase, contains one (1) set of reports at a cost of $750.00. The reports included in the Termination Package are:

1. Eligibility Listing

2. Out of Pocket totals by Participant

3. Deductible met by Participant

4. Lifetime Maximum by Participant

5. Detailed Paid Claims

6. Pended Claims

7. HIPAA Certificates of Creditable Coverage

SCHEDULE B
Fee Schedule

	April 1, 2012 through March 31, 2013
Medical Plan Administration Service Fee	$17.50 /PEPM
Care-ADVANTAGE	$ 7.25/PEPM
ADVANTAGE Proprietary Network (ADVANTAGE 360)	$ 5.05/PEPM
Midwest Behavioral Health	$ .40/PEPM
HSM Chiropractic Network	$ .35/PEPM
Optional Services and Fees	
PHCS Access Fee	20% of Savings (pass through cost)
Wellness Services	$4.65/Per Participant Per Month*
Stop-Loss Vendor Coordination Fee	$ .25 PEPM
Pharmacy Benefit Manager – Envision	Direct contract with Plan Sponsor

*Wellness Services Fee reduced to $3.07 for Police and Firemen to accommodate outside vendor biometric screenings.

Other Fees and Services

(a) Subrogation - Fees for Subrogation services through HRI are billed at 30% of recovery. Hence, HRI retains 28% of the recovery and ADVANTAGE retains 2% of the recovery.

(b) Administrative Services- External physician review, medical records, postage, Plan Document and Summary Plan Description preparation, Plan Amendments, printing and materials are billed at cost.

(c) Remittance Services – From time to time, at Plan Sponsor's request, ADVANTAGE may collect certain fees from Plan Sponsor for remittance to a third party, e.g. a Stop-Loss Reinsurer, Optum, PHCS, diabetic supplies, etc. In these instances, ADVANTAGE will notify Plan Sponsor of such fees in writing. ADVANTAGE will pass- through all fees and will not collect or retain an administrative or service fee.

(d) Additional Fees and Services - ADVANTAGE reserves the right to charge for certain additional services as requested by Plan Sponsor, including but not limited to: (1) customized ID cards with Employer logo; (2) non-standard format for eligibility; (3) billing and reporting; (4) non-standard banking arrangements; (5) vendor's fees; and (6) fees incurred by ADVANTAGE in performing services on behalf of Plan Sponsor that are not specifically listed in this Agreement. To the extent possible, ADVANTAGE will notify Plan Sponsor in writing prior to performing any services requested by Plan Sponsor for which an added fee would be charged to Plan Sponsor, for Plan Sponsor's written approval.

EXHIBIT A
Care-ADVANTAGE Program Description Summary

Disease Management

Our Care-ADVANTAGE Disease Management Programs

- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Diabetes
- Asthma
- Migraine
- Hypertension
- Depression/Anxiety

Care-ADVANTAGE Disease Management Components Include:

- Population identification and stratification
- Personal assessment of condition and depression screening
- Refer to Behavior Health Care Manager if appropriate
- Educational outreach and self help tools based on evidence based clinical practice guidelines
- Motivational interviewing and SMART goal setting
- Refer to a Wellness Coach if appropriate
- Refer to our Case Manager if appropriate
- Routine reporting loop tools using Managedcare.com to identify gaps in care
- Outcome measurement, evaluation and management

Wellness Coaching

Our Care-ADVANTAGE Wellness Coaching Programs

- Smoking Cessation
- Weight Management
- Stress Management

Care-ADVANTAGE Wellness Coaching Components:

- An issue is identified during the disease management educator call or a case management contact
- A goal is set with the Participant and their "readiness to change" has been established by using the "Readiness Rule" tool
- The Participant is then referred to the Wellness team who works with the Participant to help support the specific goal

- Health coaching is conducted using evidence based methods of behavioral change
- Reporting loop via managedcare.com with the Participant's disease management educator
- Conduct follow up to support the Participant's change in behavior

Case Management

Our Care-ADVANTAGE Case Management Programs

- Complex Medical Case Management
- Behavioral Health Case Management
- Emergency Room Management and Continuity of Care Management

Complex Case Management

- Assure the Participant is receiving the best care and correct service when a Participant is at their sickest (care coordination)
- Give ongoing support and education through the "medical maze"
- Reporting and referral loop to Wellness and Disease Management

Behavioral Health Care Management

- Assess the depression/anxiety screening tool sent by disease or case management
- Help get the services needed if depression and anxiety are an issue
- Follow up to reassess condition

Emergency Room Management and Continuity of Care Management

- Outreach to Participants who are using the emergency room as their only medical care with emphasis on safety
- Outreach to Participants recently discharged from the hospital to assure a follow up visit with their primary care provider

Prior Authorization of Services

- Services in accordance with the Plan Document
- Utilization Review
- Concurrent Review
- Discharge Planning

EXHIBIT B
BUSINESS ASSOCIATE AGREEMENT

This agreement ("Agreement") is made by and between ADVANTAGE Health Solutions, Inc.[SM] ("Business Associate or ADVANTAGE") and City of Greenwood Employee Health Benefit Plan, ("Covered Entity"), hereinafter collectively referred to as "Parties" and individually as "Party," effective April 1st, 2012 ("Effective Date").

RECITALS

A. WHEREAS Covered Entity wishes to disclose certain information to Business Associate, some of which may constitute Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI"), as defined in the federal regulations set forth at 45 C.F.R. §§ 160 and 164 (the "Privacy Rule" and "Security Rule");

B. WHEREAS Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI and/or ePHI disclosed to Business Associate in compliance with the Privacy Rule and Security Rule;

C. NOW THEREFORE, in consideration of the mutual promises below and the exchange of information pursuant to this Agreement, the Parties agree as follows:

ARTICLE I: DEFINITIONS

a. ***"Business Associate"*** shall have the meaning given to such term at 45 C.F.R. § 160.103. For the purposes of this Agreement, Vendor is the Business Associate.

b. ***"Covered Entity"*** shall have the meaning given to such term at 45 C.F.R. § 160.103. For the purposes of this Agreement, the Covered Entity is City of Greenwood Employee Health Benefit Plan.

c. **"*Designated Record Set*"** has the meaning assigned to such term in 45 C. F. R. 160.501.

d. **"*Discovery*"** shall mean the first day on which a Breach is known to Business Associate (including any person, other than the individual committing the breach, that is an employee, officer, or other agent of Business Associate), or should reasonably have been known to Business Associate (or person), to have occurred.

e. ***"HIPAA"*** **or "Health Insurance Portability and Accountability Act of 1996"** is the law under which the Privacy and Security Rules were promulgated.

f. ***"HITECH Act"*** **or "Health Information Technology for Economic and Clinical Health Act"** are those provisions set forth in Title XIII of Public Law 111-5 as enacted on February 17, 2009.

g. **"*Individual*"** shall have the meaning given to such term at 45 C.F.R. § 160.103, and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

h. *"Privacy Rule"* is the regulation entitled "Standards for Privacy of Individually Identifiable Health Information," promulgated under HIPAA and/or the HITECH Act that is codified at 45 C.F.R. parts 160 and 164, Subparts A and E.

i. ***"Protected Health Information" ("PHI") and "Electronic Protected Health Information"*** *("ePHI")* shall have the meaning given to such terms at 45 C.F.R. § 160.103.

j. ***"Required by Law"*** shall have the meaning given to such term at 45 C.F.R. § 164.103.

k. ***"Secretary"*** shall mean the Secretary of the United States Department of Health and Human Services or her designee.

l. ***"Breach"*** means the unauthorized acquisition, access, use or disclosure of PHI without regard to whether such access, use or disclosure compromises the security of the PHI such that the Breach poses a significant risk of financial, reputational, or other harm to the individual, as provided in 45 C.F.R. § 164.402.

m. *"Security Rule"* is the regulation entitled "Security Standards for the Protection of Electronic Protected Health Information," promulgated under HIPAA and/or the HITECH Act that is codified at 45 C.F.R., parts 160 and 164, Subparts A and C.

n. ***"Unsecured Protected Health Information"*** means Protected Health Information that is not secured through the use of a technology or methodology specified by guidance issued by the Secretary from time to time.

ARTICLE II: OBLIGATIONS OF BUSINESS ASSOCIATE

a. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law. Business Associate shall also comply with any further limitations on uses and disclosures agreed to by Covered Entity in accordance with 45 C.F.R. 164.522 provided that such agreed upon limitations have been communicated to Business Associate.

b. ***Permitted Uses and Disclosures.*** Business Associate may use and disclose PHI and/or ePHI created or received pursuant to this Agreement as follows:

i. ***To carry out the purposes of this Agreement.*** Business Associate may use and disclose Covered Entity's PHI and/or ePHI received or created by Business Associate (or its agents and subcontractors) in performing its obligations pursuant to this Agreement, solely in accordance with the specifications set forth in this Agreement.

ii. ***Use for Management and Administration.*** Business Associate may use PHI and/or ePHI created or received in its capacity as a Business Associate of Covered Entity for the proper management and administration of Business Associate, if such use is necessary (i) for the proper management and administration of Business Associate or (ii) to carry out the legal responsibilities of Business Associate.

iii. ***Disclosure for Management and Administration.*** Business Associate may disclose PHI and/or ePHI created or received in its capacity as a Business Associate of Covered Entity

for the proper management and administration of Business Associate if (i) the disclosure is Required by Law or (ii) Business Associate (a) obtains reasonable assurances from the person to whom the PHI and/or ePHI is disclosed that it will be held confidentially and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person and (b) the person agrees to notify Business Associate of any instances of which it becomes aware in which the confidentiality and security of the PHI and/or ePHI has been breached.

iv. *Data Aggregation Services.* Business Associate may aggregate the PHI and/or ePHI created or received pursuant this Agreement with the PHI and/or ePHI of other covered entities that Business Associate has in its possession through its capacity as a business associate of such covered entities for the purpose of providing Covered Entity with data analyses relating to the health care operations of Covered Entity (as defined in 45 C.F.R. § 164.501).

v. ***De-Identification of PHI and/or ePHI.*** Business Associate may de-identify any and all PHI and/or ePHI received or created pursuant to this Agreement, provided that the de-identification process conforms to the requirements of 45 C.F.R. § 164.514(b).

c. *Nondisclosure.* Business Associate shall not use or further disclose Covered Entity's PHI and/or ePHI otherwise than as permitted or required by this Agreement or as Required by Law.

d. *Safeguards.* Business Associate shall use appropriate administrative, physical, and technical safeguards, including, among others, policies and procedures regarding the protection of PHI and/or ePHI and the provision of training on such policies and procedures to applicable employees, independent contractors and volunteers, that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI and/or ePHI that Business Associate creates, receives, maintains or transmits on behalf of Covered Entity.

(i) With respect to ePHI, Business Associate shall implement and comply with (and ensure that its subcontractors implement and comply with) the administrative safeguards set forth at 45 C.F.R. 164.308, the physical safeguards set forth at 45 C.F.R. 310, the technical safeguards set forth at 45 C.F.R. 164.312, and the policies and procedures set forth at 45 C.F.R. 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of ADVANTAGE Health Solutions Business Associate acknowledges that (a) the foregoing safeguards, policies and procedures requirements shall apply to Business Associate in the same manner that such requirements apply to ADVANTAGE Health Solutions, and (b) Business Associate may be liable under the civil and criminal enforcement provisions set forth at 42 U.S.C. 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with the safeguards, policies and procedures requirements and any guidance issued by the Secretary from time to time with respect to such requirements.

(ii) With respect to ePHI, Business Associate shall ensure that any agent, including a subcontractor, to whom it provides ePHI, agrees to implement reasonable and appropriate safeguards to protect it.

e. ***Reporting of Breaches.*** Except as specifically provided in subsection (d)(ii), Business Associate agrees to report to Covered Entity any Breach of Unsecured PHI without unreasonable delay and in no case later than fifteen (15) calendar days after Discovery of a Breach. Such notice shall

include the identification of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate, to have been, accessed, acquired, or disclosed in connection with such Breach. In addition, Business Associate shall provide any additional information reasonably requested by Covered Entity for purposes of investigating and responding to the Breach.

(i) Business Associate specifically agrees that it shall be Covered Entity's right and responsibility to determine whether a Breach compromises the security or privacy of the PHI such that the Breach poses a significant risk of financial, reputational, or other harm to the individual

(ii) Exceptions to Reporting Obligation. Business Associate shall not be required to report an individual Breach to Covered Entity that is described in this subparagraph (ii) as follows:

(a) The unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of Business Associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.

(b) Any inadvertent disclosure by a person who is authorized to access PHI at Business Associate to another person authorized to access protected health information at Business Associate, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.

(c) The unauthorized access, use or disclosure of PHI relates solely to PHI that is a "limited data set" as set forth in 45 C.F.R. § 164.514(e)(2).

Provided, however, that Business Associate shall document the occurrence of each such Breach and the steps it took to determine that the Breach falls within one of the excepted categories. Business Associate shall retain the documentation required by this subparagraph (ii) and shall make it available to Covered Entity every thirty (30) days, or immediately upon request. Business Associate shall provide Covered Entity with any further information or documentation that Covered Entity requests related to such Breach.

f. ***Additional Responsibilities in the Event of Breach.*** Business Associate shall take prompt steps to limit or avoid the recurrence of any Security Breach and take any other action pertaining to such unauthorized access or disclosure required by applicable federal and state laws and regulations. Business Associate must comply with this provision regardless of any actions taken by Covered Entity. Business Associate further agrees to mitigate, to the extent practicable, any harmful effect that becomes known to Business Associate as a result of a Breach or a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

g. ***Use of Agents and Subcontractors.*** Business Associate shall ensure that any of its agents and subcontractors to whom it provides PHI and/or ePHI created or received pursuant to this Agreement agrees to the same restrictions, conditions and safeguards that apply to Business Associate pursuant to this Agreement with respect to such PHI and/or ePHI. With respect to the obligations of Article II.d. and e. hereof, Business Associate represents that any agent or subcontractor shall be obligated to notify Business Associate of any Breach within fifteen (15) days in the same manner and according to the same terms as provided herein. In no event shall Subcontractor, without Covered Entity's prior written approval, provide PHI received from, or

created or received by Business Associate on behalf of Covered Entity, to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes or otherwise has access to the PHI outside of the United States.

h. ***Availability of Information to Covered Entity.*** Within five (5) business days of receipt of a request from Covered Entity, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill Covered Entity's obligations to provide access to, and a copy of, PHI and/or ePHI pursuant to this Agreement in accordance with the Privacy Rule, including but not limited to 45 C.F.R. § 164.524. If an Individual requests such information directly from Business Associate, Business Associate must notify Covered Entity in writing within five (5) business days. Business Associate shall not give the Individual access to the information unless access is approved by Covered Entity. Covered Entity shall have full discretion to determine whether the Individual shall be given access.

i. ***Amendment of PHI.*** Within five (5) business days of receipt of a request from Covered Entity, Business Associate shall make Covered Entity's PHI and/or ePHI available to Covered Entity as it may require to fulfill Covered Entity's obligations to amend such PHI and/or ePHI pursuant to the Privacy Rule, including but not limited to, 45 C.F.R. § 164.526. Business Associate shall incorporate any amendments to Covered Entity's PHI and/or ePHI Business Associate maintains.

j. ***Accounting of PHI.*** Within (5) business days of notice by Covered Entity of a request for an accounting of disclosures of PHI, Business Associate shall make available the PHI, including ePHI, to Covered Entity as required for Covered Entity to fulfill its obligations to provide an accounting pursuant to the Privacy Rule, including but not limited to, 45 C.F.R. § 164.528. Business Associate shall implement a process that allows for such an accounting.

k. ***Availability of Books and Records.*** Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI, including ePHI, created or received pursuant to this Agreement available to the Secretary of the United States Department of Health and Human Services, for the purpose of determining Covered Entity's compliance with the Privacy and Security Rules as set forth in 45 C.F.R. § 160.310.

l. ***Record Retention.*** Subject to Article 5 below, Business Associate shall retain all PHI and/or ePHI received from Covered Entity, or created or received in the course of performing its obligations, for the duration of the term of this Agreement.

m. ***Minimum Necessary Amount of PHI.*** Business Associate acknowledges that it shall request from Covered Entity and so disclose to its affiliates, agents and subcontractors or other authorized third parties, only (i) the information contained in a "limited data set," as such term is defined at 45 C.F.R. 164.514(e)(2), or, (ii) if needed by Business Associate or its affiliates, agents, subcontractors or other authorized third parties, to the minimum necessary data to accomplish the intended purpose of such requests or disclosures. In all cases, Business Associate shall request and disclose PHI only in a manner that is consistent with guidance issued by the Secretary from time to time.

n. If Business Associate conducts any Standard Transactions on behalf of Covered Entity, Business Associate shall comply with the applicable requirements of 45 C.F.R. Parts 160-162.

o. ***Data Ownership.*** Business Associate acknowledges that Covered Entity is the owner of all PHI and/or ePHI.

p. *Indemnification.*

(1) Business Associate shall indemnify and hold harmless Covered Entity and any of Covered Entity's affiliates, directors, officers, employees and agents from and against any claim, cause of action, liability, damage, cost or expense (including reasonable attorneys' fees) arising out of or relating to any Breach or other non-permitted use or disclosure of PHI, failure to safeguard ePHI, or other breach of this Agreement by Business Associate or any affiliate, director, officer, employee, agent or subcontractor of Business Associate.

(2) Covered Entity shall indemnify and hold harmless Business Associate and any of Business Associate's affiliates, directors, officers, employees and agents from and against any claim, cause of action, liability, damage, cost or expense (including reasonable attorneys' fees) arising out of or relating to any Breach or other non-permitted use or disclosure of PHI, failure to safeguard ePHI, or other breach of this Agreement by Covered Entity or any affiliate, director, officer, employee, agent or subcontractor of Business Associate.

III. COVERED ENTITY'S OBLIGATIONS

a. Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity's or any applicable Covered Entity's notice of privacy practices that are produced in accordance with 45 C.F.R. 164.520 (as well as any changes to that notice), to the extent that such limitation(s) may affect Business Associate's use or disclosure of Protected Health Information.

b. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes affect Business Associate's use or disclosure of PHI.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

IV. AUDITS, INSPECTION AND ENFORCEMENT

Covered Entity, after providing ten (10) business days' written notice, may inspect, during regular business hours, the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of PHI pursuant to this Agreement for the purpose of determining whether the Business Associate has complied with this Agreement.

V. TERM AND TERMINATION

a. ***Termination by Covered Entity for Material Breach.*** Covered Entity may terminate this Agreement immediately if Covered Entity determines that Business Associate has acted or failed to act in a manner that constitutes a material breach of this Agreement and Business Associate has failed to cure the breach within thirty (30) business days of receiving written notice of an alleged material breach from Covered Entity. If termination of this Agreement is not feasible, Covered Entity shall report the problem to the Secretary of U.S. Health and Human Services. Business Associate acknowledges that any material breach would result in irreparable harm to Covered Entity and that Covered Entity has the right to seek an injunction and other legal and equitable rights and remedies available under the law.

b. ***Effect of Termination.*** Upon termination or expiration of this Agreement for any reason, Business Associate shall return and/or destroy all PHI and/or ePHI received or created pursuant to this Agreement that Business Associate maintains in any form, and shall retain no copies of such PHI and/or ePHI; or if return or destruction is not feasible, Business Associate shall continue to extend protections of this Agreement to such information, and limit further use of such PHI and/or ePHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI and/or ePHI. Upon Plan's request, Business Associate may provide Plan with a declaration of destruction of records containing PHI.

VI. NO THIRD PARTY BENEFICIARIES

Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Covered Entity, Business Associate and their respective successors and assigns, any rights, remedies, obligations or liabilities whatsoever.

VII. CHANGE IN APPLICABLE LAWS OR REGULATIONS

In the event the laws or regulations of the United States or the State of Indiana are modified or amended in any material way with respect to this Agreement, this Agreement shall not be terminated but rather, to the extent feasible, shall be promptly amended by the Parties to operate in compliance with the existing law. The Parties acknowledge that their responsibilities under this Agreement may be affected and governed by the requirements of HIPAA and/or the HITECH Act, to the extent that regulations implementing HIPAA and/or the HITECH Act (the "Regulations") become effective during the Term of this Agreement or any renewal thereof. Both Parties agree that, upon the effective date of any such Regulations, this Agreement shall be deemed to incorporate, and impose on the Parties, any obligations applicable to each of them under such Regulations pursuant to their responsibilities hereunder. To the extent any amendments to this Agreement shall be necessary to effectuate or clarify the obligations of the Parties pursuant to such Regulations, the Parties hereby agree to negotiate such amendments in good faith, subject to the right of either party to terminate this Agreement in accordance with its terms.

IX. SURVIVAL

The respective rights and obligations of Business Associate under Article 2 of this Agreement shall survive the termination of this Agreement.

X. INTERPRETATION

Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy and Security Rules.

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement as of the date set forth below.

ADVANTAGE Health Solutions, Inc.sm
(Business Associate)

Signature: Janice Teal
Name: JANICE TEAL
Title: CCO
Date: 2/6/13

City of Greenwood Employee Health
Benefit Plan (Covered Entity)

Signature: Mark W Myers
Name:Mark W. Myers
Title:Mayor (as authorized by Board of Public Works & Safety Resolution 12-13)
Date: 10/1/2012

CITY OF GREENWOOD

EMPLOYEE HEALTH BENEFIT PLAN

April 1, 2015

3/16/2015

TABLE OF CONTENTS

ADOPTION

The **City of Greenwood by and through its Board of Public Works and Safety** has caused this **City of Greenwood** Employee Health Benefit Plan ("Plan") to take effect as of **the first day of April, 2015**. We hereby certify that the document reflects the terms and conditions of the employee health benefit plan as established by the City of Greenwood and approved by Board of Public Works & Safety Resolution 15-03.

Kevin Hoover, Member

Michael Newbold, Member

Shan Rutherford, Member

APPROVED:

Mark W. Myers, Mayor

Marilyn M. Allen, Human Resources Director

Adam Stone, Controller

Krista S. Taggart, Corporation Counsel

INTRODUCTION

This Plan Document is a description of The City of Greenwood ("City") Health Benefit Plan ("Plan") and was prepared to help explain your health benefits. This document replaces and supersedes any Plan or summary that you have received previously. Please read this Plan carefully and refer to it whenever you require medical services.

This Plan describes how to get medical care, what health services are covered and not covered, and what portion of health care costs you will be required to pay. Many of the provisions in this Plan are interrelated; therefore, reading just one or two sections may not give you an accurate understanding of your Coverage. You are responsible for knowing the terms of this Plan.

The City has chosen Advantage Health Solutions as its third party Provider for health benefits, however, complete authority to control, operate, and manage the Plan remains with the City. The City reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

If any changes or amendments are made to this Plan, they will be documented and issued in a notice explaining the changes. No verbal statements of any person will change the benefits or limitations and exclusions of the Plan, nor shall any such statements convey or void any Coverage, or increase or reduce any benefits under the Plan.

Many words used in this Plan have special meanings. These words are capitalized. If the word or phrase is not explained in the text where it appears, it may be defined in the "Definitions" section. Refer to these definitions for the best understanding of what is being conveyed.

The Plan is a self-insured plan. This means the City of Greenwood is responsible for paying all claims and other expenses associated with providing Plan participants with health care Coverage.

PLAN SPECIFICATIONS

PLAN NAME:
City of Greenwood Employee Health Benefit Plan

NAME, ADDRESS AND PHONE NUMBER OF EMPLOYER PLAN SPONSOR:
City of Greenwood Board of Public Works & Safety
300 South Madison Avenue
Greenwood, IN 46142
(317) 887-5604

EMPLOYER TAX ID NUMBER:
35-6001050

PLAN NUMBER:
2000SF100

PLAN YEAR:
April 1, 2015 – March 31, 2016

TYPE OF PLAN:
Employee Health Benefit Plan: medical and prescription drug benefits

NAME, ADDRESS, PHONE NUMBER OF PLAN ADMINISTRATOR, FIDUCIARY AND AGENT FOR SERVICE OF LEGAL PROCESS:
City of Greenwood – Board of Public Works & Safety ("BPW")
300 South Madison Avenue
Greenwood, IN 46142
(317) 887-5604

With copies to: Office of Corporation Counsel
300 South Madison Avenue
Greenwood, IN 46142

Human Resources Department
300 South Madison Avenue
Greenwood, IN 46142

The Plan Administrator has the sole discretionary authority to control and manage the operation and administration of the Plan, subject to applicable law. The BPW may designate the Mayor, Deputy Mayor, Corporation Counsel, Director of Human Resources and/or Controller as its agent/representative for routine matters of administration.

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

For health benefits:
ADVANTAGE Health Solutions, Inc.
9045 River Road, Suite 200
Indianapolis, IN 46240
(317) 573-0290

For prescription drugs:
Envision
2181 East Aurora Road, Suite 201
Twinsburg, OH 44987

SCHEDULE OF MEDICAL BENEFITS

The Schedule of Benefits is designed as a quick summary and provides a summary of services, maximums and other limits that apply when you received Covered Services from a Provider. Please refer to the Covered Services section of this Plan for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Plan, including any endorsements, amendments, or riders. This Plan is a self-funded health plan and is not subject to the essential health benefits requirements under PPACA.

City of Greenwood **2015 BENEFITS-AT-A-GLANCE**	**Participating Providers** **Level 1**	**Non-Participating Providers** **Level 2**
Annual Plan Year Maximum	$1,000,000	$1,000,000
Lifetime Maximum **(Combined Level 1 & 2)**	No limit	No limit
Individual Plan Year Deductible	$500	$1,000
Plan Year Family Deductible	$1,000	$2,000
Individual Max Co-Insurance Limit (Not including deductible)	$1,000	$4,000
Family Max Co-Insurance Limit (Not including deductible)	$2,000	$4,000
Maximum Individual Out-Of-Pocket (Includes Co-Pay, Deductible and Co-Insurance	$2,000	N/A
Maximum Family Out-Of-Pocket (Includes Co-Pay, Deductible and Co-Insurance	$3,000	N/A
Primary Care Physician Office Visit	$20 Co-pay, no deductible	70%, after deductible
Specialty Care Physician Office Visit	$35 Co-pay, no deductible	70%, after deductible
Physician Services for Wellness & Preventive Services	100%, no deductible	70%, after deductible
Services for wellness and preventative services will be covered as regulated by the Patient Protection and Affordable Care Act (PPACA).		
Emergency Room Services	$200 Co-pay, no deductible	70% after deductible
Ambulance Services	80% after deductible	70%, after deductible
Urgent Care Center	$30 Co-pay, no deductible	70%, after deductible
Inpatient Hospital (Semi-private room)	80%, after deductible	70%, after deductible
Outpatient Surgery and Related Services	80%, after deductible	70%, after deductible
Colonoscopy (including diagnostic)	100%, no deductible	70%, after deductible
Labs, Pathology, Radiology	80%, after deductible	70%, after deductible
MRI, CT, MRA, PET and SPECT scan	80%, after deductible	70%, after deductible
DME & Corrective Appliances	80%, after deductible	70%, after deductible
Home Health Care (100 day per year limit)	80%, after deductible	70%, after deductible
Pregnancy Benefits (Employee/Spouse only)	80%, after deductible	70%, after deductible
Short-term Therapies Physical, Speech, Occupational Therapy (Limited to 60-days per distinct condition)	80%, after deductible	70%, after deductible
Chiropractic Services ($1000 maximum per year)	80%, after deductible	70%, after deductible

Acupuncture Services (12 visits per Plan Year)	80% after deductible	70% after deductible
Transplant Services (Donor charges limited to $20,000 per lifetime)	80%, after deductible	70%, after deductible
TMJ Benefits ($1,500 lifetime maximum)	80%, after deductible	70%, after deductible
Mental Health Inpatient	80%, after deductible	70%, after deductible
Mental Health Outpatient	$10 Co-pay, no deductible	70%, after deductible
Substance Abuse Inpatient	80%, after deductible	70%, after deductible
Substance Abuse Outpatient	$10 Co-pay, no deductible	70%, after deductible
Prescription Drug Coverage MANDATORY GENERIC when available	**Retail** (30 day supply)	**Mail-Order** (90 day supply)
OTC with Prescription (Allegra, Claritin, Prevacid 24-hr, Prilosec, Zyrtec)	$5 Co-pay	$10 Co-pay
Generic Drug	$5 Co-pay	$10 Co-pay
Brand Name Drug (when a Generic Drug is available, you pay the difference between the Generic drug and Brand-Name Drug plus the Brand-Name Copay)	$25 Co-pay	$50 Co-pay
Non-Preferred Brand Name Drug (when a Generic Drug is available, you pay the difference between the Generic drug and Non-Preferred Brand-Name Drug plus the Non-Preferred Brand-Name Copay)	$40 Co-pay	$80 Co-pay
Specialty Drug - PRIOR AUTHORIZATION REQUIRED	$60 Co-pay	$120 Co-pay
Diabetic Supplies (Includes glucometer, lancets & test strips) refer to the Care Advantage Program for additional benefits	Included in Rx Co-pays	Not covered

THIS SUMMARY IS A GENERAL OUTLINE OF COVERED BENEFITS UNDER YOUR PLAN AND DOES NOT INCLUDE ALL THE BENEFITS, LIMITATIONS AND NON-COVERED SERVICES OF THE SUMMARY PLAN DESCRIPTION. PLEASE SEE THE SUMMARY PLAN DESCRIPTION FOR SPECIFIC DETAILS.

Many Second Level (non-preferred) non-emergency benefits (except Physician office visits and Outpatient diagnostic tests) require you to seek Prior Authorization by calling the Pre-Cert phone number on your ID card during regular business hour. An additional Coinsurance penalty may apply for any service that is received out of network without Prior Authorizations.

The following items do not apply toward satisfaction of the Plan Year Deductible or Plan Year Co-insurance limit:
- Co-pays
- Charges in excess of reasonable and customer, except as otherwise stated herein;
- Penalties incurred for failing to obtain Precertification ;
- Services and supplies not eligible for Coverage under this plan.

When a Participant utilizes both in and out of network Providers during the Plan Year, the maximum Plan Year Deductible will not exceed the out of network Provider Deductible. Similarly, the Plan Year maximum out of pocket expenses will not exceed the out of network maximum out of pocket expenses when both in and out of network services are utilized.

MEDICAL NETWORK PLAN PROVIDERS

Preferred Provider
A Preferred Provider is a Physician, Hospital or ancillary service Provider which has an agreement with the City of Greenwood to accept a reduced rate for services provided to Covered Persons called a Negotiated Rate. Because a Preferred Provider cannot charge more than the Negotiated Rate, you and the Plan save money when services, supplies, or treatment are obtained from Preferred Providers. To find a list of participating Preferred Providers, please log onto www.Advantageplan.com or contact the Customer Service telephone number listed on the back of your Plan ID card.

Non-Preferred Provider
A Non-Preferred Provider does not have an agreement with the City of Greenwood. The Plan will pay its percentage of the Negotiated Rate for services, supplies and treatment. You are responsible for the remaining balance. This will often result in greater out-of-pocket expenses to you.

Non-Preferred Provider services shall be paid at the Preferred Provider rate in the following Instances:

- Emergency treatment rendered at a Non-Preferred Facility. Also, if a Covered Person is admitted to the Hospital after Emergency treatment, Covered Expenses shall be payable at the Preferred Provider level.

- Anesthesiology, radiology, and laboratory/pathology services provided at a Preferred Provider Facility.

- Consultations with Non-Preferred Providers, requested by Preferred Provider Physicians while a Covered Persons is confined at a Preferred Provider Hospital.

- Medically Necessary services, supplies and treatments not available through any Preferred Provider. Prior to obtaining such services, you must call the Pre-Certification number listed on the back of your Plan ID card and request Authorization. You will be provided with written notice of the scope of the Authorized Services. Non-Preferred Provider review requests will not be approved for follow-up testing after active treatment is completed unless pre-certified.

- For treatment provided to Covered Persons who do not have access to a Preferred Provider within thirty-five (35) miles of their place of residence.

- For Emergency treatment rendered while traveling and/or attending school outside the thirty-five (35) miles of their place of residence.

- For treatment provided to a Covered Person at a Preferred Provider Care Facility (ies) from a Non-Preferred Provider.

COST CONTAINMENT PROCEDURES

Plan cost containment procedures include a utilization review process, a Pre-Certification requirement for certain services, care management and a disease management program.

UTILIZATION REVIEW

ADVANTAGE is the Utilization Review Organization for the Plan. Utilization Review is the process of evaluating whether services, supplies or treatment are Medically Necessary and appropriate.

Certification of Medical Necessity and appropriateness by ADVANTAGE does **not** establish eligibility under the Plan or guarantee benefits. Certification of services as Medically Necessary and appropriate does not constitute Plan liability for any Pre-Existing Condition charges during the Pre-Existing Condition waiting period.

PRE-CERTIFICATION

The Plan requires Pre-certification of certain services, supplies, and treatment, as detailed below. A Pre-certification call is considered a Pre-Service Claim for benefits. Please see the Claim Filing Procedures section of this Plan for details regarding a Covered Person's rights regarding Pre-Service Claim determinations and appeals. To ensure services are Pre-certified as required, you should call the Pre-certification phone number listed on the Plan ID card.

Services Requiring Pre-certification:

Inpatient Hospital Admissions

- All planned or anticipated Inpatient admissions or surgeries should be pre-certified in advance.
- Emergency Hospital admissions must be reported to ADVANTAGE within forty-eight (48) hours following admission or on the next business day after admission.
- Pursuant to federal law, no Pre-Certification of Hospital stays in connection with childbirth is necessary for the mother or child for stays less than 48 hours (vaginal delivery) or 96 hours (cesarean delivery). Stays longer than 48 or 96 hours must be Pre-Certified.

Outpatient Procedures and Surgeries

- ***PET, MRI, CT, MRA, and SPECT scans***
  - Those done on an emergency basis must be reported within 48 hours to ADVANTAGE or on the next business day after the scan

Behavioral/Mental Health

- All inpatient services, intensive outpatient programs, electroconvulsive therapy and partial hospitalizations.

Biopharmaceutical Drugs

Chemotherapy/Radiation Therapy

Corrective Appliances and Prosthetics

Dialysis

Extended Care Facilities/Skilled Nursing Facilities/Hospice Care/Home Health Care

- ADVANTAGE must be notified by calling the Precertification phone number listed on the Plan ID card at least three (3) business days prior to the Confinement or service.
- Benefits payable for any days or services not certified as Medically Necessary and appropriate shall be denied.

Injections (Therapeutic) and Infusion Therapy with costs exceeding $1,000

Physical Therapy, Occupational Therapy, Speech Therapy

- For all therapies exceeding eight (8) sessions

Durable Medical Equipment

- For charges exceeding $1,500 in total cost or rental exceeding thirty (30) days

CARE MANAGEMENT

ADVANTAGE provides care management services for the Plan that includes:

Concurrent Review

- Concurrent Review is a review conducted of all Inpatient admissions to assess whether there is a need for a continued stay. This process ensures that a Covered Person's confinement is no longer than Medically Necessary and that discharge do not occur prior to necessity. It also includes Discharge Planning to make sure that Covered Persons are moved from a Hospital at the appropriate time to a more appropriate level and setting of care, such as home health care.

Case Management/Alternate Treatment

- Case Management is a program designed to be used in cases where the Covered Person's condition is serious or complex. A nurse case manager may be assigned to work with the Covered Person and his Physician throughout the treatment plan.
- The Covered Person, the Physician, and case manager must all agree on the most cost effective treatment method, while assuring quality medical care.
- The City has the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of care.
- Alternate treatment will be determined based upon the merits of each individual case and shall not be considered as setting a precedent or creating any future obligations whether with respect to the Covered Person or any other individual.
- Both Case Management and Alternate Treatment are voluntary programs, however, both usually result in a greater benefit to the Covered Person as a result of his participation

Disease Management

- ADVANTAGE provides Disease Management services to Covered Persons with Asthma, Chronic Obstructive Pulmonary Disease (COPD), Hypertension (high blood pressure), Congestive Heart Failure (CHF), Depression/Anxiety, Migraines, Coronary Artery Disease (CAD), and Diabetes.
- As part of its disease management program, ADVANTAGE provides Covered Persons with information to assist you with overall management of the above conditions, including newsletters and other materials.
- Covered Persons can choose to enroll and actively participate in ADVANTAGE's Disease Management to receive discounts on prescriptions related to one of the conditions listed above.

COPAYS, DEDUCTIBLES, AND COINSURANCE

COPAYS

Copay is the amount payable by a Covered Person for certain services, supplies, or treatment. Copay amounts under the Plan are shown on the Schedule of Benefits. You must pay the Copay each time a treatment or service is rendered. Copays will not be applied toward:

- The Plan Year Deductible.
- The Plan Year Co-insurance Limit.

DEDUCTIBLES

Individual Deductible

The individual Deductible is the dollar amount of Covered Expense which each Covered Person must have incurred during each Plan Year before the Plan pays applicable benefits. The individual Deductible amount is shown on the Schedule of Benefits.

Family Deductible

Any number of family members may help to meet the family Deductible amount, but no more than each person's individual Deductible amount may be applied toward satisfaction of the family Deductible by any family member. The family Deductible amount is shown on the Schedule of Benefits.

Common Accident

If two or more covered members of a family are injured in the same accident and, as a result of that accident, incur Covered Expenses, only one individual Deductible amount will be deducted from the total Covered Expenses related to the accident for the remainder of the Plan Year.

COINSURANCE

The Plan pays a specified percentage of Covered Expenses at the Customary and Reasonable Amount for Non-Preferred Providers or the percentage of the Negotiated Rate for Preferred Providers. That percentage is specified in the Schedule of Benefits. The Covered Person is responsible for the difference between the percentage the Plan paid and 100% of the Negotiated Rate for Preferred Providers and between the percentage the Plan paid and 100% of the billed amount for Non-Preferred Providers.

MAXIMUM OUT OF POCKET EXPENSE LIMIT

After a covered individual or family incur expenses equal to the maximum out of pocket expense limit listed on the Schedule of Benefits, the Plan will begin to pay 100% for Covered Expenses for the remainder of the Plan Year. This includes level one (1) deductibles, co-pays and co-insurance.

ANNUAL BENEFIT MAXIMUM

The Annual Maximum Benefit payable for services on behalf of a Covered Person is shown on the Schedule of Benefits. The Annual Benefit Maximum applies to services incurred on a plan year basis. There is no lifetime maximum. Essential benefits, if covered by the plan, are excluded from the Annual Maximum. If the Covered Person's Coverage under the Plan terminates and at a later date he again becomes covered under the Plan, the Annual Maximum Benefit will include all benefits paid by the Plan for the Covered Person during any period of Coverage.

The Schedule of Benefits contains separate Maximum Benefit limitations for specified conditions. Any separate Maximum Benefit will include all such benefits paid by the Plan for the Covered Person during any and all periods of Coverage under this Plan.

COVERED EXPENSES – BENEFITS

This section describes the Covered Expenses of the Plan. All Covered Expenses are subject to applicable Plan provisions including, but not limited to: Deductible, Copays, Coinsurance and Maximum Benefit provisions as shown in the Schedule of Benefits, unless otherwise indicated. Any expenses Incurred by the Covered Person for services, supplies or treatment provided will not be considered Covered Expenses by this Plan if they are greater than the Customary and Reasonable Rate or Negotiated Rate, as applicable. The Covered Expenses for services, supplies or treatment provided must be recommended by a Physician or Professional Provider and be Medically Necessary care and treatment for the Illness or Injury suffered by the Covered Person. Specified preventive care expenses will be covered by this Plan.

All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions explained in this Plan, including any attachments. All Copayments, Deductibles and Coinsurance in effect at the time of service will apply to all Covered Services. Please refer to Other Non-Covered Services and Limitations on Benefits for additional explanation of the specific services not covered under this Plan.

You are entitled to the Covered Services listed in this section when those services meet the following criteria:

- Services are Medically Necessary; and
- Services are not excluded elsewhere in this Plan

Allergy Tests and Procedures

- Includes administration of serum, subject to Deductible and Coinsurance.

Ambulance Transportation

Ambulance services are subject to Deductible and Coinsurance and is considered are transportation by a vehicle including ground, water, fixed wing and rotary wing air transportation designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals: 1) from your home, scene of accident or medical Emergency to a Hospital; 2) between hospitals; 3) between a Hospital and Skilled Nursing Facility; or 4) from a Hospital or Skilled Nursing Facility to your home. Transfer from a Hospital to a lower level of care is covered only when Medically Necessary and authorized by your Physician except when ordered by an employer, school, fire, or public safety official and the Covered Person is not in a position to refuse. The Medically Necessary Ambulance transport Coinsurance applies to each transport. Coinsurance waived if transferred from one acute Inpatient facility to another.

Charges for Ambulance service that are for convenience or non-emergency care shall not be considered an eligible expense. Ambulance usage is not covered when another type of transportation can be used without endangering the Covered Person's health.

Behavioral/Mental Health

You may access mental health Providers directly by calling the Mental Health telephone number listed on your ID card. Treatment for Behavioral and Mental health conditions is provided in compliance with federal law.

Inpatient Psychiatric Hospital Services:

Evaluation and treatment in a psychiatric day treatment facility. Pre-Certification required except for emergency situations. For emergencies, notification required within 48 hours.

- **Outpatient Visits:**
  Copayments apply to both individual therapy and group therapy sessions.

- **Psychological Testing:**
  If performed in a Physician's office, Co-pay applies. If performed outside the Physician's office, Deductible and Co-insurance applies.
- **Partial Hospitalizations:**
  Two (2) days of Partial Hospitalization count as one (1) day of Inpatient services.
- **All Intensive Outpatient programs, Electroconvulsive Therapies and Partial Hospitalizations require pre-certification.**

Substance Abuse
Detoxification for alcohol or other drug addiction is covered on an Inpatient and/or Outpatient basis, whichever is determined to be Medically Necessary. To be covered, services must be authorized by your designated Behavioral Health Network. Covered Services are subject to the limitations listed below:

- Inpatient Substance Abuse Services, Deductible and Co-insurance apply.
- Outpatient Substance Abuse Services, Co-pay applies.

Chiropractic Services Option
Maximum of $1000 Covered Services per Plan Year, subject to Deductible and Coinsurance.
Covered Services are for Medically Necessary care in the treatment of musculoskeletal conditions and spinal manipulation only. Definitions applicable to chiropractic services:

- *Medically Necessary* is defined as health care services that are appropriate, in terms of type, frequency, level, setting and duration, to the Enrollee's diagnosis or condition, and diagnostic testing and preventive services. (MN Rule 4685.0100 subpart 9b).
- *Musculoskeletal pain* is defined as pain that affects the muscles, ligaments and tendons, along with the bones.

Acupuncture Services Option
Maximum of 12 visits per Plan Year at $40 each visit; subject to Deductible.
Covered Services are for Medically Necessary care and must be administered by a licensed Chiropractor or Medical Doctor or Nurse Practitioner.

Clinical Trials
The plan will cover expenses incurred for members undergoing care in clinical trials per PPACA regulation § 10103 and § 2709.

Corrective Appliances and Prosthetics
Corrective appliances and prosthetics are subject to Deductible and Coinsurance. Services must be Medically Necessary and used to restore function or to replace body parts. They must be provided with a Prior Authorization and as prescribed by the Participating Physician. Examples of corrective appliances include, but are not limited to:

- Pacemakers
- Hemodialysis equipment
- Breast prostheses
- Prosthetic limbs
- Back braces
- One pair of eyeglass lenses following cataract surgery not to include tinting, scratch-proofing or transitioning.
- Ostomy supplies

Covered Services include the purchase, replacement or adjustment of artificial limbs or eyes, when required due to a change in your physical condition or body size due to normal growth.

Non-Covered Services or limitations

- Appliances and aids which are not necessary for the restoration, function or replacement of a body part.
- Non-durable appliances
- Hearing aids
- Dental appliances
- Dentures
- Foot Orthotics

Dental – Limited Covered Services

Medical services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or fact which are required as a result of an accident or injury and are not excessive in scope, duration or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition, subject to Deductible and Coinsurance. Injury as a result of chewing or biting is not considered an accidental Injury. Initial dental work to repair injuries due to an accident means performed within 18 months from the Injury or as reasonable soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child less than 18 years of age, several years may lapse between the accident and the final repair. Covered services for accidental dental include, but are not limited to: oral examinations, x-rays, tests and laboratory examinations, restorations, prosthetic services, oral surgery, mandibular/maxillary reconstruction, anesthesia.

After emergency treatment, follow-up care must be obtained from a Participating Provider with Prior Authorization.

Hospital and anesthesia services related to dental care are covered for Covered Persons less than 19 years of age or who are physically or mentally disabled if their mental or physical condition requires that dental care be provided in a Hospital or Outpatient surgical center.

The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the standards for determining whether performing dental procedures necessary to treat the individual's condition under general anesthesia constitutes appropriate treatment. The dental procedure is excluded from Covered Services.

The Inpatient Hospital Services Coinsurance will apply to Inpatient services. The Outpatient Surgical Services Coinsurance will apply for Outpatient services in a Provider Network Hospital or Provider Network Outpatient facility.

Diabetes Self-Management Training

Refer to the Care-ADVANTAGE Section for information regarding Diabetes training, supplies and other services.

Dialysis

Outpatient or Inpatient dialysis services with a Prior Authorization, subject to Deductible and Coinsurance.

Durable Medical Equipment (DME)

Rental or purchase of DME, whichever is economically justified, is subject to Deductible and Coinsurance. Replacement of purchased DME that is needed as a result of natural grown, pathological changes, or to maintain functionality is covered. This includes durable and non-durable supplies that are an integral part of the DME set up. Routine maintenance of DME is an eligible expense if needed to keep the DME functional. Training in the use of DME is also covered when necessary and authorized. Pre-Certification is

required for DME expenses exceeding $1500 or thirty days in rental. DME must be Medically Necessary, able to withstand repeated use, and used primarily and customarily to serve a medical purpose.

External Prosthetic Appliances and Devices

Charges made or ordered by a Physician for:

- The initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of injury, sickness or congenital defect. Coverage for external prosthetic appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.
- External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses, orthotic devices, braces, and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- Basic limb prostheses;
- Terminal devices such as hands or hooks; and
- Speech prostheses.

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - Rigid and semi-rigid custom fabricated orthoses;
  - Semi-rigid prefabricated and flexible orthoses; and
  - Rigid pre-fabricated orthoses including preparation, fitting and basic additions, such as bars and joints;
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

Emergency Services

An emergency service means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain that in the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions;
- result in serious dysfunction of a bodily organ or part of the individual.

If you feel you have a medical emergency, you are encouraged to call your PCP for advice and instructions. Your PCP may direct you to a Hospital emergency room or Urgent Care center, or your PCP may be able to see you in the office. If a medical emergency is so serious that in the absence of immediate medical

attention it could be life-threatening or cause serious disability or significant jeopardy to your health, go immediately to an emergency facility or call 911.

While notice to the PCP is not required, it allows the PCP to be informed of your condition and, once you are stabilized, to coordinate your care. In the case of a Non-Participating Hospital, contact the Plan as soon as possible. The Plan and your attending Physician may direct your transfer to a Hospital in the Provider Network once your health condition has been stabilized.

To "stabilize" means to provide medical treatment to an individual in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of the individual's condition is not likely to result from or during any of the following:

- The discharge of the individual from an emergency department or other care setting where Emergency Services are provided to the individual;
- The transfer of the individual from an emergency department or other care setting where Emergency Services are provided to the individual to another health care facility;
- The transfer from a Hospital emergency department or other Hospital care setting where Emergency Services are provided to the individual to the Hospital's Inpatient setting.

If you become ill or injured while you are temporarily away from the Service Area, the Plan will cover care for Emergency Services and Urgent Care. If you are hospitalized outside of the Service Area, contact the Plan as soon as you are able. If you have any questions about how to obtain medical services when you are out-of-area, please call the Plan Member Services phone number listed on the back of your ID card. If there is time, you should try to call your PCP for advice and instructions.

If you are admitted following emergency care, you **must** contact the Plan or your PCP (or someone may contact your PCP on your behalf) **within forty-eight (48) hours** of admission or when you are medically able to do so. If the Covered Person is a minor, the parent or guardian must contact the PCP. If you are admitted to the Hospital directly from the emergency room, your Copayment is waived for the Emergency Service.

Emergency Room includes all related services billed by the Hospital, including other services billed separate from the Hospital. All charges are subject to Copayment, but in-network services are not subject to Deductible or Coinsurance.

Urgent Care

Includes related services and after hours and Physician home visits. Charges are subject to a Copayment, but in-network services are not subject to Deductible or Coinsurance. Out of area Urgent Care services are treated the same as in-network. Urgent Care is determined by medical condition, not the place of service. Urgently needed services or Urgent Care services are instances when you need Covered Services urgently:

- to prevent serious deterioration of health;
- resulting from an unforeseen Illness or Injury;
- while outside of the Service Area; or
- for which treatment cannot be delayed until you return to the Service Area without your condition growing much worse.

If you have an urgent medical problem that is not an emergency, but needs timely attention, you are encouraged, but not required to call your PCP's office, even if you are out of the Service Area. Your PCP knows your medical history and will be in the best position to evaluate your needs. You may be directed by your PCP to an Urgent Care center or emergency room.

An Urgent Care center is a medical facility, where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive Urgent Care services. Coverage for Urgent Care includes after hours and Physician home visits and is subject to a Copay, but not Deductible and Coinsurance.

Health Education
Health education provided by the PCP as part of preventive health care and other health education classes approved by the Plan and covered at the office visit Copay. Classes in weight loss, stress management and smoking cessation are covered under the Wellness section of this document.

Home Health Services
Medically Necessary Home Health Services, subject to Deductible and Coinsurance, with a Prior Authorization, (limited to 100 days per year) including Skilled Medical services. If continuous medical or skilled nursing services are required, the Plan may require:

- transfer to a SNF or other facility if Medically appropriate and more cost effective;
- nursing care given or supervised by a Registered Nurse (RN);Nutritional counseling furnished or supervised by a registered dietician;
- home hospice services;
- home health aides;
- medical supplies, laboratory services, drugs, and medicines prescribed by a Physician in connection with home health care;
- medical social services;
- training of family members or significant other to provide those Home Health Services that can be performed by laypersons.

Services are considered Covered Services only if they are not considered Custodial Care and the services are prescribed in writing by a Participating Physician:

- As Medically Necessary for the care and treatment of your Illness or Injury at home;
- As being in place of Inpatient Hospital care or a convalescent nursing home that would be required in the absence of such services; and
- The services are furnished to you while under a Participating Physician's care.

Hospital Care
Pre-Certification required

Inpatient Hospital Services
Subject to Deductible and Coinsurance.

Outpatient Surgical Services:
Outpatient surgery facility services including those diagnostic invasive procedures that may or may not require anesthesia, subject to Deductible and Coinsurance. All Outpatient surgical services must be preauthorized.
What do I do when I need to be hospitalized?
For Preferred Provider services, your Physician will arrange your admission to a Hospital in the Provider Network. You are responsible for contacting the Plan for Prior Authorization for all Hospital services.

What are the Covered Services?
The Inpatient and Outpatient medical and surgical Hospital services are covered when Medically Necessary, and prior authorized by the Plan.

- Inpatient medical and surgical services;
- Semi-private room and board (Private room provided when Medically Necessary);
- Intensive Care Unit/Coronary Care Unit;
- Inpatient cardiac rehabilitation, limited to annual maximum of 90-days;

- Inpatient rehabilitation therapy which includes physical, occupational, speech and pulmonary of acute Illness or Injury to the extent that significant potential exists for progress toward a previous level of functioning limited to an annual maximum of 60 days.
- Outpatient medical and surgical services, including those diagnostic invasive procedures, which may or may not require anesthesia;
- Other Medically Necessary Inpatient Hospital Services, including but not limited to: general nursing care; use of operating room or delivery suite; surgical and anesthesia services and supplies; ordinary casts; splints and dressings; drugs and oxygen used in Hospital; laboratory and x-ray examinations; electrocardiograms; and special duty nursing (when requested by a Physician and certified as Medically Necessary).
- *Inpatient* biologic/biopharmaceutical medications do not require additional Copayment or Coinsurance.
- Medically Necessary professional services for surgical operations (major and minor), which are ordered or approved by your Physician include but are not limited to:
    - Reconstructive procedures as outlined herein; Replacement of diseased tissue surgically removed while a Covered Person;
- Treatment of a birth defect in a Dependent child;
- Federal law requires health Carriers that provide medical and surgical benefits for mastectomies to also cover reconstructive surgery and other related services following a mastectomy. Under the law, if a Covered Person has a mastectomy and, in consultation with the Physician, elects to have reconstructive surgery, the Covered Services would include:
    - Reconstruction of the breast upon which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

The manner of treatment for any given patient is to be decided in consultation with the attending Physician and patient. The law permits Coinsurance and Deductibles to apply.

Infertility Coverage
Coverage is provided for the treatment of an underlying medical condition ***UP TO THE POINT OF AN INFERTILITY DIAGNOSIS.*** There is no coverage for the treatment of infertility following diagnosis.

Injections (Therapeutic) and Infusion Therapy
Therapeutic Injections and Infusion Therapy must be preauthorized. Outpatient therapeutic injections which are Medically Necessary and which may not be self-administered are covered. Injections include, but are not limited to chemotherapy, radiation, antibiotics, analgesics, hydration, total parenteral nutrition (TPN), Prolactin, and Factor 8 injections, which are Medically Necessary. Self-injectable are Covered Services only when authorized by the Plan. Biopharmaceutical Drugs are subject to the Co-payment of $60. Therapeutic injections and infusions (non-Biopharmaceutical Drugs or insulin drugs), including Home IV Therapy are subject to the Co-payment of $40.

Internal Implantable Devices
Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functioning body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Maternity and Newborn Infant Coverage
Please refer to Hospital Care for Inpatient benefits
(Covered for Employee/Spouse only)

The benefits include Physician services, Hospital services, and laboratory and x-ray services as Medically Necessary and appropriate.
Pursuant to The Newborn's and Mother's health Protection Act, no Pre-Certification of Hospital stays in connection with childbirth is necessary for the mother or child for stays less than 48 hours for vaginal delivery or 96 hours for cesarean delivery. Stays longer than 48 or 96 hours must be pre-certified.

Unplanned interruption of pregnancy (miscarriage) will be treated as any other Illness, including, but not limited to Medically Necessary Physician's services, Hospitalizations, x-ray and laboratory services.

An election to enroll a newborn must be made within the first 31 days of birth for Coverage to continue past the 31st day.

Professional obstetrical care, including prenatal visits, antepartum care, and one postpartum visit per pregnancy term regardless of date of conception. Including Physician services, laboratory and x-ray services as Medically Necessary and appropriate. Copayment applies to professional services but there is no Deductible or Coinsurance.

Newborn Examinations
Newborn examinations are covered under maternity care, or Hospital care, or Physician office visits. Newborn examinations include the detection of:

- Inherited Metabolic Disease, includes services for Medical Food and Low Protein Modified Food
- Products (not subject to copayment, regardless of supplier)
- Hypothyroidism
- Hemoglobin paths, including sickle cell anemia
- Galactosemia
- Maple Syrup Urine Disease
- Homocystinuria
- Inborn errors of metabolism that result in mental retardation and that are designated by the State Health Department
- Physiologic hearing screening examinations for detection of hearing impairments
- All other tests and examinations required by federal and/or state law, applicable to this Plan, including but not limited to, PPACA
- Charges related to circumcisions

If a parent of an infant objects in writing, for reasons pertaining to religious beliefs only, the infant is exempt from the examinations. For additional information regarding Coverage, please refer to the Baby-on-Board section of this Plan.

Breast Pumps
Electric breast pumps are covered at 100% up to a $300 maximum benefit. The pump must be purchased within 30 days prior to or 30 days after giving birth.

Medical Social Services
Hospital services to assist you and your family in understanding and coping with the emotional and social problems affecting health status. There is no cost for this covered service.

Medical Supplies
Casts, dressings, splints, and other devices used for reduction of fractures and dislocations, subject to Deductible and Coinsurance.

Nutritional Supplements
Pre-Certification and Prior Authorization is required. Nutritional supplements must be Medically Necessary and is subject to Deductible and Coinsurance.

Pervasive Developmental Disorder
Treatment is limited to services provided by your Physician in accordance with a treatment plan, subject to Deductible and Coinsurance. Pervasive Developmental Disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic & Statistical Manual of Mental Disorders of the American Psychiatric Association.

Outpatient Services
Outpatient Services including but not limited to:

- Laboratory, pathology, radiology*, MRI*, CT*, MRA*, PET*, and SPECT* scan -
  *Pre-Certification or Prior Authorization required.
- Electro cardiology (EKG) and electroencephalography (EEG)

Physician Services – Office visits

Office Visit Services

- Primary Care Physician Office Visit subject to PCP Copayment.
- Specialty and Referral Physician Office Visit subject to Specialist Copayment.
  Other services provided in PCP or SCP office included in office visit Copayment:
- Office visits, services and supplies for the determination and/or treatment of Illness or Injury. These services include medical consultations, and procedures performed in the Physician's office, Second Opinion consultations, and specialist treatment services.
- Allergy Testing.
- Maternity Care – refer to Maternity Care benefit.

Physician Services – Non-Office Visit Services

- Primary Care Physician, Specialty and Referral for all Physician Services in the Hospital or Outpatient Facility subject to Deductible and Coinsurance.
- Primary Care Physician, Specialty and Referral Physician Visits in the home when provided by your Participating Physician subject to Deductible and Coinsurance.

Physician Services for Wellness and Preventive Services
The following services will be covered as a wellness visit with no Deductible and no Co-payment and no out-of-pocket expense:

- Services for wellness and preventative services will be covered as regulated by the Patient Protection and Affordable Care Act (PPACA).
  - Provided by the PCP or other authorized Provider including, but not limited to:
- Routine Physical Exam:
  - Periodic health appraisal examinations for Covered Persons who are less than 18 years of age for the prevention and detection of disease as recommended by the American Academy of Pediatrics. For Covered Persons age 18 and older, history and annual health evaluations (physical examinations for the prevention and detection of disease) limited to the extent Medically Necessary or appropriate.

- Routine Colorectal Cancer screening:
    - Colorectal cancer examinations and laboratory tests must be covered for any non-symptomatic individual in accordance with current American Cancer Society Guidelines for a Covered Person who is:
        - at least fifty (50) years of age; or
        - Less than fifty (50) years of age and at high risk for colorectal cancer.
        - Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.
- Routine gynecological services
- Routine Mammograms:
    - Breast cancer screening tests include;
        - One (1) baseline screening mammography before the age of forty (40) for a Covered Person who is at least thirty-five (35) years old;
        - Annual screening mammography if at risk and less than forty (40);
        - Annual screening mammography for Covered Persons forty (40) years old and older;
        - Any additional mammogram views needed for proper evaluation and ultrasound services; if Medically Necessary;
        - Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.
    - Routine Women's Health Care including:
        - Well-woman visits;
        - Screening for gestational diabetes;
        - Human papillomavirus testing in certain instances;
        - Counseling for sexually transmitted infections, including HIV;
        - Contraceptive methods and counsel;
        - Breastfeeding support, supplies, and counseling; and
        - Screening and counseling for interpersonal and domestic violence
    - Routine Prostate Specific Antigen (PSA) Test:
        - PSA tests include:
            - At least one (1) PSA test annually for an individual who is at least fifty (50) years old:
            - At least one (1) PSA test annually for an individual less than fifty (50) who is at high risk of prostate cancer according to the American Cancer guidelines;
            - Please log onto www.cancer.org to obtain the specific American Cancer Society guidelines.
    - Routine Immunizations:
        - Immunizations and inoculations (vaccine and administration of vaccine) based on the guidelines of the Advisory Committee on Immunization Practices (ACIP) or at the Plan's discretion, other nationally recognized organizations, such as the American Academy of Pediatrics (AAP) or the Academy of Family Physicians (AAFP). Influenza, pneumonia and shingles immunizations also covered. Covered at 100% if done either in a physician's office or via physician's order under pharmacy benefits of a $0 Copayment.
    - Hearing tests:
        - Hearing examinations including an infant physiological hearing screening examination at the earliest feasible time for the detection of hearing impairments.
    - Vision screenings;
    - Other evidence based items that have in effect a ration of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved
    - With respect to women, to the extent not described above, evidenced informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including, but not limited to, contraceptive services described therein.

Pharmacy Services

What is a Generic drug?

A Generic drug is a copy of a brand name drug for which the patent has expired. The Generic drug may be of different shape, size, color or flavor, but the active, therapeutic agents are the same as the brand name drug. The same quality and safety standards that apply to brand name drugs also apply to the Generic form. The FDA sets standards and reviews all Generic medications before marketed.

What is a Brand-Name Drug?

A brand name drug is a drug that has been manufactured under a patent and in accordance with the approval for the FDA.

All Covered Services for Outpatient prescription drugs will be subject to the drug Formulary.

All prescriptions must be prescribed by a Participating Provider in order to receive this covered service. All compound prescriptions must contain at least one covered prescription ingredient. Insulin and insulin needles and syringes, when prescribed by a Participating Physician and dispensed to you shall be limited to treat that acute condition or phase of Illness or a thirty-(30) day supply, whichever is less, per Copayment.

Outpatient Prescription Drug FOUR TIER Option
(Please refer to the Formulary for more details)

MANDATORY GENERIC drugs are required by the Plan when available. If the member chooses to purchases the brand drug, the member responsibility will be the difference in cost between the generic and brand medication in addition to the brand copay. Please refer to the 2015 Step Therapy requirements as outlined in the Prescription Drug Formulary Document. Step Therapy is a program that encourages the use of safe and effective first-line medications. First-line drugs are well established and known to be both safe and effective.

TIER 1 - Generic Drug
When you receive a Generic drug you pay the lowest out-of-pocket cost for the prescription.

TIER 2 - Brand-Name Drug
If you or your Physician requests a Brand-Name Drug when there is a Generic equivalent available, you will be charged the Brand-Name Drug Copayment, plus the difference in cost between the Generic Drug and Brand-Name Drug. For some conditions, your doctor will need to prescribe one medication before trying another. Please refer to the 2015 Step Therapy requirements as outlined in the Prescription Drug Formulary Document.

TIER 3 -Non-Preferred Brand-Name Drug
If you or your Physician requests a non-Formulary Brand-Name Drug when there is a Generic equivalent available, you will be charged the Non-Preferred Brand-Name Drug Copayment, plus the difference in cost between the Generic Drug and Brand-Name Drug.

TIER 4 – Specialty Drug (Prior Authorization Required)
Refer to the Specialty Drug section below for additional information.

Over-The-Counter Medications
Includes coverage for certain over-the-counter medications when prescribed by your PCP. The over-the-counter medications are listed within the Plan Prescription Formulary.

Diabetes Supplies

All diabetes supplies must be obtained through the approved pharmacy Participating Providers or the Plan's pharmacy mail order program. Covered Services include:

- Alcohol swabs
- Glucose blood test strips
- Glucose monitoring test strips
- Insulin
- Lancet devices
- BD/pen/needles syringes
- Selected glucometers

What are the Non-Covered Services or limitations?

- Luxury items will only be Covered Services if a non-luxury item is not available or the luxury item is deemed Medically Necessary for its intended purpose as prescribed and approved by a Participating Provider.
- Insulin pumps and supplies associated with insulin pumps are not a covered service under this benefit. Instead, insulin pumps and supplies are Covered Services under the DME section of this Plan Document.

Specialty Drugs

- Specialty or Biopharmaceutical Drugs means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings.
- Biological or biopharmaceutical products typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct Physician involvement, and significant Covered Person education. These services must be authorized by the Plan. A $60 Tier Three Pharmacy Copayment applies to each dispensing of the Biopharmaceutical Drug.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of Medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Skilled Nursing Facility/Hospice Facility/Extended Care Facilities
Limited to 60 days per year. Coinsurance waived if transferred from an Inpatient facility following an Inpatient admission. Day limits do not apply to hospice.
Covered Services when Medically Necessary with a Prior Authorization includes:

- Semi-private room; private room provided when Medically Necessary.
- Drugs, Biologicals, medical social services, short term physical, speech, occupational therapies (subject to limitations listed in the Short-term Therapies indicated below) and other services generally provided by skilled nursing facilities.
- Hospice Care provided if you are Terminally Ill, in accordance with a treatment plan developed before your admission to the Hospice Care program. Treatment plan must include a statement from the Physician documenting that life expectancy is six months or less.

Therapies -- Short-Term

Short-term Physical Therapy:

- Short-term physical therapy –a condition that the Physician believes is subject to continuing improvement.
- Prior Authorization is required for therapies beyond eight (8) sessions.
- Covered Expenses limited to 60 sessions per Illness, Injury, or Congenital Defect.

Short-term Speech and Occupational Therapy:

- Short-term speech or occupational therapy – services are covered to correct an impairment due to Injury, Illness, or congenital defect.
- Prior Authorization is required for therapies beyond 10 sessions.
- Covered Expenses limited to 60 sessions for occupational therapy and 25 sessions for speech therapy per Illness, Injury, or congenital defect.
- Covered Services for speech therapy when provided to restore speech after a loss or impairment of previous, demonstrated ability to speak; or develop or improve speech after surgery to correct a defect that existed at birth and impaired, or would have impaired, the ability to speak. Covered Services do not include speech therapy due to a delay in speech development.

Short-Term Rehabilitative Therapy:

- Short-Term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, pulmonary and cardiac rehabilitation therapy, when provided in the most Medically appropriate setting.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or sickness.
- A separate copayment will apply to the services provided by each Provider.

Short-Term Rehabilitative Therapy services ***that are not covered include*** but are not limited to:

- Sensory integration therapy, group therapy, treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and;
- Maintenance or preventive treatment consisting of routine, long-term or non-Medically necessary care provided to prevent recurrence or to maintain the patient's current status.

Sterilization
Charges for elective sterilization procedures such as tubal ligations are covered at 100% with no Copays, Deductibles or Coinsurance in accordance with PPACA;

- Charges for reversal or attempted reversal of these procedures are not covered.

TMJ/Orthognathic Surgery
Charges related to TMJ including diagnosis and treatment up to a lifetime maximum of $1500.

Transplant Services
Human organ and tissue transplant services for both the recipient and the donor, when the recipient is a Covered Person includes a maximum lifetime limit of $20,000 for Covered Services related to transportation and lodging for the donor.

- The maximum lifetime limit for Covered Services related to transportation and lodging applies to the Policy Maximum.
- No Coverage is provided for the donor or the recipient when the recipient is not a Covered Person.
- The Inpatient medical Coinsurance applies as specified
- SCP office visit Copayment applies as specified for pre-transplant evaluation.
- Non-Experimental, non-Investigational organ and other transplants are covered.
- The Plan will cover the donor's medical expenses if the person receiving the transplant is a Plan Covered Person and the donor's expenses are not covered by another health benefit Carrier.

NON-COVERED SERVICES AND LIMITATIONS

The following section indicates the items which are not Covered Services under this Plan and are thus your financial responsibility. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

1. Services and supplies that are not Medically Necessary, except for preventive care as described herein;
2. Services and supplies that are not specifically listed as Covered Services;
3. Services not within the scope of the Provider's license;
4. Services of a Provider who is a member of the patient's immediate family or who normally resides in the patient's household.
5. Services and supplies provided by your family, i.e., parent, brother, sister, or child, or someone who lives with you;
6. Services of a Provider treating himself or herself;
7. Services and supplies that are furnished by a government plan, Hospital, or institution, unless you are legally required to pay for the service;
8. Services and supplies provided prior to your Effective Date of Coverage or after your Coverage is terminated;
9. Services and supplies incurred after you leave a program of Inpatient care for the same condition, against the medical advice of your Physician;
10. Services and supplies that would have been provided at no cost if you did not have Coverage under the Plan;
11. Services and supplies which are covered, or would have been covered, under any worker's compensation or occupational disease act or law;
12. Except when required by law, services and supplies provided to treat an Illness or Injury caused by:
    - any act of war, declared or undeclared, while serving in the military;
    - service in the military forces of any country, including non-military units supporting such forces;
    - the commission or attempt to commit a civil or criminal battery or felony; or participating in a riot ("taking part in a riot" means the use or threat to use, force or violence without authority of law, by four or more persons).
13. General population based genetic screening or pre-implantations genetic screening in the absence of any symptoms or proven risk factors. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease;
14. All treatments, procedures, facilities, equipment, drugs, devices, services, or supplies that are considered Experimental;
15. Cosmetic or reconstructive procedures, and any related services or supplies, which alter appearance, but do not restore or improve impaired physical function, except as specifically provided herein including wigs, except when hair loss is the result of burns, chemotherapy, radiation therapy or surgery. The purchase of a wig or artificial hairpiece is limited to one per Plan Year. Services and supplies provided to treat hair loss, promote hair growth, or remove hair. Prescriptions, while not a covered benefit, can still be filled utilizing the Plan's discount for such drugs through a Participating Pharmacy;
16. Orthognathic Surgery charges beyond $1500 lifetime benefit;
17. Services and supplies related to narcotic maintenance treatment for opiate addiction;

18. Storage of blood products when not Medically Necessary or not provided in conjunction with a scheduled covered surgery; blood products when replaced by donation;
19. Items or devices primarily used for comfort, including, but not limited to air purifiers, humidifiers, dehumidifiers, whirlpools, air conditioning, waterbeds, exercise equipment, and ultraviolet lighting, even if prescribed by a Physician;
20. Non-skilled care, rest cures, respite care, or domiciliary care, regardless of the setting;
21. Private duty nursing services provided for the convenience of you or the convenience of your family (for example, bathing, feeding, exercising, moving the patient, giving oral medication or acting as a companion or sitter);
22. Room and board services while you are permitted to temporarily leave a Hospital, SNF, or Hospice Facility;
23. Standby charges of a Physician;
24. Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under this Plan, unless otherwise required by law;
25. Orthodontia and other dental services, except as expressly provided for in this Plan Document or any attachment to this Plan Document;
26. All unauthorized dental services, or services rendered by a non-Participating Provider; dental appliances; dentures; dental prostheses;
27. All dental services not completed within 18 months from initiation of covered treatment, except for children under the age of 18 as provided herein;
28. Repair of dental Injury caused by an intrinsic force, such as the force of the upper and lower jaw in chewing;
29. Repair of artificial teeth, dentures, or bridges;
30. Physical exams and related x-ray and lab expenses, when provided for employment, school, sports' programs, travel, immigration, administrative purposes, or insurance purposes;
31. Pre-marital tests or exams;
32. Services and supplies for the treatment of: adult hyperkinetic syndrome, learning disabilities, mental retardation, behavioral disorders, or senile deterioration, beyond the period necessary to diagnose the condition, except for pervasive developmental disorder as described herein;
33. Marriage counseling or personal growth therapy;
34. Hypnotherapy, behavioral modification, or milieu therapy, when used to treat conditions that are not recognized as mental disorders by the American Psychiatric Association;
35. Self-help training and other related forms of non-medical self-care, which are unrelated to mental health;
36. Services and supplies unrelated to mental health for the treatment of co-dependency or caffeine addiction;
37. Immunizations provided for the purpose of travel;
38. Supportive devices of the feet, including but not limited to foot orthotics, corrective shoes, arch supports for the treatment of plantar fasciitis, flat feet, fallen arches, weak feet, chronic foot strain, co*rn*s, bunions, and calluses.
39. Routine foot care except when medically Necessary for the treatment of diabetes and lower extremity circulatory diseases.
40. Telephone consultants, charges for completion of claim forms;

41. Fees that the Provider may charge you if you miss scheduled appointments without canceling with reasonable notice;
42. Court-ordered services, unless appropriate, Medically Necessary, and authorized by your Physician;
43. Travel or Hospitalization for environmental change, or Physician services connected with prescribing environmental changes;
44. Naturopathic medicine or Christian Science medicine;
45. Massage Therapy;
46. Preparation of special medical records or court-ordered appearances for hearing or proceedings;
47. Medical care provided outside the U.S., unless an emergency;
48. Services, drugs, and supplies for weight loss, diet, health or exercise programs, health clubs dues, or weight reduction clinics. However, you are entitled to access the Plan's discount for such drugs through a Participating Pharmacy;
49. Non-prescription glasses or vision devices; orthoptics or vision therapy including eye exercises and any associated supplemental testing;
50. Services or supplies for, or related to:
    - sex change operations or reversal, except for congenital deficiency;
    - artificial insemination
    - gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or in-vitro or in-vivo fertilization;
    - abortion;
    - reversal of sterilization;
    - use of a surrogate for any reason
51. Charges for services and supplies related to sexual dysfunction or inadequacies, included but not limited to sexual therapy, counseling, penile prosthetics and pumps, medications and all other procedures and equipment for the treatment of impotency;
52. Hearing aids, Hearing therapy, or their fitting;
53. Audiometric exams for the purpose of hearing aids;
54. Extensive long-term neuromuscular rehabilitation, i.e., physical, speech or occupational therapy is excluded. Rehabilitation that the Physician reasonably believes will require in excess of 60 days per each distinct condition or episode, beginning with the first rehabilitation treatment for that condition, will be considered "long-term" and is not covered. (When you undergo a rehabilitative treatment for a specific and distinct condition, that visit constitutes one treatment). The Plan reserves the right to extend Covered Services through a formal medical management regimen;
55. Personal comfort items, including but not limited to services and supplies not directly related to your care, such as guest meals and accommodations, private room (unless Medically Necessary), personal hygiene products, telephone charges, travel expenses (other than approved Ambulance services as provided in the basic health services), take-home supplies including prescription drugs and similar items;
56. Recreational or educational therapy;
57. Treatment and testing for adolescents and children, which are state mandated services by or of the school system, unless therapy is deemed Medically Necessary by a Participating Provider
58. Court ordered therapy, unless appropriate, Medically Necessary, and authorized by your participating behavioral health Provider;

59. Vocational therapy, including work hardening programs;
60. Newborn deliveries performed by a midwife in the home and any charges, including but not limited to supplies and equipment as a result of such deliveries.
61. Treatment or services related to Pre-Existing Medical Condition which are incurred during the Pre-Existing Medical Condition Exclusion Period as defined in this Plan Document;
62. Growth Hormones and related products except where pre-authorized by Plan;
63. Corrective appliances and artificial aids which are not necessary for the restoration, function, or replacement of a body part; non-durable appliances;
64. Speech therapy due to a delay in speech development;
65. Common first aid supplies;
66. Durable Medical Equipment that:
    - cannot withstand repeated use;
    - is not medical or not primarily and customarily used to serve a medical purpose;
    - serves as useful in the absence of Illness or Injury;
    - is not suitable for use in the home;
    - specifically fitted to an individual and not appropriate for repeated use by multiple patients;
    - is considered deluxe equipment. Covered Services are only for the basic type of DME necessary to provide for your medical needs as determined by your Physician and authorized by the Plan.
67. Non-durable supplies and/or convenience items which are not required to operate a durable medical device and are not an integral part of the DME set-up;
68. Non-durable medical supplies for use outside the Hospital or Physician office;
69. Bariatric surgery;
70. Maternity services when Covered Person is acting as a surrogate mother.
71. Services and supplies for non-essential benefits provided after the Annual Policy Maximum has been exceeded by the Covered Person.
72. Services and supplies while incarcerated in a federal, state or local penal institution or required while in custody of federal, state, or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
73. For surgical treatment of gynecomastia.
74. Treatment of telangiectatic dermal veins (spider veins) by any method.
75. Treatment of varicose veins when not Medically Necessary and done for cosmetic purposes.
76. Charges for injuries due to hazardous activity including automobile racing, motorcycle racing, sky diving, parasailing, boat racing, hang gliding, cave diving, piloting of an ultra-light aircraft, base jumping, and bungee jumping; motorcycle and all-terrain vehicle (ATV) activities IF NO HELMET WAS USED;

Other Limitations:

Cost Effectiveness

- The Plan will not pay the cost of any Inpatient or other care which could have been provided by a Participating Physician's office, in the Outpatient department of a Hospital, or in another less costly location without adversely affecting the patient's condition or the quality of medical care rendered, unless the UM Committee has determined the care to be Medically Necessary.

- Nor will the Plan pay the cost of any service or article which is significantly more expensive than an available alternative, unless the UM Committee has determined the more expensive service or article has been demonstrated to be of significantly greater therapeutic value than the other, less expensive, alternative.

Circumstances Beyond the Plan's Control:

Neither, the Plan, nor Participating Hospitals, nor any Participating Provider shall have any liability or obligation for delay or failure to provide health care services:

- Due to causes beyond the control of the Plan or the Plan's Participating Providers. Such causes might include: complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant part of the Hospital personnel or Health Professionals, or similar causes, under which the rendition of medical or *Hospital* services hereunder is delayed or rendered impractical.
- Due to lack of available facilities or personnel if caused by disaster or epidemic.

In such events, Physicians and Hospitals shall render medical and Hospital services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel as are then available.

PHARMACY BENEFIT MANAGER

Envision Pharmaceutical Services is the pharmacy benefit manager for the Plan's prescription drug program. Envision is responsible for:

- Processing pharmacy claims. When a Covered Person of the Plan goes to a Participating Pharmacy to fill a prescription drug, the pharmacy electronically enters the prescription and Covered Person's information off of the ID card for claim payment. The claim is routed to the PBM where it is checked for eligibility, Coverage of drug, and the Covered Person's financial obligation, usually a Copayment.
- Managing the prescription drug mail order program.
- Developing and maintaining a network of participating pharmacies.
- Developing a list of preferred drugs.

Most large pharmacy chains participate in the Plan's pharmacy network, as well as many local and regional pharmacies. You can find a complete listing of pharmacies that participate with the Plan's network by calling 800-553-8933. All prescriptions must be filled through the Pharmacy Benefit Manager network.

Mail Order Program
Under the Prescription Drug Program, you may receive covered maintenance prescriptions through the Pharmacy Benefit Manager approved mail order program. Maintenance prescriptions are those that eligible Covered Persons may receive a savings for up to a maximum 90-day supply per prescription.

You may begin using the mail order prescription program by completing the Mail Order Form provided with your new Covered Person welcome packet (contact a Member Services Representative if you need a Mail Order Form). You must call your Physician's office and request a new prescription for the maximum days' supply allowed. Mail your new prescription(s) and your Copayment(s) along with the completed form in the envelope attached to the order form. Please allow for an average delivery time of two weeks. If you have questions about the prescription drug benefits, please contact a Plan Member Services representative for assistance.

Formulary
The Plan utilizes a prescription drug Formulary. A Formulary is a list of Generic and brand name prescription medications that have been approved by the Food and Drug Administration (FDA). Each "Tier" is described in the Formulary document and you may review the most-recent Formulary by logging on to www.Advantageplan.com.

You may also contact a Plan Member Services representative to receive a copy of the drug Formulary.

Your Participating Physician will refer to the Formulary to select medications that are appropriate to meet your healthcare needs, while helping you maximize your prescription drug benefit. Participating Physicians and pharmacists are provided with information about the Plan's Formulary and updates as new medications are approved to be added to the Formulary or when current medications are replaced.

When Prior Authorization is required for Outpatient prescription drugs
A limited number of prescription drugs require Prior Authorization. The pharmacist will advise you if your prescription requires Prior Authorization. Your prescribing Physician is required to complete a "Letter of Medical Necessity" and fax it to the pharmacy benefits manager's Authorization unit. The information is reviewed for clinical information that would indicate the prescription drug is covered under your benefit plan for your circumstances.

Participating Physicians have been educated about the Prior Authorization drug process. Many Physicians will complete the "Letter of Medical Necessity" at the time he/she provides you with the prescription. If the prescription is authorized after review, a Member Services Representative will notify you as quickly as possible. If

Authorization is denied, a clinical specialist will notify the prescribing Physician to discuss the clinical guidelines used for the denial, and you will be notified of the denial in writing and of your right to appeal. If you have questions about the Prior Authorization process for prescription drugs, please contact a Member Services Representative for assistance.

Pharmacy related Non-Covered Services or limitations

Limitations

You will be reimbursed, less the applicable Copayment, Coinsurance and Deductible, if applicable for prescription drugs obtained from other than the designated Plan participating pharmacies, only when the drug was:

- Ordered in connection with an out-of-area emergency covered under the Emergency Services section described in this Plan Document;
- Ordered by a Physician for immediate use because of medical necessity and because your designated pharmacy is not open for business at that time.

Reimbursement in the above two circumstances will be limited to the Maximum Allowable Amount of costs for a quantity of the drug sufficient to treat the acute phase of the Illness or to a maximum of thirty (30) day supply, whichever is less.

- A drug not approved by the FDA may be prescribed if one of the following conditions is met:
    - the drug is recognized for treatment of the indication in at least one (1) standard referenced compendium; or
    - the drug is recommended for that particular type of cancer and found safe and effective in informal clinical studies pursuant to ACA provisions; the results which are published in the United States or Great Britain.

Covered Services will only be provided in the quantity equal to the amount prescribed for use through the last day of eligibility.

Non-Covered Services:

- Injectable, which are not listed on the Formulary;
- Implantable drugs; implantable devices for the administration of drugs;
- Devices and appliances other than insulin syringes/needles, except for contraceptive devices required to be covered by the PPACA;
- Drugs administered in Physician's offices, Hospitals, nursing homes, the Plan Skilled Nursing Facilities and hospices;
- Except for Nicotine Patches obtained through a prescription, Care-ADVANTAGE identified medications, and those over the counter drugs required to be covered by the PPACA, all over the counter (OTC) drugs;
- Drugs whose purpose is the treatment of infertility or impotence
- Except for drugs approved through the Plan review process, drugs prescribed that are investigative or Experimental in nature. A drug shall be considered Experimental if it has not been approved by the FDA and if the FDA has not approved the drug for the route of administration, the dosage involved, or except as otherwise required by law for certain cancer drugs, the specific indications for which the drug is being prescribed;
- Drugs used for Cosmetic or recreational purposes (e.g., anabolic steroids, anorexiants, topical minoxidil, or Retin-A for wrinkles, however, retonic acid creams are covered when used in connection with the treatment of severe acne.) Drugs prescribed as part of the treatment for congenital defects or anomalies, shall not be considered Cosmetic for purposes of this Section;
- Anorexiants, food supplements and other drugs when prescribed for the treatment of obesity;
- Hospital discharge drugs; take-home drugs;
- Oral prescription medications when prescribed for foreign travel;
- Replacement of drugs due to loss, theft or negligence;

- Maintenance drugs when filled at a non-Participating Pharmacy;
- Excluded prescriptions may be purchased at a participating Plan pharmacy at the Plan's negotiated discount price.
- Growth Hormones and related products, unless pre-Authorized under Plan;
- Vitamins and Nutritional Supplements, which are not listed on the Formulary.

OTHER BENEFITS

***Care*-ADVANTAGE®** is a program developed by ADVANTAGE Health Solutions to help you deal with long-term health problems; often called "chronic" conditions or Illnesses. If you have any of the following health problems, you can join *Care*-ADVANTAGE®:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Diabetes or high blood sugar*
- High blood pressure (Hypertension)
- Migraine Headaches
- Depression/Anxiety

*Diabetic supplies are provided at **no cost** to all Care-ADVANTAGE members through our Diabetic Supplies Mail Order Program. You will receive:

- A TRUEresult blood glucose meter
- A TRUEdraw lancing device
- A 90-day supply of TRUEplus lancets (based on YOUR testing requirements)

To participate in this program you must:

- Complete the HRA
- Fill out an Enrollment form (available through Human Resources or online at careadvantage@advantageplan.com)
- Send in the above items

ADVANTAGE will confirm the information and your shipment will be sent to the address provided. This generally takes two weeks to complete.

To join *Care*-ADVANTAGE®, please take a few moments to complete the online assessment available on the link below. For questions, please call our Disease Management Coordinator at 1-877-901-2237 x2922 or e-mail us at careadvantage@advantageplan.com. We are open Monday through Friday 8:00 am to 5:00 pm.
Please visit our *Care*-ADVANTAGE® site for more information on the program.

BABY-ON-BOARD

ADVANTAGE offers our Baby on Board program at no cost to our pregnant mothers. Women who see their doctors early in their pregnancies and continue to do so throughout their pregnancies have healthier babies. The Baby on Board program staff will send you a health assessment to complete about your pregnancy. This will help us decide how we can support you throughout your pregnancy. Members who enroll receive:

The Good Housekeeping Illustrated Book of Pregnancy and Baby Care, with information about:

- What to expect at your scheduled prenatal visits
- Prenatal tests
- How your baby develops
- Immunization (shot) schedule
- Parenting suggestions
- Childhood Illnesses and first-aid care
- Phone calls from a nurse educator at least three times during your pregnancy
- A phone call from a nurse educator following delivery
- Information about healthy lifestyle choices

If you are having problems during your pregnancy, a case management nurse may call you more often. He or she will help you get any additional help or services you might need to ensure you have a happy, healthy baby!

To enroll, please call 1-866-646-0288, or e-mail us at careadvantage@advantageplan.com

PREMIER HEALTHWAY

Premier Healthway is a health program that provides cost effective discounted case rate procedures for the treatment of heart disease when a specific network of Providers is used. Premier Healthway is an enhancement or value-added benefit that works in conjunction with your employer's health plan. By using a Premier Healthway Provider or facility, eligible health plan participants will have co-pays, co-insurance and Deductibles waived for covered case rate procedures.

In addition, the cost savings realized through the inclusive case rate procedures translate into decreased health plan expenses for your employer. In turn, this minimizes the impact of costly medical procedures on the employee's share of health plan costs.

Other benefits of participating in Premier Healthway include heart-healthy educational classes, stress management, and weight loss programs. These services are free or are provided to Premier Healthway members at discounted rates. The following classes are offered to the public, but Premier Healthway participants may attend at a discounted rate:

- *St. Francis Weight Loss Center* Classes (317-782-7525)
- *Change of Heart Classes* (Contact 317-782-4422)
    - Spring and Fall Classes include topics such as Heart Healthy Dining, Dealing with Stress, etc.
    - ALL CLASSES ARE FREE
        - **Note:** Registration is required for classes

For additional information, please contact your employer's Human Resources office or Premier Healthway directly at 1-866-839-0062. We also invite you to visit our website at www.StFrancisHospitals.org/sfhn.

ELIGIBILITY AND ENROLLMENT

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

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

1. Is employed by a unit of the City and is routinely schedule for at least 30 hours per week or 130 hours per month and whose work week consists of seven (7) consecutive days except for police officers and firefighters;
2. Is a full time firefighter who is employed by the City, regardless of whether the 12 month introductory period had elapsed;
3. Is a full time sworn police officer, regardless of whether the 12 month introductory period has elapsed; and
4. Is not considered a Part-time, Temporary or Seasonal employee.

Completion of an enrollment form is a Plan requirement. An Eligible Employee may enroll for Coverage immediately upon date of hire. Coverage is effective on the first day of the month following the completion of payment of two of the required bi-weekly premium amounts or as of the date specified in a written agreement of employment between the Employee and the City.

Dependents Dependents of an Eligible Employee will become eligible for Coverage under this Plan as a Dependent on the first day that the Eligible Employee is eligible for Coverage under this Plan. Eligible Dependents are:

- The Employee's legal Spouse; the Plan Administrator may require documentation proving a legal marriage for verification of eligibility at any time;
- The Employee's children until end of the month when he/she turns twenty-six (26) years of age who include biological, adopted and children placed for adoption. Step-children ***who live with the employee and who are not covered under other parent's medical insurance,*** foster children, children under a legal guardianship, or children under the legal guardianship of the spouse (if spouse is covered).
- The Employee's disabled Dependent children over the age of twenty-six (26) years of age.

A newborn child of an Employee will automatically be covered for the first 31 days of life. An Employee **MUST** make an election to enroll the newborn within the first 31 days of birth for Coverage to continue past the 31st day.

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

Adopted Children/Legal Guardianship
An adopted child of an Employee 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 for whom an 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 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 and provided satisfactory medical proof of incapacity is submitted to the Plan Administrator within 30 days after his 26th birthday.

The documentation must show that the Dependent:

- Is mentally or physically incapable of self-support;
- Is expected to be incapacitated for a period of 12 months or longer; and
- Depends on the covered employee for his support.

The Plan Administrator may require periodic proof of continuing disability, but not more than one time per 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.

Qualified Medical Child Support Orders

A child may become eligible for Coverage as a Dependent under this Plan as set forth in a qualified medical child support order. The Plan Administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a qualified medical child support order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issues the order. If the medical support order is determined to be a qualified medical child support order, each named child will be covered by the Plan in the same manner as any other Dependent child covered by the Plan. If it is determined that the order is not a qualified medical child support order, each named child may appeal that decision by submitting a letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within thirty days of receipt of the appeal.

Exceptions:

The following individuals are excluded as eligible for Dependent Coverage:

- an individual who lives in the Covered Eligible Employee's home but who is not eligible as previously described;
- the legally separated or divorced former Spouse of the Eligible Employee;
- any person who is on active duty in any military service of any country;
- or any person who is eligible for Coverage under the Plan as an Eligible Employee.

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

Married Eligible Employees

- If both married Eligible Employees are eligible for Coverage under the Plan, both Eligible Employees must carry their own coverage. Eligible dependents must be covered under the Eligible Employee whose birthday falls within the earliest month of a calendar year. The maximum cost to these Employees is no more than the cost per full family coverage.
- In the event of a dispute, the Eligible Employee who has been in the Plan the longest assumes status as the covered Eligible Employee under the Plan.
- If the Coverage is terminated, COBRA (as defined in the Section *Continuation of Coverage*) will not be offered to the extent Coverage is available through the Spouse by means of the Spouse's employment at the Company. The Spouse would automatically assume status as the covered Eligible Employee, and the individual whose Coverage was terminated will become an Eligible Dependent under the Plan.

Employment of a Dependent When a child of a covered Eligible Employee becomes eligible for Coverage as an Eligible Employee, he or she will become covered as an Eligible Employee rather than as a Dependent under the Plan.

Regular Enrollment An individual who is not enrolled in the Plan as of April 1, 2014 may enroll in the Plan within thirty (30) days of the date he or she first becomes eligible for Coverage. Coverage for a Regular Enrollee becomes effective on the first day of the month following the completion of payment of two of the required bi-weekly premium amounts. Submission of a completed and signed enrollment form is also required.

Special Enrollment An Employee and/or Dependent who did not enroll for Coverage under this Plan because he/she had other Coverage when he initially became eligible for Coverage under this Plan may request a Special Enrollment period under this provision if he/she is no longer eligible for the other Coverage. The Employee must provide the Employer with written proof of loss of Coverage and the reason for the loss. A special enrollment period will be granted if the Employee and/or the Dependent loses eligibility due to one or more of the following:

- Divorce or legal separation;
- Termination of other employment;
- Reduction in the number of hours of other employment;
- Cessation of the employer contributions (by any current or former employer) for the other Coverage;
- Exhaustion of COBRA benefits;
- Death of the Employee;
- 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
- 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 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 Coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with other Coverage).

Except for loss of eligibility tied to Medicaid or CHIP, an Employee and/or Dependent who loses eligibility must apply for Coverage under the Plan within thirty (30) days of losing his/her 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 of 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. For losses of eligibility related to Medicaid or CHIP, the notification period is sixty (60) days. If Coverage is requested within sixty (60) days, the Effective Date of Coverage under this Plan will be the date of the 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.

An Eligible Employee who previously declined Coverage, but then acquires a new Dependent, may request a Special Enrollment Period for him/her and any Eligible Dependents. A Special Enrollment period will be granted for 31 days after one of the following events:

- A marriage (new Spouse may be added, and/or the Spouse's children who qualify as Dependents);
- The birth, adoption, placement for adoption, placement of foster child, or commencement of legal guardianship (the child and/or Spouse may be added).

Coverage must be requested within 31 days. If Coverage is requested within 31 days, the Effective Date of Coverage under this Plan will be the date of the event. If the Employee fails to enroll for Coverage for self or any Eligible Dependents within 31 days, he/she will be able to enroll only during an Open Enrollment Period. An Employee or Dependent who enrolls during a Special Enrollment period is not treated as a Late Enrollee.

Late Enrollment Notwithstanding anything in the above subsection to the contrary, if an Eligible Employee or Dependent completes and returns the required enrollment form (and agrees to make the required contribution) more than thirty (30) days after the date on which he/she otherwise satisfies all other requirements for regular or special enrollment for Coverage under the Plan, he or she shall be considered a Late Enrollee. Late Enrollees may enroll for Coverage under the Plan during the next Open Enrollment Period.

Open Enrollment Late Enrollees may enroll for Coverage under the Plan during the period of March 1 thru March 31 of each year with Coverage effective the following April 1. Open enrollment allows an employee the opportunity to enroll for Coverage, terminate Coverage, and add or delete Dependent Coverage.

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

Employee ACA Status Change If a part-time employee averages thirty plus hours per week or over 130 hours per month during the Measuring Period, the employee becomes eligible as well as do his/her qualifying dependents. Coverage must be offered by the first day of the fourth month following the change in status.

Continuation During Periods of Short Term Employer-certified Disability an Eligible Employee may remain eligible for a limited time if full-time work ceases due to disability. This continuance will end as follows:

- The date this Plan terminates;
- The date of termination of employment;
- The date the Eligible Employee becomes eligible for Medicare or Medicare Disability;
- Upon eligibility for Coverage in any other Employee Benefit Plan that does not limit Coverage for the disabling condition;
- The date the Eligible Employee is no longer considered Disabled;
- If the required contribution amount is not paid, the end of the period for which the last required contribution was made; and/or
- Nine (9) months following the expiration of the Employee's Family Medical Leave eligibility or three (3) months for non-FMLA Eligible Employees.

Coverage of Public Safety Employees A Public Safety Employee is defined as a full time firefighter employed by the City and sworn police officers. The Public Safety Employees and/or their Dependents are eligible to continue Coverage under the Plan according to the provisions set out below:

- Those who are retired or receiving disability benefits under Ind. Code §§ 36-8-6, 36-8-7, 36-8-7.5, 36-8-8 or 36-8-10.
- A Public Safety Employee's Spouse.
- A Public Safety Employee's Dependent Child.

The Employee may elect to have a Spouse and/or Dependent covered under the Plan at the time the Employee retires or becomes disabled. The Employee must file a written request for the Coverage within 90 days after

retirement begins or disability benefits begin. The person must pay an amount set by the Employer, equal to the total of the Employer's and the Employee's premium for the Plan Coverage for an active Employee.

A surviving Spouse or Dependent who is eligible for Coverage under the Plan as discussed above may elect to continue Coverage under the Plan after the death of the Public Safety Employee by filing a written request for Coverage with the Employer within 90 days after the death of the Public Safety Employee. The premium that the Public Safety Employee would have been required to pay for Coverage under this provision must be paid to continue Coverage.

A retired or disabled Public Safety Employee's eligibility for the Plan under this provision ends on the earliest of:

- When the Public Safety Employee becomes eligible for Medicare or Medicare Disability Coverage as prescribed by 42 U.S.C. § 1395 *et.seq*. or
- When the Employer terminates the Plan.

A surviving Spouse's eligibility for the Plan under this provision ends on the earlier of:

- When the surviving Spouse becomes eligible for Medicare or Medicare Disability as prescribed by 42 U.S.C. §1395 *et.seq*,
- When the Employer terminates the Plan for active Public Safety Employees,
- The date of the surviving Spouse's remarriage; or
- When health insurance becomes available to the surviving Spouse through employment.

A Public Safety Employee who is on leave without pay is entitled to participate for 90 days in the Plan if the Employee pays an amount equal to the total of the Employer's and the Employee's premium for the Coverage. This provision covers public safety Employees who retire, becomes deceased or become disabled after June 30, 1989.

Coverage of Long Term Disabled Public Safety Employees In order to qualify for Coverage under this Section, a Public Safety Employee must be receiving disability benefits under Indiana Code §§ 36-8-6, 36-8-7, 36-8-7.5, 36-8-8, or 36-8-10.

The disabled Public Safety Employee must make a written request for the continuation of Coverage to the Employer within 90 days after his disability begins and the Employer may require that the disabled Public Safety Employee pay for all or a portion of the cost of the Coverage. If a Public Safety Employee who began receiving disability benefits under Indiana Code §§ 36-8-6, 36-8-7, 36-8-7.5, 36-8-8, or 36-8-10 before October 1, 1988 filed a written request for this Coverage before October 1, 1989, he will also be eligible for this Coverage.

A disabled Public Safety Employee's Coverage shall terminate upon the earlier of:

- The date the disabled Public Safety Employee becomes eligible for Medicare or Medicare Disability, or;
- The date the Employer ceases to maintain the Plan.

A disabled Public Safety Employee who is eligible for Coverage under this Section may elect the same Coverage for all of his Dependents at the time of his disability election. The Employer may require that the Dependent pay for all or a portion of the cost of the Coverage. If the disabled Public Safety Employee dies and leaves surviving Dependents, the surviving Dependent's Coverage shall terminate upon the earliest of the following:

- When the surviving Dependent Spouse becomes eligible for Medicare or Medicare Disability;
- When the Employer ceases to maintain the Plan;
- Two (2) years after the disabled Public Safety Employee's death;

- The date of the surviving Spouse's remarriage;
- The date the Dependent no longer qualifies as a Dependent for the Employer's Coverage by reason of marriage or age.

Coverage of Retirees This section shall apply to each retired Participant whose retirement date is after June 20, 1986. The retired Participant must meet at least one of the following requirements:

- He must have reached age 55 on or before his retirement date but will not be eligible for Medicare;
- He must have completed 20 years of active service with a public Employer, 10 years of which must have been completed immediately prior to his retirement date; or
- He must have completed as least 15 years of participation in the retirement plan of which he is a member on or before his retirement date.

The retired Participant must make a written request for the continuation of coverage to the employer within 90 days after his/her retirement date and the Employer may require that the retired participant pay for all or a portion of the cost of the coverage. The retired participant's coverage shall terminate herein upon the earlier of:

- The date the retired participant becomes eligible for Medicare or Medicare Disability; or
- The date the employer ceases to maintain the Plan

A retired Participant who is eligible for coverage herein may elect the same coverage for his dependent spouse at the time of the participant's retirement. The Employer may require that the Dependent Spouse pay for all or a portion of the cost of the coverage. The surviving dependent spouse's coverage shall terminate upon the earliest of the following:

- When the surviving dependent spouse becomes eligible for Medicare or Medicare Disability;
- When the Employer ceases to maintain the Plan;
- Two (2) years after the retired Participants death;
- The date of the surviving Spouse's remarriage; or
- The remaining spouse's eligibility terminates.

Coverage during Layoff The Plan will pay its share of the required contribution amount for one month from the date of layoff and Coverage shall end after that period. If recalled to work within a six (6) month period, the Waiting Period will not apply.

Part-time to Full-time Employees Part-time Employees who becomes Full-time must satisfy the waiting period as a Full-time employee.

Military Leave Notwithstanding anything in this Plan to the contrary, with respect to any Eligible Employee or Dependent who loses Coverage under this Plan during the Eligible Employee's absence from employment by reason of military service, any applicable Waiting Period and Pre-Existing Condition limitation described herein shall not be imposed upon the reinstatement of the Eligible Employee's or Dependent's Coverage upon reemployment of the Eligible Employee unless such Waiting Period or Pre-Existing Condition limitation would apply to the Eligible Employee or Dependent had the Eligible Employee or Dependent not been on military leave of absence.

TERMINATION OF COVERAGE

Except as provided in the Plan's Continuation of Coverage (COBRA), Coverage will terminate on the earliest of the following dates.

Employee Termination Date

- The date the Employer terminates the Plan and offers no other group health plan.
- The date the Employee ceases to meet the eligibility requirements of the Plan.
- The date employment terminates.
- The date the Employee becomes a Full-Time, active member of the armed forces of any country.
- The date the Employee ceases to make any required contributions.

Dependent(s) Termination Date

- The date the Employer terminates the Plan and offers no other group health plan.
- The date the Employee's Coverage terminates.
- The date such person ceases to meet the eligibility requirements of the Plan.
- The date the Employee ceases to make any required contributions on the Dependent's behalf.
- The date the Dependent becomes a Full-Time, active member of the armed forces of any country.
- The date the Plan discontinues Dependent Coverage for any and all Dependents.
- The date the Dependent becomes eligible as an Employee.

Upon termination, deductions for premiums will continue through the last and final paycheck equal to normal payroll deductions prior to termination.

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a certificate of Coverage shall be issued when Coverage ends, indicating the period of time the Covered Person was covered under this Plan. The certificate may help reduce the preexisting exclusion period of any plan that provides Coverage subsequent to this Plan.

Coverage may be rescinded in cases of fraud or intentional misrepresentation of material fact. Otherwise, the Plan may not cancel or terminate coverage retroactively.

LEAVE OF ABSENCE and FAMILY OR MEDICAL LEAVE

This Plan shall comply at all times with the provisions of the Family and Medical Leave Act of 1993 (FMLA). The FMLA entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance under the same terms and conditions as if the employee had not taken leave. Following the expiration of FMLA leave, Coverage may be continued for a limited time, not to exceed nine months, contingent upon payment by the Employee of the required contributions if the employee is on an authorized leave of absence from the City. If an Employee is not eligible for FMLA, Coverage can be continued for up to three (3) months in instances of short term Employer certified disability, at which time such Coverage shall terminate.

Contributions

While on FMLA leave, an Employee's premium contributions shall remain unchanged. If leave extends beyond the expiration of FMLA leave, the Employee shall be required to pay 100% of the premium cost. Non-eligible FMLA employees shall be eligible for up to three (3) months of continued Coverage for instances of short term Employer certified disability, during which premium contributions shall remain unchanged.

Reinstatement
If Coverage under the Plan was terminated during an approved FMLA leave and the Employee returns to active work immediately upon completion of that leave, Plan Coverage will be reinstated on the date the Employee returns to active work as if Coverage had not terminated, provided the Employee makes any necessary contributions and enrolls for Coverage within thirty-one (31) days of his return to active work.

Repayment Requirement
If an Employee fails to return from FMLA leave or a leave of absence for short term disability for reasons unrelated to a serious health condition, or events beyond Employee's control, for a period of at least ninety (90) days, the employee will be required to repay to the City all premium costs paid by the City on the Employee's behalf.

CONTINUATION OF COVERAGE

The federal law commonly referred to as COBRA requires that most employers sponsoring group health plans offer employees and their Dependents the opportunity for a temporary extension of benefit at group rates in certain instances where Coverage under the Plan would otherwise end. This section is intended to inform you, in a summary fashion, of your 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 drugs, 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.

Qualifying Events
The Employee will become a qualified beneficiary if he/she loses Coverage under the Plan because either one of the following qualifying events happens:

- Hours of employment are reduced to less than the minimum required for Coverage under the Plan; or
- ***Employment ends for any reason other than gross misconduct.***

The Spouse of an Employee will become a qualified beneficiary if the Employee loses Coverage under the Plan because any of the following qualifying events happens:

- The Employee dies;
- The Spouse's hours of employment are reduced to less than the minimum required for Coverage under the Plan;
- The Spouse's employment ends for any reason other than his or her gross misconduct;
- The Spouse becomes enrolled in Medicare or Medicare Disability (Part A, Part B, or both);
- The Employee becomes divorced or legally separated from the Spouse. If an Employee cancels Coverage for his or her Spouse in anticipation of a divorce and a divorce later occurs, then the divorce will be considered a qualifying event even though the ex-Spouse lost Coverage earlier. If the ex-Spouse notifies the Employer within sixty (60) days after the divorce and can establish that the Employee canceled the Coverage earlier in anticipation of the divorce, then COBRA Coverage may be available for the period after the divorce commencing on the date of the final divorce decree.

Dependent child(ren) will become qualified beneficiaries if he or she or they lose existing Coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced to less than the minimum required for Coverage under the Plan;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes enrolled in Medicare or Medicare Disability (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child becomes ineligible for Coverage under the Plan as a "Dependent child".

Notification Requirements
When eligibility for continuation of Coverage results from a Spouse being divorced or legally separated from a covered Employee, or a child's loss of Dependent status, the Employee or Dependent must notify the Employer, in writing, of that event within sixty (60) days of the event. The Employee or Dependent must advise the date and nature of the qualifying event and the name, address and Social Security number of the affected individual. Failure to provide such notice to the Employer will result in the person forfeiting their rights to continuation of Coverage under this provision.

Any notice the Employee provides must be in writing. Oral notice, including notice in person or by telephone, is not acceptable. The employee must mail, fax, hand deliver, or e-mail the notice to:

- City of Greenwood
  300 South Madison Avenue
  Greenwood, IN 46142
  (317) 887-5604
  Human Resources
  HR@greenwood.in.gov

If mailed, the Employee's notice must be postmarked no later than the last day of the required notice period. Any notice the Employee provides must state:

- The name of the Plan;
- The name and address of the employee covered under the Plan;
- The name(s) and address(es) of the qualified beneficiary(ies);
- The clearly defined name or type of qualifying event and the date it happened. If the qualifying event is a divorce, the notice must include a copy of the divorce decree.

If the Employee or Employee's Spouse or Employee's Dependent children do not elect continuation of Coverage within the sixty (60) day election period, the right to elect COBRA continuation Coverage will be lost.

Within fourteen (14) days of a qualifying event, or within fourteen (14) days of receiving notice of a qualifying event, the Employee or Dependent will be notified of his rights to continuation of Coverage, and what process is required to elect continuation of Coverage.

After receiving notice, the Employee or Dependent has sixty (60) days to decide whether to elect continued Coverage. Each person who was covered under the Plan prior to the qualifying event has the right to elect continuation of Coverage on an individual basis, regardless of family enrollment. If the Employee or Dependent chooses to have continued Coverage, he must advise the Employer in writing of this choice. The Employer 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 latter of the following:

- The date Coverage under the Plan would otherwise end; or
- The date the person receives the notice from the Employer of his or her rights to continuation of Coverage.

Within forty-five (45) days after the date the person notifies the Employer that he has chosen to continue Coverage, the person must make the initial payment. The initial payment will be the amount needed to provide Coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued Coverage are to be made monthly, and are due in advance, on the first day each month.

The *Employee* or *Dependent* must make payments for the continued Coverage.

Payment of COBRA Continuation Coverage

The Employer requires that Covered Persons pay the entire costs of their continuation Coverage, plus a two percent (2%) administrative fee. This must be remitted to the Employer's designated representative, by 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.

Notice will be provided to the Employee that will specify the amount of the premium, to whom the premium is to be paid, and the day of each month the premium is due. Failure to pay premiums on a timely basis will result in the cancellation of Coverage.

When Continuation Coverage Begins
When continuation Coverage is elected and the contributions paid within the time period required, Coverage is reinstated back to the date of the loss of Coverage, 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.

Family Members Acquired During Continuation
A Spouse or Dependent child newly acquired during continuation Coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to Enrollees during 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.

Subsequent Qualifying Events
Once covered under continuation Coverage, it is possible for a second qualifying event to occur, including:

- Death of an Employee.
- Divorce or legal separation from an Employee.
- Employee's entitlement to Medicare or Medicare Disability if it results in a loss of Coverage under this Plan.
- The child's loss of Dependent status.

If one of these subsequent qualifying events occurs, a Dependent may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

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 again as the result of a subsequent qualifying event. Any other Dependent acquired during continuation Coverage is not eligible to continue Coverage as the result of a subsequent qualifying event.

End of Continuation
Continuation of Coverage under this provision will end on the earliest of the following dates:

- Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the Employee.
- Thirty-six (36) months from the date continuation began for Dependents whose Coverage ended because of the death of the Employee, divorce or legal separation from the Employee, or the child's loss of Dependent status.
- The end of the period for which contributions are paid if the Covered Person fails to make a payment on the date specified by the Employer.
- The date Coverage under this Plan ends and the Employer offers no other group health benefit plan.
- The date the Covered Person first becomes entitled to Medicare or Medicare Disability after the date of election of COBRA continuation Coverage.
- The date the Covered Person first becomes covered under any other group health plan after the date of election of COBRA continuation Coverage, with exception of the Pre-Existing provision below.

Special Rules Regarding Notices

- Any notice required in connection with continuation Coverage under this Plan must, at minimum, contain sufficient information so that the Plan Administrator (or its designee) is able to determine from such notice the Employee and Dependent(s) (if any), the qualifying event or disability, and the date on which the qualifying event occurred.
- In connection with continuation Coverage under this Plan, any notice required to be provided by any individual who is either the Employee or a Dependent with respect to the qualifying event may be provided

by a representative acting on behalf of the Employee or the Dependent, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

- As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
  - A single notice addressed to both the Employee or the Spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the Plan, the Spouse resides at the same location as the Employee; and
  - A single notice to the Employee or the Spouse will be sufficient as to each Dependent child of the Employee if, on the basis of the most recent information available to the Plan, the Dependent child resides at the same location as the individual to whom such notice is provided.

Pre-Existing Conditions
In the event that a Covered Person becomes eligible for Coverage under another employer-sponsored group health plan, and that group health plan has an exclusion or Pre-Existing limitation on a condition that is covered by this Plan, the Covered Person may remain covered under this Plan with continuation of Coverage and elect Coverage under the other employer's group health plan. This Plan shall be primary payor for the Covered Expenses that are excluded or limited under the other employer sponsored group health plan and secondary payor for all other expenses.

Extension for Disabled Individuals
A person who is Totally Disabled may extend continuation Coverage from eighteen (18) months to twenty-nine (29) months. The 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 continuation Coverage period and no later than sixty (60) days after the Social Security Administration's determination. The Employer may charge 150% of the contribution during the additional eleven (11) months of continuation of Coverage.

Military Mobilization
If an Employee is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the Employee may continue their health Coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the Employee may not be required to pay more than the Employee's share, if any, applicable to that Coverage. If the leave is more than thirty-one (31) days, then the Employer may require the Employee to pay no more than 102% of the full contribution.

The maximum length of the continuation Coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

- Twenty-four (24) months beginning on the day that the leave commences, or
- A period beginning on the day that the leave began and ending on the day after the Employee fails to return to employment within the time allowed.

The Employee's Coverage will be reinstated without exclusions or a waiting period.

Trade Adjustment Assistance
If a Covered Person's Coverage under this Plan terminates due to circumstances which would qualify that Covered Person for trade adjustment assistance (TAA) under the terms of the Trade Act of 1974 (19 U.S.C. 2101 *et seq.*) which covers workers whose employment has been adversely affected by international trade – increased imports or a shift in production to another country, and that Covered Person did not elect to continue Coverage under the Continuation of Coverage provisions of this Plan during his or her initial sixty (60) day election period as specified herein, a second sixty (60) day election period will be granted. This second sixty (60) day election period shall

begin on the first day of the month in which the Covered Person is determined to be a TAA-eligible individual. However, the election to continue Coverage under this provision of the Plan cannot be made more than six (6) months after the date of the TAA-related loss of Coverage.

If continued Coverage is elected under this provision of the Plan, such Coverage shall begin on and any applicable COBRA time frames shall be measured from the first day of the second election period and not on the date of the original qualifying event. All other requirements for continued Coverage under the COBRA provisions of this Plan shall apply.

CLAIMS FILING PROCEDURE

A claim for benefits is any request for a benefit that is provided by this Plan made by a Covered Person or the Authorized Representative of a Covered Person which complies with the Plan's procedures for making claims. Claims for health care benefits are one of two types: Pre-Service Claims or Post-Service Claims.

Pre-Service Claims are claims for services for which preapproval must be received before services are rendered in order for benefits to be payable under this Plan, such as those services listed in the section Utilization Review. A Pre-Service Claim is considered to be filed whenever the initial contact or call is made by the Covered Person, Provider or Authorized Representative to the Utilization Review Organization, as specified in Utilization Review.

Post-Service Claims are those for which services have already been received (any claims other than *Pre-Service Claims*).

If the Covered Person would like the Plan Administrator/Claims Processor to deal with someone other than them regarding a claim for benefits then the Covered Person must provide the Plan Administrator with a written Authorization in order for an Authorized Representative (other than the Employee) to represent and act on behalf of the Covered Person. The Covered Person must consent to release information related to the claim to the Authorized Representative.

FILING A PRE-SERVICE CLAIM

A Pre-Service Claim begins when the Covered Person, Provider, or the Covered Person's Authorized Representative makes a call to the Utilization Review Organization to pre-certify specified services, supplies or treatment. See Utilization Review for specific details regarding the services that require Precertification, the number to call, and time frames for making the Precertification call.

If a call is made to the Utilization Review Organization that fails to follow the Precertification procedure as specified in Utilization Review, but at least identifies the name of the patient, a specific medical condition or symptom and the specific treatment, service or product for which Precertification is being requested, the Covered Person or the Covered Person's Authorized Representative will be orally notified (in writing, if requested) within five (5) calendar days (twenty-four (24) hours in the case of Urgent Care Claims) of the failure to follow correct procedures.

Pre-Service Claims fall into three categories: Precertification Claims, Urgent Care Claims or Concurrent Care Claims.

- A Precertification Claim is a claim for any services for which the Plan requires Precertification, however the services that are required are not services which would qualify as Urgent Care Claims, as defined below.
- Urgent Care Claims are claims for services which require Precertification, however, the services are of such a nature such that the application of the longer time periods for making Precertification Claim determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or – in the opinion of a Physician with knowledge of the patient's medical condition – would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Concurrent Care Claims are claims for continuing care for which additional services are being requested or claims for which benefits for additional care are being reduced or terminated.

TIME FRAME FOR BENEFIT DETERMINATION OF A PRE-SERVICE CLAIM

When a Pre-Service Claim has been submitted to the Plan (call made to the Utilization Review Organization) and no additional information is required, the Plan will generally complete its determination of the claim within the following timeframes:

- Precertification Claims – within a reasonable time frame, but no later than fifteen (15) calendar days from receipt of claim;
- Urgent Care Claims – within a reasonable time frame, but no later than seventy-two (72) hours following receipt of claim;
- Concurrent Care Claims – if a request for an extension of an on-going course of treatment is received, determination will be made as follows:
    - If the request for additional care is of an Urgent Care nature and the request is made at least twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within twenty-four (24) hours of the request. If the request is made less than twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within seventy-two (72) hours of the request;
    - For non-Urgent Care, the determination must be made within fifteen (15) calendar days after the request is received.

When a Pre-Service Claim has been submitted to the Plan and additional information is needed in order to determine whether and to what extent, services are covered or benefits are payable by the Plan, then the Plan Administrator or its designee (Utilization Review Organization), shall notify the Covered Person as follows:

- If the Pre-Service Claim is for care of an Urgent Care nature, the Plan Administrator or its designee shall notify the Covered Person as soon as possible, but no later than twenty-four (24) hours after the initial call, of the specific information necessary to complete the claim. The Covered Person or Authorized Representative will have forty-eight (48) hours to provide the requested information and the Plan Administrator or its designee will complete the claim determination no later than forty-eight (48) hours after receipt of the requested information. Failure of the Covered Person to respond in a timely and complete manner will result in a denial of the Precertification request.
- If the Pre-Service Claim is for non-Urgent Care or if an extension of time is required due to reasons beyond the control of the Plan Administrator or its designee, the Plan Administrator or its Designee will, within fifteen (15) calendar days from the date of the initial call, provide the Covered Person or the Covered Person's Authorized Representative with a notice detailing the circumstances and the date by which the Plan Administrator, or its designee, expects to render a decision. If additional information is required, the notice will provide details of what information is needed and the Covered Person will have forty-five (45) days to provide the requested information. The Plan Administrator, or its designee, will complete its determination of the claim no later than fifteen (15) calendar days following receipt of the requested information. Failure to respond in a timely and complete manner will result in a denial of the Precertification request.

NOTICE OF PRE-SERVICE CLAIM BENEFIT DENIAL

If the Pre-Service Claim for benefits is denied, the Plan Administrator or its designee shall provide the Covered Person or Authorized Representative with a written notice of benefit denial within the timeframes listed above.

The notice will contain the following:

- Explanation of the denial, including:
    - The specific reasons for the denial;
    - Reference to the Plan provisions on which the denial is based;
    - A description of any additional material or information necessary and an explanation of why such material or information is necessary;
    - A description of the Plan's review procedure and applicable time limits;

- A statement that if the Covered Person's appeal (See "Appealing a Denied Claim" below) is denied, the Covered Person has the right to bring a civil action

- If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either
  - A copy of that criterion, or
  - A statement that such criterion was relied upon and will be supplied free of charge, upon request
- If denial was based on medical necessity, Experimental treatment or similar exclusion or limit, the Plan will supply either
  - An explanation of the scientific or clinical judgment, applying the terms of the Plan to the Covered Person's medical circumstances, or
  - A statement that such explanation will be supplied free of charge, upon request
- In the case of an adverse benefit determination concerning a claim involving Urgent Care, a description of the expedited review process applicable to such claims;
- A statement that questions about or assistance with the claimant's appeal rights or the adverse determination can be directed to or obtained from the Employee Benefits Security Administration at 1-866-444-3272.

APPEALING A DENIED PRE-SERVICE CLAIM

A Covered Person, or the Covered Person's Authorized Representative, may request a review of a denied claim by making written (for any claim involving Urgent Care, the request may be verbal) request to the City of Greenwood Appeals Committee within one hundred eighty (180) calendar days from receipt of notification of the denial. An appeal form can be obtained from the Human Resources Department. The written request should state the reasons the Covered Person feels the claim should not have been denied. The following describes the review process:

- The *Covered Person* has a right to submit documents, information and comments
- The *Covered Person* has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information.
  - Relied on in making the benefit determination; or
  - That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
  - That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions; or
  - That constitutes a statement of policy or guidance for the *Plan* concerning the denied treatment or benefit for the *Covered Person's* diagnosis, even if not relied upon.
- The review shall take into account all information submitted by the *Covered Person*, even if it was not considered in the initial benefit determination.
- The review by the Appeals Committee will not afford deference to the original denial.
- The Appeals Committee will not be
  - The individual who originally denied the claim, nor
  - Subordinate to the individual who originally denied the claim
- If the original denial was, in whole or in part, based on medical judgment:
  - The Appeals Committee will consult with a *professional Provider* who has appropriate training and experience in the field involving the medical judgment.
  - The *Professional Provider* utilized by the Appeals Committee will be neither
    - An individual who was considered in connection with the original denial of the claim, nor
    - A subordinate of any other *Professional Provider* who was considered in connection with the original denial.
  - If requested, the Appeals Committee will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

- In the case of a claim involving emergency or Urgent Care, there shall be an expedited review process pursuant to which:
    - A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant to the Human Resources Department; and
    - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

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

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

NOTICE OF BENEFIT DETERMINATION FOR PRE-SERVICE CLAIMS ON APPEAL

The Appeals Committee shall provide the Covered Person or Authorized Representative with a written notice of the appeal decision within the following timeframes:

- Urgent Care Claims or Concurrent Care Claims involving Urgent Care – as soon as possible, but not later than seventy-two (72) hours from receipt of appeal;
- Precertification Claims or Concurrent Care Claims involving non-Urgent Care – as soon as possible, but not later than fifteen (15) calendar days from receipt of appeal;

If the appeal is denied, the notice will contain the following:

- Explanation of the denial including:
- The specific reasons for the denial
- Reference to specific Plan provisions on which the denial is based
- A statement that the Covered Person has the right to access, free of charge, information relevant to the claim for benefits.
- If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:
- A copy of that criterion, or
- A statement that such criterion was relied upon and will be supplied free of charge, upon request
- If the denial was based on Medical Necessity, Experimental treatment or similar exclusion or limit, the Notice will supply either:
- An explanation of the scientific or clinical judgment, applying the terms of the Plan to the Covered Person's medical circumstances, or
- A statement that such explanation will be supplied free of charge, upon request
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;" and
- A statement that questions about or assistance with the claimant's appeal rights or the adverse determination can be directed or obtained from the Employee Benefits Security Administration at 1-866-444-3272.

FILING A POST-SERVICE CLAIM A claim form is to be completed on each covered family member at the beginning of the Plan Year and for each claim involving an Injury. Appropriate claim forms are available from the Human Resources Department. Claims should be submitted to the address shown on the Covered Person's identification card. All bills submitted for benefits must contain the following:

- Name of patient.
- Patient's date of birth.
- Name of Employee.
- Address of Employee.
- Name of Employer.
- Name, address and tax identification number of Provider.
- Date of service.
- Diagnosis.
- Description of service and procedure number.
- Charge for service.
- The nature of the accident, Injury or Illness being treated.

Properly completed claims not submitted within one (1) year of the date of incurred liability will be denied.

The Covered Person may ask the Provider to submit the bill directly to the Claims Processor, or the Covered Person may file the bill with a claim form. However, it is ultimately the Covered Person's responsibility to make sure the claim has been filed for benefits.

TIME FRAME FOR BENEFIT DETERMINATION OF A POST-SERVICE CLAIM

When a completed claim has been submitted to the Claims Processor and no additional information is required, the Claims Processor will generally complete its determination of the claim within thirty (30) calendar day of receipt of the completed claim, unless an extension of time is necessary due to circumstances beyond the Plan's control.

When a completed claim has been submitted to the Claims Processor and additional information is required for determination of the claim, the Claims Processor will provide the Covered Person or Authorized Representative with a notice detailing the information needed. This notice will be provided within thirty (30) calendar days of receipt of the completed claim and will indicate the date when the Claims Processor expects to make a decision, if the requested information is received. The Covered Person will have forty-five (45) calendar days to provide the information requested, and the Claims Processor will complete its determination of the claim within fifteen (15) calendar days of receipt of the requested information. Failure to respond in a timely and complete manner will result in a denial of benefit payment.

NOTICE OF POST-SERVICE CLAIM BENEFIT DENIAL

If the post-service claim for benefits is denied, the Plan Administrator or their designee shall provide the Covered Person or Authorized Representative with a written notice of benefit denial within thirty (30) calendar days of receipt of a completed claim, or if the Plan had requested additional information from the Covered Person or Authorized Representative, within fifteen (15) calendar days of receipt of such information. The notice will contain the following:

- Explanation of the denial, including:
  - The specific reasons for the denial;
  - Reference to the Plan provisions on which the denial is based
  - A description of any additional material or information necessary and an explanation of why such material or information is necessary
  - A description of the Plan's review procedure and applicable time limits
- A statement that if the Covered Person's appeal (See "Appealing a Denied Claim" below) is denied, the Covered Person has the right to bring a civil action

- If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either:
    - A copy of that criterion, or
    - A statement that such criterion was relied upon and will be supplied free of charge, upon request
        - If the denial was based on Medical Necessity, Experimental Treatment or similar exclusion or limit, the Plan will supply either:
        - An explanation of the scientific or clinical judgment, applying the terms of the Plan to the Covered Person's medical circumstances, or
        - A statement that such explanation will be supplied free of charge, upon request

APPEALING A DENIED POST-SERVICE CLAIM

The Appeals Committee for purposes of an appeal of a Post-Service Claim was established by the Board of Public Works & Safety.

A Covered Person, or the Covered Person's Authorized Representative, may request a review of a denied claim by making written request to the Appeals Committee within one hundred eighty (180) calendar days from receipt of notification of the denial. An Appeals Form can be obtained from the Human Resources Department. The request for review should state the reasons the Covered Person feels the claim should not have been denied.

The review process is as follows:

- The Covered Person has a right to submit documents, information and comments
- The Covered Person has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information:
    - Relied on in making the benefit determination, OR
    - That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon, OR
    - That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions, OR
    - That constitutes a statement of policy or guidance for the Plan concerning the denied treatment or benefit for the Covered Person's diagnosis, even if not relied upon.
- The review takes into account all information submitted by the Covered Person, even if it was not considered in the initial benefit determination.
- The review by the Appeals Committee will not afford deference to the original denial.
- The Appeals Committee will not be
    - The individual who originally denied the claim, nor
    - Subordinate to the individual who originally denied the claim
- If original denial was, in whole or in part, based on medical judgment,
    - The Appeals Committee will consult with a Professional Provider who has appropriate training and experience in the field involving the medical judgment.
    - The Professional Provider utilized by the Appeals Committee will be neither
        - An individual who was considered in connection with the original denial of the claim, nor
        - A subordinate of any other Professional Provider who was considered in connection with the original denial.
    - If requested, the Appeals Committee will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR POST-SERVICE CLAIM APPEAL

The Appeals Committee shall provide the Covered Person or Authorized Representative with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal. If the appeal is denied, the notice will contain the following:

- An explanation of the denial including:
  - The specific reasons for the denial
  - Reference to specific Plan provisions on which the denial is based
  - A statement that the Covered Person has the right to access, free of charge, information relevant to the claim for benefits.
- If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:
  - A copy of that criterion, or
  - A statement that such criterion was relied upon and will be supplied free of charge, upon request
- If the denial was based on Medical Necessity, Experimental treatment or similar exclusion or limit, will supply either
  - An explanation of the scientific or clinical judgment, applying the terms of the Plan to the patient's medical circumstances, or
  - A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a Covered Person incurs a Covered Expense in a foreign country, the Covered Person shall be responsible for providing the following to the Claims Processor before payment of any benefits due are payable:

- The claim form, Provider invoice and any other documentation required to process the claim must be submitted in the English language.
- The charges for services must be converted into dollars.
- A current conversion chart validating the conversion from the foreign country's currency into dollars.

ABSENCE OF CONFLICTS OF INTEREST

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

ADDITIONAL RULES REGARDING NOTICE OF ADVERSE DETERMINATIONS

The Plan must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care Provider, the claim amount (if applicable), and the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

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

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

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

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

NON-EXPEDITED EXTERNAL REVIEW

- If a claimant appeals an adverse benefit determination and that adverse benefit determination is upheld on appeal, the claimant may, but is not required to request an external review of the Plan's benefit determination.
- External review is not available to review a determination that a claimant failed to meet the Plan's eligibility requirements or to any adverse benefit determination (including a final internal adverse benefit determination) by the Plan other than one that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer.

Any external review will be conducted as follows.

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

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

- The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    - The final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;
    - The claimant has exhausted the Plan's internal appeal process; and
    - The claimant has provided all the information and forms required to process an external review.

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

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

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating Provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents that the clinical reviewer or reviewers consider appropriate.
    - The assigned IRO must provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.
    - The assigned IRO's decision notice will contain:
        - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
        - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
        - References to the evidence or documentation, including the specific Coverage provisions and evidence-based standards, considered in reaching its decision;
        - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
        - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant;
        - A statement that judicial review may be available to the claimant; and
        - A statement that questions about or assistance with the external review can be directed to or obtained from the Employee Benefits Security Administration at 1-866-444-3272.

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

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

EXPEDITED EXTERNAL REVIEW

A claimant may make a request for an expedited external review with the Plan at the time the claimant receives:

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

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

Immediately upon receipt of the request for expedited external review, the Plan must determine whether the request meets the reviewability requirements set forth above for standard external review. The Named Fiduciary shall immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

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

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

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

DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEALS PROCESSES

The following rules shall apply to the extent the Plan fails to follow the internal claims and appeals processes.

- If the Plan fails to adhere to all the requirements with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process, except as provided below.

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

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the Covered Person is also covered by any Other Plan(s). When more than one Coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When Coordination of Benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by this Plan will be charged against the Maximum Benefit.

The Coordination of Benefits provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this Plan, part or all of which would be covered under this Plan. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this Plan.

When this Plan is secondary, "Allowable Expense" will include any Deductible or Coinsurance amounts not paid by the Other Plan(s).

When this Plan is secondary, "Allowable Expense" shall **not** include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a Provider of service in which such Provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the Provider's contracted amount and the Provider's regular billed charge.

"Other Plan" means 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:

- Group insurance or any other arrangement for Coverage for Covered Persons in a group, whether on an insured or uninsured basis, including, but not limited to, Hospital indemnity benefits and Hospital reimbursement-type plans;
- 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;
- A licensed Health Maintenance Organization (HMO);
- Any Coverage for students which is sponsored by, or provided through, a school or other educational institution;
- Any Coverage under a government program and any Coverage required or provided by any statute;
- Group automobile insurance;
- Individual automobile insurance Coverage;
- Individual automobile insurance Coverage based upon the principles of "No-fault" Coverage;
- 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;
- Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

"This Plan" shall mean that portion of the Employer's Plan which provides benefits that are subject to this provision.

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

EFFECT ON BENEFITS
This provision shall apply in determining the benefits for a Covered Person for each claim determination period for the Allowable Expenses. If this Plan is secondary, the benefits paid under this Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

If the rules set forth below would require this Plan to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this Plan.

ORDER OF BENEFIT DETERMINATION
Each plan will make its claim payment according to the following order of benefit determination:

No Coordination of Benefits Provision
If the Other Plan contains no provisions for Coordination of Benefits, then its benefits shall be paid before all Other Plan(s).

Member/Dependent
The Plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining Covered Expenses are paid under a plan which covers the claimant as a Dependent.

Dependent Children of Parents not Separated or Divorced
The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the 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.

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

- 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 pays fourth.
- 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 pays fourth.

Active/Inactive
The plan covering a person as an active (not laid off or retired) Employee or as that person's Dependent pays first. The plan covering that person as a laid off or retired Employee or as that person's Dependent pays second.

Limited Continuation of Coverage
If a person is covered under another group health plan, but is also covered under this Plan for continuation of Coverage due to the Other Plan's limitation for Pre-Existing Conditions or exclusions, the Other Plan shall be primary for all Covered Expenses which are not related to the Pre-Existing Condition or exclusions. This Plan shall be primary for the Pre-Existing Condition only.

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

LIMITATIONS ON PAYMENTS

In no event shall the Covered Person recover under this Plan and all Other Plan(s) combined more than the total Allowable Expenses offered by this Plan and the Other Plan(s). Nothing contained in this section shall entitle the Covered Person to benefits in excess of the total Maximum Benefits of this Plan during the claim determination period. The Covered Person shall refund to the Employer any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan, the Employer shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Employer shall be fully discharged from liability.

SUBROGATION

The Plan is designed to only pay Covered Expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a Covered Person in a time of need, however, the Plan may pay Covered Expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Plan, as well as by applying for payment of Covered Expenses, a Covered Person is subject to, and agrees to, the following terms and conditions with respect to the amount of Covered Expenses paid by the Plan:

Assignment of Rights (Subrogation)
The Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of the same Covered Expenses from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a Covered Person or paid to another for the benefit of the Covered Person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Person constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance Carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist Coverage.

Equitable Lien and other Equitable Remedies
The *Plan* shall have an equitable lien against any rights the *Covered Person* may have to recover the same *Covered Expenses* from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the *Plan*. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the *Plan* has paid *Covered Expenses* prior to a determination that the *Covered Expenses* arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the Covered Person, the Covered Person's attorney, and/or a trust) as a result of an exercise of the Covered Person's rights of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the Plan may reduce any future Covered Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002), even though this Plan is not subject to the Employee Retirement Income Security Act of 1974. The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

Assisting in Plan's Reimbursement Activities

The Covered Person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the Covered Person, and to provide the Plan with any information concerning the Covered Person's other insurance Coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the Covered Person. The Covered Person is required to (a) cooperate fully in the Plan's (or any Plan fiduciary's) enforcement of the terms of the Plan, including the exercise of the Plan's right to subrogation and reimbursement, whether against the Covered Person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the Plan Administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator or Claims Processor to enforce the Plan's rights.

The Plan Administrator has delegated to the Claims Processor the right to perform ministerial functions required to assert the Plan's rights; however, the Plan Administrator shall retain discretionary authority with regard to asserting the Plan's recovery rights.

THIS PLAN AND MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B and Part D is available to all individuals who make application and pay the full cost of the Coverage. When an Employee becomes entitled to Coverage and is still actively at work, the Employee may continue health Coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement. When a Dependent becomes entitled to Medicare or Medicare Disability Coverage and the Employee is still actively at work, the Dependent may continue health Coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare or Medicare Disability entitlement. If the Employee and/or Dependent are also enrolled in Medicare or Medicare Disability, this Plan shall pay as the primary plan. Medicare will pay as secondary plan. If the Employee and/or Dependent elect to discontinue health Coverage under this Plan and enroll under the Medicare or Medicare Disability program, no benefits will be paid under this Plan. Medicare will be the only payor.

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

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the Human Resources Department of the Employer. The Employer is the Plan Administrator. The Plan Administrator shall have full charge of the operation and management of the Plan. The Employer has retained the services of an independent Claims Processor experienced in claims review.

The Plan Administrator is the named fiduciary of the Plan for all purposes except claim appeals, as specified in Claim Filing Procedure. As fiduciary, the Plan Administrator maintains discretionary authority with respect to those responsibilities for which it has been designated named fiduciary, including, but not limited to, interpretation of the terms of the Plan, and determining eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ASSIGNMENT

The Plan will pay benefits under this Plan to the Employee unless payment has been assigned to a Hospital, Physician, or other Provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the Claims Processor is notified in writing of such assignment prior to payment hereunder.

Preferred Provider normally bills the Plan directly. If services, supplies or treatment has been received from such a Provider, benefits are automatically paid to that Provider. The Covered Person's portion of the Negotiated Rate, after the Plan's payment, will then be billed to the Covered Person by the Preferred Provider.

This Plan will pay benefits to the responsible party of an Alternate Recipient as designated in a qualified medical child support order.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible Covered Person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the Employer or Claims Processor shall operate to defeat any of the rights, privileges, services, or benefits of any Employee or any Dependent(s) hereunder, nor create or continue Coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

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

EFFECTIVE DATE OF THE PLAN

The Effective Date of this Plan is April 1, 2015.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a Hospital or to make a free choice of the attending Physician or Professional Provider.

However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person will have higher out-of-pocket expenses if the Covered Person uses the services of a Non-Preferred Provider.

INCAPACITY
If, in the opinion of the Employer, a Covered Person for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his estate, the Employer may on behalf of the Plan, at his discretion, make any and all such payments to the Provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment.

INCONTESTABILITY
All statements made by the Employer or by the Employee covered 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 Employer or by the Covered Person, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS
No action at law or in equity shall be brought to recover on the benefits from the *Plan* prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of two (2) years from the date the expense was incurred, or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY
Liability hereunder is limited to the services and benefits specified, and the Employer shall not be liable for any obligation of the Covered Person Incurred in excess thereof. The Employer shall not be liable for the negligence, wrongful act, or omission of any Physician, Professional Provider, Hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of Covered Expenses and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES
Any benefit payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the Covered Person to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the Covered Person for the forfeited benefits within the time prescribed in Claim Filing Procedure.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS
The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a Covered Person or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same services, supplies or treatment, payment under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the Plan.

MISREPRESENTATION
If the Covered Person or anyone acting on behalf of a Covered Person makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages,

including legal fees, from the Covered Person, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the Covered Person in making application for Coverage, or any application for reclassification thereof, or for service thereunder shall render the Coverage under this Plan null and void.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The Plan, at its own expense, shall have the right to require an examination of a person covered under this Plan when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the Employer and any Employee 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 Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to terminate the employment of any Employee at any time.

PLAN MODIFICATION AND AMENDMENT

The Employer may modify or amend the Plan from time to time in accordance with the provision from time to time at its sole discretion, and such amendments or modifications which affect Covered Persons will be communicated to the Covered Persons. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the Effective Date of the modifications, and shall be signed by the Employer's designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the Employer, or a written copy thereof shall be deposited with such master copy of the Plan. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to Covered Persons shall be timely made by the Employer.

PLAN TERMINATION

The Employer reserves the right to terminate the Plan at any time. Upon termination, the rights of the Covered Persons to benefits are limited to claims Incurred up to the date of termination. Any termination of the Plan will be communicated to the Covered Persons.

Upon termination of this Plan, all claims incurred prior to termination, but not submitted to either the Employer or Claims Processor within 12 months of the Effective Date of termination of this Plan, will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this *Plan* shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

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. If the company makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an Employee or Dependent has a status change while covered under this Plan (i.e. Dependent to Employee, COBRA to Active) and no interruption in Coverage has occurred, the Plan will provide continuance of Coverage with respect to any Pre-Existing Condition limitation, Deductible(s), Coinsurance and Maximum Benefit.

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

WORKERS' COMPENSATION NOT AFFECTED
This Plan is not in lieu of, and does not affect any requirement for, Coverage by Workers' Compensation Insurance.

HIPAA PRIVACY & SECURITY REGULATIONS

City will comply with HIPAA regulations regarding privacy, confidentiality and disclosure of protected health information in accordance with City of Greenwood Health Information Privacy Policies and Procedures.

GLOSSARY OF TERMS

This section defines terms that have special meanings. The word or phrase is defined in this section or elsewhere in this Plan Document.

AMBULANCE – A specially designed and equipped vehicle or aircraft that is used for the purpose of responding to emergency life-threatening situations and providing emergency transportation services and is staffed by staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. An Ambulance must be certified as such in the state(s) in which it operates.

AUTHORIZATION, or AUTHORIZED SERVICES, PRIOR AUTHORIZATION OR PRE-CERTIFICATION– A covered service which has been authorized in advance by the Plan.

BEHAVIORAL HEALTH NETWORK – An organization or entity that the Plan has a contract with to provide mental health or substance abuse treatment and/or services.

BIOLOGICAL or BIOPHARMACEUTICAL DRUG - A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings.

BRAND-NAME (DRUG) - A drug that has been manufactured under a patent and in accordance with the approval for the Food and Drug Administration (FDA).

CARRIER – An underwriter or insurer.

CLAIMS ADMINSTRATOR - The organization under contract with City of Greenwood to maintain eligibility and process medical claims for the Plan.

COINSURANCE – The amount a Covered Person must pay after the Deductible has been met and before the out of pocket maximum has been met. There are different Coinsurance amounts for preferred and non-preferred Providers.

COPAYMENTS – The amount a Covered Person must pay directly to a Participating Provider or Pharmacy for Covered Services.

COVERED PERSON/COVERED DEPENDENT - See Eligible Dependent below.

COORDINATION OF BENEFITS (COB) - An attempt by one of the Plan's Participating Providers and/or the Plan to recover the cost of care provided to a Covered Person from a third party. The third party may be another insurer, such as automobile, home, business, and/or renter, service plan, government third party payor, or other organization, which also provides Coverage for a Covered Person's health care needs. Coordination of Benefits is subject to any limitations imposed by this Plan, or another applicable policy preventing such recovery.

COVERED SERVICES or COVERAGE – Those services or supplies that a Covered Person is entitled to under this Plan, if the services are Medically Necessary and the Covered Person has met all other requirements of this Plan,

CUSTODIAL CARE - Care furnished for the purpose of meeting personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication.

DEDUCTIBLE – The amount a Covered Person pay each Plan Year before the plan pays any applicable amount.

DURABLE MEDICAL EQUIPMENT (DME) - DME can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of Illness or Injury and is suitable for use in Covered Person's home. Examples of DME include, but are not limited to, wheel chairs, crutches, respirators, traction equipment, Hospital beds, monitoring devices, oxygen-breathing apparatus and insulin pumps.

EFFECTIVE DATE OF COVERAGE – The date when your Coverage begins under this Plan. An Eligible Dependent's Coverage begins on the effective date of the affiliated Enrollee.

ELIGIBLE DEPENDENT or DEPENDENT - A person of the Enrollee's family: who meets the eligibility requirements of the Group and eligibility requirements listed in this Plan Document; for whom the Enrollee has applied for membership; and for whom premiums have been paid by Group and/or Enrollee.

EMERGENCY SERVICES - Services provided due to a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a body organ or part of the individual.

ENROLLEE (you, your) - An employee of the Group, who resides and/or works in Indiana (the geographic area in which the Plan is licensed), who meets the eligibility requirements of the Group, who has for Coverage with the Plan, and for whom premiums have been paid by the Group.

EXPERIMENTAL or INVESTIGATIONAL - Any intervention (treatment, procedure, facility, equipment, drug device, service, or supply): that meets one or more of the following criteria:

- Intervention that is not generally and widely accepted in the practice of medicine in the U.S.; and whose effectiveness is not documented in peer-reviewed articles in medical journals published in the U.S. For interventions to be considered effective, journal articles should indicate that the intervention is more effective than other available, or, if not more effective, is safer or less costly.
- Interventions that are considered Experimental or Investigational by:
  - the U.S. Department of Health and Human Services;
  - the National Institute of Health; or
  - any of their subsidiary agencies
- Drugs or medical devices Biological products, or some combination thereof that the U.S. Food and Drug Administration (FDA) has not cleared or approved for commercial distribution, or that do not have other governmental agency approval as required by law.
- Use of an FDA cleared or approved drug, medical device, Biological product or some combination thereof for a use: (1) that FDA has not cleared or approved and that would otherwise require such clearance or approval (i.e., an 'off-label' use); and (2) the effectiveness of which has not been documented in peer-reviewed articles in medical journals published in the U.S. For used of this type to be considered effective, such articles should indicate that using the drug, medical device, Biological product, or some combination thereof for he particular use at issue is more effective than other products available for the proposed use, or, if not more effective, is safer or less costly.

FORMULARY - A Formulary is a list of preferred Generic and brand name prescription medications that have been approved by the Food and Drug Administration (FDA).

GENERIC (DRUG) - A copy of a Brand-Name Drug for which the patent has expired. The Generic drug may be of different shape, size, color or flavor, but the active, therapeutic agents are the same as the Brand-Name Drug. The same quality and safety standards that apply to Brand-Name Drugs also apply to the Generic form. The FDA sets standards and reviews all Generic medications before being marketed.

HEALTH PROFESSIONAL - A professional engaged in the delivery of health services that is licensed, where required, under the laws of the jurisdiction where services are delivered and operating within the scope of his/her license.

HOME HEALTH SERVICES - Health services delivered in a Covered Person's home setting and provided by an organization licensed by the State and operating with the scope of its license.

HOSPICE CARE OR FACILITY – A health care facility, or a system of professional home visits and supervision, for supportive care of the Terminally Ill.

HOSPITAL - An acute care facility duly licensed in the jurisdiction where services are rendered.

ILLNESS - A sickness or disease and all related conditions and recurrences. The term Illness includes pregnancy and all related conditions.

INJURY - An accident to the body that requires medical or surgical treatment.

INPATIENT - Confinement as a bed-patient for 24 hours or longer in a Hospital, SNF, or Hospice Facility.

LATE ENROLLEE – An Enrollee or Eligible Dependent who did not request enrollment during the initial enrollment period in which he/she was first entitled to enroll; or during any special enrollment period as described in this Plan Document,.

LOW PROTEIN MODIFIED FOOD PRODUCT - A food product that is (1) specially formulated to contain less than one (1) gram of protein per serving; and (2) intended to be used under the direction of a Physician for dietary treatment of an inherited metabolic disease.

MAXIMUM ALLOWABLE AMOUNT – The amount that the Plan determines is the maximum payable for Covered Services you receive, up to but not exceed charges actually billed for non-essential services. For a non-Participating Provider the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the contract used with Participating Providers. The Maximum Allowable Amount is reduced by any penalties for which a Covered Person is responsible under the terms of this Plan.

MEDICAL FOOD - A food that is (1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by a medical evaluation; and (2) formulated to be consumed or administered internally under the direction of a Physician.

MEDICALLY NECESSARY - Medical or surgical treatment which a Covered Person requires, as determined by one or more Participating Physicians, which is: 1) in conformity with the professional and technical standards adopted by the Quality improvement committee and Utilization Review Committee of the Provider Network, the Medical Group, and the Plan; and 2) in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment. Services shall not be deemed Medically Necessary if the treatments are Experimental or Investigational, or are rendered primarily for the convenience of the Covered Person or Participating Provider.

- appropriate for the symptoms, diagnosis, or treatment of the medical condition; and
- provided for the diagnosis or direct care and treatment of the medical condition; and
- within standards of good medical practice within the organized medical community; and
- not primarily for the convenience of the Covered Person's Physician or another Provider; and
- not otherwise subject to Non-Covered Services under this Plan; and
- the most appropriate procedure, supply, equipment, or service that can safely be provided. The most appropriate procedures, supplies, equipment, or service must satisfy the following requirements:
  - there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, *supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a* disproportionately greater risk of harm or complications, for the Covered Person with the particular medical condition being treated than other alternatives; and
  - generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

- for Hospital stays, acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

COVERED PERSON (you, your) – An eligible person enrolled in the Plan's health plan, as an Enrollee or Eligible Dependent.

NON-COVERED SERVICES - Those services not covered under this Plan, and are listed as Non-Covered Services in this Plan Document.

OPEN ENROLLMENT PERIOD – The period of time established by the Plan and the Group during which eligible employees and their Eligible Dependents may enroll as new Covered Persons.

MAXIMUM OUT-OF-POCKET- Maximum paid by member including deductible, co-insurance and copay for non-essential Covered Services

OUTPATIENT - Covered Person who receives medical services, but is not an Inpatient.

PARTIAL HOSPITALIZATION - A structured mental health and/or substance abuse treatment program with sessions of three hours or longer.

PARTICIPATING HOSPITAL – A Hospital that contracts with the Plan to provide Covered Services to a Covered Person.

PARTICIPATING PHARMACY - A pharmacy or organization of pharmacies that contracts with the Plan to provide Covered Services to a Covered Person.

PARTICIPATING PHYSICIAN - A Physician who contracts with the Plan to provide Covered Services to a Covered Person.

PARTICIPATING PROVIDER – A Health Professional or other entity that contracts with the Plan to provide Covered Services to a Covered Person.

PCP or **PRIMARY CARE PHYSICIAN** –May include Family or General Physicians, Internists, Pediatricians and OB-GYN's that provides primary care to a Covered Person.

PHYSICIAN – An appropriately licensed Physician or surgeon.

PROVIDER NETWORK - An organized group of Physicians, facilities and Health Professionals contracted with the Plan. A Physician network has as its primary purpose the delivery, or the arrangement for the delivery, of Covered Services.

PLAN YEAR - A twelve-month period beginning on the contract effective date. The City of Greenwood's contract begins April 1 and ends March 31st.

ANNUAL POLICY MAXIMUM– Total annual maximum dollar amount payable for non-essential Covered Services the Covered Person receives under the Agreement, including any renewals, endorsements, amendments or addendums thereto. If there is a lapse in Coverage, the Policy Maximum applies to all non-essential benefits received either before or after the lapse.

PRIOR AUTHORIZATIONS - Process where a Covered Person's Physician directs the Covered Person to seek or obtain Covered Services from another participating or non-participating Health Professional or Inpatient facility, subject to the Plan's Pre-Certification requirements. .

PROVIDER - Any Hospital, Physician, pharmacy, SNF, individual, organization, or agency that is licensed to provide professional services within the scope of that license or certification.

REGISTERED NURSE (RN) - A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "RN" after his name.

SECOND OPINION - Medical or surgical opinion that is provided by a Physician to reevaluate the condition. The Second Opinion is made with Prior Authorization from the Plan.

SERVICE AREA - The Central Indiana geographical area where the Plan is based, to be defined as a thirty (30) mile circumference area from the City building in Greenwood, Indiana.

SKILLED NURSING FACILITY or **SNF** – An institution, or a distinct part of an institution, which:

- is duly licensed in the state of Indiana; is regularly engaged in providing 24-hour skilled care under the regular supervision of a Physician and the direct supervision of a RN;
- maintains a daily record on each patient; and
- provides each patient with active treatment of an Illness or Injury, or related rehabilitation, in accordance with existing standards of medical practice for that condition.

A SNF does not include any institution or portion of any institution that is primarily for rest, the aged, non-skilled care, or care of mental diseases or substance abuse.

SPECIALTY CARE PHYSICIAN (SCP) - A Physician who has an identified specialty other than a family practice, internal medicine, or pediatrics; and who is not acting in the role of a PCP to the Covered Person at the time services are provided. Examples of SCPs would include surgeons (orthopedic, cardiovascular, vascular, etc.), cardiologists, oncologists, urologists, etc.

SPOUSE - Enrollee's legal Spouse.

SPECIALTY DRUG – Please refer to BIOLOGICAL or BIOPHARMACEUTICAL DRUG

TERMINALLY ILL OR TERMINAL ILLNESS - A Physician has given a prognosis that a Covered Person has six months or less to live.

URGENT CARE - Urgently needed services or Urgent Care services are instances when a Covered Person needs Covered Services urgently:

- to prevent serious deterioration of health;
- resulting from an unforeseen Illness or Injury;
- while outside of the Service Area;
- for which treatment cannot be delayed until the Covered Person returns to the Service Area without the Covered Person's condition growing much worse. Urgently needed services are determined by medical condition not the place of treatment

IMPORTANT CONTACTS

Plan Sponsor:	City of Greenwood Board of Public Works and Safety
Address:	300 South Madison Avenue Greenwood, IN 46142
Telephone:	317-887-5604
Customer Services	ADVANTAGE Health Solutions, Inc. Customer Services Department
Address:	9045 River Road, Suite #200 Indianapolis, IN 46240 www.AdvantagePlan.com
Telephone:	888-671-5897 TDD: 1- 800 743-3333 (hearing impaired) Business Hours: 7:30am – 5:30pm FAX: 317-573-2839 **NOTE:** To ensure quality service, *your* call may be monitored.
Claims Administrator:	ADVANTAGE Health Solutions, Inc.
Address:	P. O. Box 503386 Indianapolis, IN 46250
Telephone:	888-671-5897
Care Management:	ADVANTAGE Health Solutions, Inc. 9045 River Road, Suite #200
Address:	Indianapolis, IN 46240
Telephone:	877-901-2236 TDD: (800) 743-3333 (hearing impaired) FAX: 317-536-5391
Pharmacy	Envision RX
Address:	2181 E. Aurora Road Twinsburg, OH 44087 www.Envisionrx.com
Telephone:	877-684-0014 TDD: 1- 866- 763-9630 (hearing impaired)

DELTA DENTAL

www.DeltaDentalIN.com

February 2, 2015

Mr. Jon Pierre Fox
Regions Insurance, Inc.
PO Box 2224
2701 Albright
Kokomo, IN 46904-2224

Dear Mr. Fox,

Enclosed is renewal information for one of your Delta Dental Plan of Indiana groups that renews in the month of April. A renewal letter indicating the group's renewal rates is included.

Please ensure that the enclosed renewal documents are delivered to the group.

If you have any questions or need additional information, please feel free to contact me.

Sincerely,

Melinda L Tyo
Account Manager

Enclosures:
0505-0007, 0100, 0110, 0135, 0150, 0160, 0200, 0210, 0211, 0222, 0272, 0300, ... City of Greenwood

DELTA DENTAL OF INDIANA
225 S. East Street, Suite 358
Indianapolis, IN 46202

DELTA DENTAL

www.DeltaDentalIN.com

February 2, 2015

Ms. Marilyn Allen
Director of Human Resources
City of Greenwood
2 N Madison Ave
Greenwood, IN 46142-3565

Re: Dental Plan Rate Review, Group #0505-0007, 0100, 0110, 0135, 0150, 0160, 0200, 0210, 0211, 0222, 0272, 0300, ...

Dear Ms. Allen,

Thank you for placing your confidence in Delta Dental. We are committed to improving the oral health of our communities by providing access to the nation's largest dental network at competitive rates. This allows your enrollees to obtain the dental care they need to remain healthy.

We have completed a comprehensive review of your dental plan premiums. Enclosed are the rates and renewal documents related to your contract renewal. Payment of the new rates will be your consent to renew Delta Dental coverage. No action is required from you at this time unless you wish to change the benefits you offer.

If your coverage or budget goals have changed, please contact Mr. Jon Pierre Fox or me for more plan design options. We can administer many different plan designs to suit your needs and provide you with a comprehensive analysis of how any changes would affect your rates. Benefit changes can be effective at your renewal, but you must request them no later than 15 days prior to your plan's renewal date.

This is a prepaid dental benefits program, so your group's first payment at these rates is due by April 1. If you do not wish to renew coverage, please provide notice to us in accordance with your Contract. Notwithstanding the above terms of this "evergreen" contract, all delinquent balances due to Delta Dental must be paid in full prior to acceptance on the above-mentioned renewal date. If there is a deficit at the time of your acceptance, Delta Dental reserves the right to revoke this offer and terminate your existing contract upon its natural expiration date.

Please call me at (317) 348-1820 if you have any questions or if I can be of help in any way. Thank you, we look forward to continuing our relationship with you and we greatly appreciate your business.

Sincerely,

Melinda L Tyo
Account Manager

cc: Mr. Jon Pierre Fox

DELTA DENTAL OF INDIANA
225 S. East Street, Suite 358
Indianapolis, IN 46202

DELTA DENTAL

Delta Dental of Indiana

Renewal Rates for City of Greenwood #0505

Effective April 1, 2015

Rates - Non-Retention		
Rates per subscriber per month	**Current Rate(s)** April 1, 2013 through March 31, 2015	**Renewal Rate(s)** April 1, 2015 through March 31, 2016
Subscriber only	$28.32	$30.30
Subscriber and spouse	$61.63	$65.94
Subscriber and child(ren)	$67.78	$72.52
Subscriber, spouse and child(ren)	$101.38	$108.48
Overall Percent Change	7.00%	

Rating Requirements
Minimum client contributions: 100 percent for employee and 100 percent for dependent(s).
Tied to medical: No

Rating Assumptions
Rates do not include any applicable claims taxes. The rates are valid only for the effective date noted above and are guaranteed for a one year non-retention contract.
These rates assume that claims from nonparticipating dentists will be paid using our national out-of-network fee table.
Self-billing is not allowed and you agree to pay as invoiced each month.
Standard subscriber materials will be provided to you to distribute to your members. These include the Summary of Dental Plan Benefits, Certificate, and reference cards.
Printed dentist directories are not included. You can find participating dentists on our website at www.DeltaDentalIN.com.
The plan specifications are subject to Delta Dental's standard exclusions and limitations, including: ➢ Oral exams (including evaluations by a specialist) are payable twice per benefit year. ➢ Prophylaxes (cleanings) are payable twice per benefit year. ➢ People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment. ➢ Fluoride treatments are payable twice per benefit year with no age limit. ➢ Space maintainers are payable once per area per lifetime for people up to age 13. ➢ Bitewing X-rays are payable once per benefit year and full mouth X-rays (which include bitewing X-rays) are payable once in any four-year period. ➢ Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 15. The surface must be free from decay and restorations. ➢ Composite resin (white) restorations are Covered Services on posterior teeth. ➢ Porcelain and resin facings on crowns are optional treatment on posterior teeth. ➢ Implants and implant related services are payable once per tooth in any five-year period.

Delta Dental of Indiana
Dental Benefit Highlights for
City of Greenwood #0505

DELTA DENTAL

Delta Dental PPO (Point-of-Service) *Coverage effective April 1, 2015*	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Non-participating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	80%	80%	80%
Endodontic Services - root canals	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Extractions - removal of teeth	80%	80%	80%
Major Restorative Services - crowns	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
Major Services			
Emergency Palliative Treatment - to temporarily relieve pain	50%	50%	50%
Periodontal Maintenance - cleanings following periodontal therapy	50%	50%	50%
Other Oral Surgery - dental surgery other than extractions	50%	50%	50%
Relines and Repairs - to bridges, implants, and dentures	50%	50%	50%
Prosthodontic Services - bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	No Age Limit	No Age Limit	No Age Limit

** When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.*

Maximum Payment – $1,000 per person total per Benefit Year on all services, except oral exams, preventive services, X-rays, brush biopsy, sealants, and orthodontic services. $1,000 per person total per lifetime on orthodontic services.

Deductible – None.

Note - *This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.*

Welcome to Indiana's largest dental benefits family!

As a member of Delta Dental of Indiana, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier.

- It's easy to find a dentist! Four out of five dentists nationwide participate in our network.
- You have superior access to care and fee savings because of our agreements with participating dentists.
- Our dentists cannot balance bill you, which means more money in your pocket!
- No troublesome paperwork! Network dentists will fill out and file your claims.
- Pay only your copayments and/or deductibles when you receive care from network dentists – there are no hidden fees.
- You can still visit nonparticipating dentists, but you may be billed the full amount at the time of service and then have to wait to be reimbursed.

Quality Dental Program

With our quick and accurate claims processing, *we pay more than 90% of claims in 10 days or less.* Delta Dental also offers world-class customer service from our Certified Center of Excellence call center, as awarded by Benchmark Portal.

Online Access

Our online Consumer Toolkit lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more – all at your own convenience.

A Healthy Smile

Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions?

If you have questions, please call our Customer Service team at (800) 524-0149 or look online at www.DeltaDentalIN.com.

DELTA DENTAL

Delta Dental Contract
For
City of Greenwood

This ("Contract") is entered into by and between City of Greenwood (the "Contractor") and Delta Dental Plan of Indiana, Inc., an Indiana non-profit corporation ("Delta Dental"). This is a legally binding contract between the Contractor and Delta Dental and is effective on April 1, 2015, the ("Effective Date").

SECTION I - DECLARATIONS

The Benefits afforded are only with respect to such benefits as are indicated in this Contract, including the Summary of Dental Plan Benefits. Delta Dental's liability is limited to the Benefits stated herein; subject to all the terms of this Contract having reference thereto. This Declarations Section and the Summary of Dental Plan Benefits supersedes any contrary provision of the subsequent sections of this Contract.

A. **Effective Date:** 12:01 A.M. Standard Time, April 1, 2015

B. **First Renewal Date:** April 1, 2016

C. **Client Number:** 0505-0007, 0100, 0110, 0135, 0150, 0160, 0200, 0210, 0211, 0222, 0272, 0300, 0460, 0485, 0500, 0600, 0750, 0760, 0770, 0790, 0900

D. **Rate(s):**

Subscriber only - $30.30 per month per Subscriber
Subscriber and spouse - $65.94 per month per Subscriber
Subscriber and child(ren) - $72.52 per month per Subscriber
Subscriber, spouse and child(ren) - $108.48 per month per Subscriber

These rates are contingent upon the enrollment of a minimum of 95 percent of the eligible members of the defined group and their eligible dependents with 100 percent of the cost paid by the Contractor. Rates do not include any applicable claims taxes.

These rates assume that claims from nonparticipating dentists will be paid using our national out-of-network fee table.

DELTA DENTAL PLAN OF INDIANA, INC.

BY: Laura L. Golada
President and CEO

DATE: February 2, 2015

CONTRACTOR

BY: Mark W Mayor
(Authorized Signature)
Mayor
(Title)

BY: Amanda Leach
(Witnessed By)
Board Clerk
(Title)

DATE: March 17, 2015

Section II - Definitions

A. Benefit Year

means the calendar year, unless the Contractor elects a different period to serve as the Benefit Year.

B. Benefits

means payment for the Covered Services that have been selected under the Contract.

C. Children

means the Subscriber's natural Children, stepchildren, adopted Children, Children by virtue of legal guardianship, or Children who are residing with the Subscriber during the waiting period for adoption or legal guardianship.

D. Contract

means this document, including, if applicable, any appendices, supplements, riders, successor agreements, renewal letters, or renewals now or hereafter issued or executed.

E. Copayment

means the percentage of the charge, if any, that an Eligible Person must pay for Covered Services.

F. Covered Services

means the unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms and conditions of this Contract.

G. Deductible

means the amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Contract. If the Contractor has selected a Deductible, it will be indicated in the Summary of Dental Plan Benefits.

H. Delta Dental

means Delta Dental Plan of Indiana, Inc., a nonprofit limited service health maintenance organization providing dental benefits programs. Delta Dental is not an insurance company.

I. Delta Dental Plan

means an individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

J. Delta Dental PPO

means Delta Dental's national preferred provider organization program that can reduce the out-of-pocket expenses for Eligible Persons if they receive care from a Delta Dental PPO Dentist.

K. Delta Dental Premier

means Delta Dental's managed fee-for-service dental benefits program.

L. Dentist

means a person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

1. **Delta Dental PPO Dentist (PPO Dentist)** means a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental PPO.
2. **Delta Dental Premier Dentist (Premier Dentist)** means a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental Premier.

3. **Nonparticipating Dentist** means a Dentist who has not signed an agreement with any Delta Dental Plan to participate in Delta Dental PPO or Delta Dental Premier.

4. **Out-of-Country Dentist** means a Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Premier Dentists are sometimes collectively referred to herein as **"Participating Dentists."** Wherever a definition or provision of this Contract differs from another state's Delta Dental Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist shall be controlling.

Premier Dentists, Nonparticipating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **"Non-PPO Dentists."**

M. Eligible Dependent(s)

means (1) the Subscriber's legal spouse and (2) any other dependents who meet the criteria for eligibility set forth in the Eligibility Section or Summary of Dental Plan Benefits. If dependent coverage has been selected, it will be indicated in the Summary of Dental Plan Benefits.

N. Eligible Person(s)

means any Subscriber or Eligible Dependent under this Contract.

O. Maximum Approved Fee

means a system used by Delta Dental to determine the approved fee for a given procedure for a given Participating Dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

1. The Submitted Amount.

2. The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.

3. The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstances, based upon applicable Participating Dentist schedules and internal procedures.

Delta Dental may also approve a fee under unusual circumstances.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

P. Maximum Payment

means the maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. The Maximum Payment is specified in the Summary of Dental Plan Benefits.

Q. Nonparticipating Dentist Fee

means the maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

R. Open Enrollment Period

means the period of time as determined by the Contractor, during which an Eligible Person may enroll or be enrolled for Benefits.

S. Out-of-Country Dentist Fee

means the maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

T. Post-Service Claims

means claims for Benefits that are not conditioned on the Eligible Person seeking advance approval, certification, or authorization to receive the full amount for any Covered Services. Post-Service Claims arise when the Eligible Person receives the dental service or treatment before the claim is filed for Benefits.

U. PPO Dentist Schedule

means the maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Plan.

V. Pre-Treatment Estimate

means a voluntary and optional process where, at the request of a Subscriber, Eligible Dependent or Dentist, Delta Dental issues a written estimate of dental benefits that may be available for a proposed dental treatment under the terms of the Subscriber's coverage.

Pre-Treatment Estimate is for informational purposes only and is not required in advance of obtaining dental care or as a prerequisite or condition for approval of future dental benefits payment. The benefits estimate provided on a Pre-Treatment Estimate notice is determined based on the information provided to Delta Dental and the benefits available for the Subscriber or Eligible Dependent on the date the notice is issued. It is not a guarantee of future dental benefits payment.

Availability of dental benefits at the time a dental service is completed depends on several factors. These factors include, but are not limited to, eligibility for benefits, annual or lifetime Maximum Payments, coordination of benefits, Contract and Dentist status, Contract limitations, and any other Contract provisions, together with any additional information or changes to the dental treatment. A request for a Pre-Treatment Estimate is not a claim for Benefits or a preauthorization, precertification or other reservation of future Benefits.

W. Premier Dentist Schedule

means the maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Plan.

X. Processing Policies

means Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of claims. The Processing Policies may be amended from time to time.

Y. Rate

means the amount, per Subscriber and Subscriber classification, the Contractor agrees to pay Delta Dental each month. This amount, or the information necessary to compute it, is specified in the Declarations Section.

Z. Submitted Amount

means the amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge the Eligible Person for the difference between this amount and the amount Delta Dental approves for the treatment.

AA. Subscriber

means all people who are members or employees of the group specified in the Summary of Dental Plan Benefits, are certified as being eligible by the Contractor, and are enrolled to receive Benefits under this Contract.

BB. Summary of Dental Plan Benefits

means a description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Contract, and supersedes any contrary provision of this Contract.

CC. This Plan

means the dental coverage established for Eligible Persons pursuant to this Contract.

Section III - Eligibility

A. Effective Date of Eligibility

1. **Initial Effective Date:** All Subscribers on the Effective Date of this Contract are immediately eligible for Benefits. If Eligible Dependents of a Subscriber are covered by this Contract, their eligibility commences on the same date as the Subscriber.

2. **After the Initial Effective Date:** For all Subscribers (and their Eligible Dependents, if dependent coverage is selected) not associated with the Contractor on the initial Effective Date of this Contract, eligibility for Benefits will begin following whichever of the following dates is applicable provided, however, that for Sections III.A.2.c., 2.d., and 2.f., in those circumstances when dental benefits are not "excepted benefits," as defined in Section 9832(c) of the Internal Revenue Code of 1986, as amended ("IRC" or the "Code"), the eligibility for dental benefits will begin on the applicable date set forth therein:

   a. Newly hired or rehired employees: The date for which employment compensation begins or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Dental Plan Benefits.

   b. Spouse: Date of marriage.

   c. Newborn: Date of birth.

   d. Legal adoptions or guardianships: Date that the legal petition for adoption or guardianship becomes legally final, or the date on which the Child begins residing with the Subscriber and the Subscriber assumes responsibility for the Child while waiting for adoption or guardianship to become final.

   e. Stepchild: Date that the Child's natural parent becomes an Eligible Dependent.

   f. Special Enrollment Periods: For dental benefits not provided under a group health plan providing only dental benefits and where the dental benefits are "integral" to the group health plan (i.e., where dental benefits are not "excepted benefits" under IRC Section 9832(c)), the date required under the special enrollment provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, Section 701(f), and IRC Section 9801(f).

   g. All others: Date that Delta Dental approves in writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Child or Eligible Dependent.

B. General Eligibility Rules

1. No person will be eligible for Benefits under this Contract unless the Contractor has either currently enrolled that person as a Subscriber or currently listed or acknowledged that person as an Eligible Dependent, unless the enrollment or listing is otherwise allowed under this Contract. In no event will retroactive updates to eligibility be accepted for an effective date more than six months prior to receipt of the update by Delta Dental. To the extent the dental benefits provided under this Contract are not "excepted benefits," as defined in IRC Section 9832(c), no person will be ineligible for dental benefits under this Contract on account of any of the health status-related factors set forth in ERISA Section 702(a)(1) and IRC Section 9802(a)(1).

2. Unless the eligibility requirements stated in the Summary of Dental Plan Benefits are different, an Eligible Dependent is:

   a. The legal spouse of the Subscriber; or

   b. Unmarried Children of the Subscriber who have not yet reached the dependent age limit stated in the Summary of Dental Plan Benefits; or

c. Unmarried Children of the Subscriber who have reached the dependent age limit stated in the Summary of Dental Plan Benefits, but are eligible to be claimed by the Subscriber as a dependent under the U. S. Internal Revenue Code during the current calendar year; or

d. Unmarried Children of the Subscriber or the Subscriber's legal spouse for whom the Subscriber or the Subscriber's legal spouse is financially responsible for the medical, health, or dental care under the terms of a court decree or who have been named as alternate recipients, as defined in ERISA Section 609(a)(2)(C), under a qualified medical child support order, as defined in ERISA Section 609(a)(2)(A); or

e. Children of the Subscriber who have reached the dependent age limit stated in the Summary of Dental Plan Benefits, but who were at that time (and continue to be) totally and permanently disabled by a physical or mental condition and who are eligible to be claimed by the Subscriber or the Subscriber's legal spouse as a dependent under the U.S. Internal Revenue Code. If Delta Dental asks the Subscriber to do so, the Subscriber shall submit medical reports confirming the Child's initial or continuing total disability.

3. No person will be eligible for Orthodontic Services under this Contract unless Orthodontic Services are selected in the Summary of Dental Plan Benefits, and, even if Orthodontic Services are selected, no person will be eligible for Orthodontic Services on or after that person's 19th birthday, unless specified otherwise in the Summary of Dental Plan Benefits.

C. Termination of Eligibility

Eligibility for Benefits will terminate for all Eligible Persons under this Contract at the earlier of:

1. The termination of this Contract; or
2. Midnight of the last day of the month for which payment has been made if the Contractor fails to make the payments required by this Contract.

Eligibility of an individual Subscriber, and of that Subscriber's Eligible Dependents, also will terminate under the following circumstances:

1. The Subscriber ceases to be a Subscriber as defined by this Contract.
2. Lack of compliance with the eligibility requirements of this Contract.
3. Fraud or misrepresentation in the submission of any claim.

Eligibility for Benefits will also automatically terminate for Children when they no longer qualify as an Eligible Dependent.

Delta Dental will not continue eligibility for any Eligible Person covered under this Contract beyond the eligibility termination date requested by the Contractor, provided that notice of the termination request is received by Delta Dental within six months of the effective date. However, if the Contractor requests that a Subscriber or Eligible Dependent's eligibility be terminated retroactively and a claim was incurred for any eligible member of that person's family after the requested termination date, eligibility for the entire family will continue at the expense of the Contractor until the end of the month in which the claim was incurred. In no event will any Rate adjustments for time periods greater than six months be made for retroactive terminations, and no credit will be issued for any month in which claims were incurred.

An Eligible Person whose eligibility is terminated may not continue group coverage under this Contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, or comparable, non-preempted state law ("COBRA"). An affiliate of Delta Dental also may offer coverage under an individual direct payment policy to an Eligible Person whose eligibility is terminated.

D. Loss of Eligibility During Treatment

1. If an Eligible Person loses eligibility while receiving dental treatment, only Covered Services received while that person was eligible under the Contract will be payable.

2. Certain services begun before the loss of eligibility may be covered if they are completed within a 60 day period measured from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental.

E. Continuation Coverage – COBRA

The other provisions of this Contract notwithstanding, eligibility for Benefits will continue for a person who is required to be provided with and elects continuation coverage pursuant to COBRA, provided:

1. Continuation coverage is required to be provided under COBRA, the person elects COBRA coverage and the Contractor notifies Delta Dental that the person is eligible for Benefits under COBRA. Not all employers are subject to the continuation coverage requirements contained in COBRA. For those that are not, this Section III.E. does not apply. Contractors should consult with their legal counsel to determine how and when the law applies.
2. Continuation coverage shall only be in effect up to the first day of the month after the person notifies the Contractor that he or she no longer wants coverage from Delta Dental, the date a COBRA premium payment was due and was not remitted by the end of the COBRA Grace Period, or until the end of that person's continuation coverage period, whichever occurs first.
3. Further, if the Contractor fails to make payments required by this Contract, continuation coverage shall only remain in effect until the last day of the month for which payment has been made to Delta Dental by the Contractor; provided, however, that any payment for COBRA continuation coverage received during a period that is 30 days following the date the COBRA premium payment was due (the "COBRA Grace Period") will provide continuation coverage from the due date. A person's coverage may be retroactively reinstated for the 60-day COBRA "election" period if the Contractor pays the applicable rate for the period within the 45-day period following the date of the COBRA election. Delta Dental may, at its sole option and without notice, continue coverage, if legally required.
4. Continuation coverage will not continue beyond the termination of this Contract.
5. The person who is receiving continuation coverage is responsible for the costs of any services provided after he or she is no longer eligible for continuation coverage under this Section III.E.
6. Contractor shall be solely responsible for identifying Eligible Persons entitled to COBRA continuation coverage. Contractor shall provide all required notices, collect all necessary payments, and otherwise administer all facets of its COBRA program. In the event that Contractor continues to provide eligibility information to Delta Dental for an Eligible Person during the COBRA election period, as opposed to terminating coverage and then retroactively reinstating the Eligible Person upon the Eligible Person's election of COBRA coverage, Contractor shall be liable for any Benefits paid or Rates due during that period if the Eligible Person ultimately does not elect COBRA coverage.
7. The monthly Rate that must be paid on behalf of any person who is provided coverage under this Section III.E. will be based on the COBRA continuation coverage rates in effect during that month.
8. A person who continues coverage will be considered to be either a Subscriber or an Eligible Dependent under this Contract and the dental care certificate as long as coverage is provided under this Section III.E.
9. Delta Dental does not assume any of the obligations assigned by COBRA to the Contractor or any employer (including the obligation to notify potential beneficiaries of their rights or options under COBRA), and the Contractor agrees that it will perform those obligations in full.

Section IV - Benefits

Types of Benefits

Delta Dental agrees to provide Benefits to Eligible Persons under the policies and procedures of Delta Dental, including the Processing Policies, and under the terms and conditions of this Contract, including, but not limited to,

the following categories of services, exclusions, and limitations listed below. Benefits are divided into the following categories of services **unless otherwise specified in the Summary of Dental Plan Benefits:**

1. **Diagnostic and Preventive Services**

   a. **Diagnostic and Preventive Services**

   Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include examinations, evaluations, prophylaxes, space maintainers and fluoride treatments.

   b. **Brush Biopsy**

   Oral brush biopsy procedure and laboratory analysis used to detect oral cancer, an important tool that identifies and analyzes precancerous and cancerous cells.

   c. **Emergency Palliative Treatment**

   Emergency treatment to temporarily relieve pain.

   d. **Radiographs**

   X-rays as required for routine care or as necessary for the diagnosis of a specific condition.

2. **Basic Services**

   a. **Oral Surgery Services**

   Extractions and dental surgery, including pre-operative and post-operative care.

   b. **Endodontic Services**

   The treatment of teeth with diseased or damaged nerves (for example, root canals).

   c. **Periodontic Services**

   The treatment of diseases of the gums and supporting structures of the teeth. This includes periodontal maintenance following active therapy (periodontal prophylaxes).

   d. **Relines and Repairs**

   Relines and repairs to partial dentures and complete dentures, and repairs to bridges.

   e. **Restorative Services**

   Services to rebuild and repair natural tooth structure damaged by disease, decay, fracture, or injury. Restorative services include:

   (1) Minor restorative services, such as amalgam (silver) fillings and composite resin (white) fillings.

   (2) Major restorative services, such as crowns, when teeth cannot be restored with another filling material.

3. **Major Services**

   Prosthodontic Services

   Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, partial dentures, and complete dentures).

4. **Orthodontic Services**

   Services, treatment, and procedures to correct malposed teeth (for example, braces).

Section V - Exclusions and Limitations

A. Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits, and all charges for the same will be the responsibility of the Eligible Person.

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act; that is, Medicaid.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services started or appliances started before a person became eligible under this Contract. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, and histopathological examinations.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental, that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized techniques.
12. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
13. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional as determined by Delta Dental under the scope of his or her license as permitted by applicable state law.
14. Services or supplies excluded by the policies and procedures of Delta Dental, including the Processing Policies.
15. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
16. Services or supplies received due to an act of war, declared or undeclared.
17. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
18. Services or supplies that are not within the categories of Benefits selected by the Contractor and that are not covered in the Contract.
19. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
20. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
21. Sealants.
22. Space maintainers for maintaining space due to premature loss of anterior primary teeth.

23. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.

24. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.

25. Veneers.

26. Prefabricated crowns used as final restorations on permanent teeth.

27. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the Contract.

28. Paste-type root canal fillings on permanent teeth.

29. Replacement, repair, relines, or adjustments of occlusal guards.

30. Chemical curettage.

31. Services associated with overdentures.

32. Metal bases on removable prostheses.

33. The replacement of teeth beyond the normal complement of teeth.

34. Personalization or characterization of any service or appliance.

35. Temporary crowns used for temporization during crown or bridge fabrication.

36. Posterior bridges in conjunction with partial dentures in the same arch.

37. Precision attachments and stress breakers.

38. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.

39. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

40. Diagnostic photographs and cephalometric films, unless done for orthodontics and Orthodontics are a Covered Service.

41. Myofunctional therapy.

42. Mounted case analyses.

B. Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Eligible Persons for these services or supplies. All charges from Nonparticipating Dentists for the following will be the responsibility of the Eligible Person.

1. The completion of forms or submission of claims.

2. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.

3. Local anesthesia.

4. Acid etching, cement bases, cavity liners, and bases or temporary fillings.

5. Infection control.

6. Temporary, interim, or provisional crowns.

7. Gingivectomy as an aid to the placement of a restoration.

8. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
9. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
10. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
11. Post-operative X-rays, when done following any completed service or procedure.
12. Periodontal charting.
13. Pins and preformed posts, when done with core buildups for crowns, onlays, or inlays.
14. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
15. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
16. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
17. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
18. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing.
19. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
20. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
21. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

C. **The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be the responsibility of the Eligible Person. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental plan or, at the request of the Contractor, any dental plan.**

1. Bitewing X-rays are payable once per calendar year. Panoramic or full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
2. Any combination of teeth cleanings (prophylaxes, full mouth debridement, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable only once in a lifetime.
3. Oral examinations and evaluations are only payable twice per calendar year, regardless of the Dentist's specialty.
4. Patient screening is payable once per calendar year.
5. Preventive fluoride treatments are payable twice per calendar year for people under age 19.
6. Space maintainers are payable for people under age 14.
7. Cast restorations (including jackets, crowns, and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth.
8. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture.
9. Individual crowns over implants are payable at the prosthodontic benefit level.
10. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.

11. An occlusal guard is payable once in a lifetime.

12. An interim partial denture is payable only for the replacement of permanent anterior teeth for people under age 17 or during the healing period for people age 17 and over.

13. Prosthodontic Services limitations:

    a. One complete upper and one complete lower denture are payable once in any five-year period.

    b. A removable partial denture, implant, or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.

    c. Fixed bridges and removable partial dentures are not payable for people under age 16.

    d. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.

    e. Implant removal is payable once per lifetime per tooth or area.

    f. Implant maintenance is payable once per calendar year.

14. Orthodontic Services limitations:

    a. Orthodontic services are payable for Eligible Persons under age 19.

    b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

    c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

    d. An observation and adjustment is payable twice in a 12-month period.

15. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.

16. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.

17. Care terminated due to the death of an Eligible Person will be paid to the limit of Delta Dental's liability for the services completed or in progress.

18. Optional treatment: If an Eligible Person selects a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. The Eligible Person is responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

    Listed below are services for which Delta Dental will provide an allowance for optional treatment:

    a. Plastic, resin, porcelain fused to metal, and porcelain crowns on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.

    b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.

    c. Plastic, resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.

    d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.

    e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.

f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.

g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.

h. Stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.

19. Maximum Payment:

a. The maximum Benefits payable in any one Benefit Year will be limited to the Maximum Payment stated in the Summary of Dental Plan Benefits.

b. Delta Dental's payment for Orthodontic Services will be limited to the annual or lifetime Maximum Payment stated in the Summary of Dental Plan Benefits.

20. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.

21. Processing Policies may limit Delta Dental's payment for services or supplies.

D. **Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges will be the responsibility of the Eligible Person. However, Participating Dentists may not charge Eligible Persons for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental plan or, at the request of the Contractor, any dental plan.**

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.

2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.

3. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six months of the seating date.

4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.

5. Root planing is payable once in any two- year period.

6. Periodontal surgery is payable once in any three-year period.

7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.

8. Tissue conditioning is payable twice per arch in any three-year period.

9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.

10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.

11. Processing Policies may limit Delta Dental's payment for services or supplies.

Section VI - Agreements

A. **Delta Dental Agrees:**

1. To provide all claims processing, service, and administration of Benefits for employees or members of the Contractor subject to the terms and conditions of this Contract.

2. To provide to the Contractor, for submission to the Subscriber, a standard certificate of the Benefits provided pursuant to this Contract.

3. To endeavor to enlist Dentists to become Participating Dentists in sufficient number to ensure an adequate choice of Dentists, and to make periodic checks as to the adequacy of care provided by Dentists to people covered by this Contract. Delta Dental is not required to provide a dental appointment to an Eligible Person.

4. To contractually require each Participating Dentist to schedule and render all dental treatment provided under this Contract according to the standards of the dental profession in the community in which the dental procedures are rendered.

5. To make payments for Covered Services provided to Eligible Persons in accordance with the Plan selected by the Contractor. The Plan chosen by the Contractor shall be specifically identified in the Summary of Dental Plan Benefits.

   a. If Delta Dental PPO (Point-of-Service) has been selected, payments shall be made as follows:

      (i) If the Dentist is a Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee. Delta Dental will send payment directly to Participating Dentists and the Eligible Person will be responsible for any applicable Copayments or Deductibles. Unless prohibited by state law, the Eligible Person will be responsible for the Maximum Approved Fee for non-covered services.

      (ii) If the Dentist is a Nonparticipating Dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Nonparticipating Dentist Fee. Delta Dental will usually send payment to the Subscriber, who is responsible for making full payment to the Nonparticipating Dentist. The Eligible Person will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

      (Iii) If the Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Out-of-Country Dentist Fee. Delta Dental will send payment to the Subscriber, who is responsible for making full payment to the Dentist. The Eligible

      Person will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

   b. If Delta Dental PPO (Standard) has been selected, payments shall be made as follows:

      Payments for Covered Services provided to Eligible Persons shall be based on the lesser of the Submitted Amount or the PPO Dentist Schedule.

      Delta Dental will send payment directly to Participating Dentists and the Eligible Person will be responsible for any applicable Copayments or Deductibles. If the Dentist is not a PPO Dentist, but is a Premier Dentist, the Eligible Person will also be responsible for any difference between the PPO Dentist Schedule and the Premier Dentist Schedule for Covered Services, in addition to Copayments or Deductibles. Unless otherwise prohibited by state law, the Eligible Person will be responsible for the Maximum Approved Fee for non-covered services.

      For Covered Services rendered by a Nonparticipating Dentist or Out-of-Country Dentist, Delta Dental will usually send payment to the Subscriber, who is responsible for making full payment to the Dentist. The Eligible Person will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

   c. Delta Dental will pay or deny each clean claim within 45 days after receipt if the claim is filed on paper, and 30 days after receipt if the claim is filed electronically. If Delta Dental fails to pay or deny a clean claim in this time period, and Delta Dental subsequently pays the claim, Delta Dental will pay interest on such claim at the appropriate interest rate determined by Indiana Code Section 12-15-21-3(7)(A). If interest is due, the accrual will begin 31 days after the date the claim is filed if it is an electronic claim and 46 days after the date the claim is filed if it is a paper claim. Accrual of interest stops when the claim is paid. As used here, a "clean claim" means a claim submitted by a provider for payment that

has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If a submitted claim has deficiencies, Delta Dental will notify the provider of such deficiencies not more than 45 days after receipt of the claim if filed on paper, and 30 days if the claim is filed electronically, with a description of any remedy necessary to establish a clean claim.

6. Consistent with any applicable law protecting the confidentiality of a patient's health records, data, or information, to make standard reports available to the Contractor upon request for no additional charge and to provide agreed-to, non-standard reports on a time and materials basis.

B. Contractor Agrees:

1. To pay Delta Dental the monthly Rate specified in the Declarations Section of this Contract as billed by Delta Dental, with no payment adjustments for updates not yet reflected on the monthly invoice.

   To ensure timely coverage, the amount to be paid will be due by the 5th of the month of the intended coverage. For example, the premium for April coverage is due on April 5th. If payment is not received by the due date, Delta Dental shall, at its sole discretion, have the right to suspend claims processing. Coverage will terminate effective the first day of the coverage month if Delta Dental receives no payment by the end of the coverage month.

   Delta Dental may, at its sole option, send notification to the Contractor of an adjustment in Rates, Benefits, or Copayments to correct potential adverse group experience resulting from the following:

   a. Information provided upon enrollment proves to be in error; or

   b. Terms and provisions of the Contract are violated; or

   c. Initial size or composition of the group changes to the extent it adversely affects the Rates; or

   d. Monthly invoices are not paid as billed.

   Delta Dental will provide the Contractor written notice 30 days prior to implementing any adjustment. If the Contractor refuses to accept this adjustment, Delta Dental may, in its sole discretion, implement the adjustment, implement an alternative adjustment, or cancel this Contract.

2. To enroll as Subscribers with Delta Dental all eligible employees or members of the Contractor who enroll for Benefits and to list, if covered, all Eligible Dependents of those employees or members, to the extent required under the Contract. The Contractor will provide Delta Dental with updates to Subscribers and, if applicable, all Eligible Dependents as necessary, but no less than monthly and no later than six months following the effective date of those updates. No retroactive updates, additions, or terminations to eligibility will be accepted for an effective date more than six months from the date of receipt by Delta Dental.

3. To provide Delta Dental with all eligibility data needed to process claims under this Contract. Eligibility data shall be provided in a timely manner and in the format requested by Delta Dental. Contractor shall be solely responsible for any claims processing errors caused by Contractor's failure to comply with the terms of this subparagraph.

4. To permit Delta Dental, by its auditors or other authorized representatives, on reasonable advance written notice, to inspect the Contractor's records to verify the accuracy of the Subscribers and Eligible Dependents submitted to Delta Dental. Clerical errors or delays in keeping or relaying data will not invalidate eligibility that would otherwise be validly in force or continue eligibility that would otherwise be validly terminated if, after discovery of the errors or delays, an equitable adjustment of the Contractor's payment can be made in a reasonable period of time not to exceed six months.

5. To provide each Subscriber with a standard certificate of the Benefits provided under this Contract and all privacy notices as may be required by any applicable federal or state law, at such intervals as may be required by law from time to time. Delta Dental will provide said documents to the Contractor for distribution at the Contractor's expense.

6. To collect and remit to Delta Dental any amounts that the Contractor's employees or members are required to pay to Delta Dental under this Contract or any written employment contracts, including amounts for COBRA continuation coverage. Any amounts not collected will be the responsibility of the Contractor.

   Should the Contractor collect any amounts paid by employees or members and not remit them to Delta Dental in a timely fashion, with the result that an Eligible Person's coverage is terminated, the Contractor, not Delta Dental, will be liable for any Benefits to which the Eligible Person may have been entitled but for the Contractor's tardy remittance or failure to remit, unless, after discovery of the errors or delays, an equitable adjustment of the Contractor's payment can be made in a reasonable period of time not to exceed six months.

7. To pay for any agreed-to, non-standard reports on a time and materials basis.

Section VII - General Provisions

A. Independent Contractors. Dentists providing services are independent contractors, and neither the Contractor nor Delta Dental will be liable for any act or omission of any Dentist, his or her employees or agents, or any person providing dental or other professional services to Eligible Persons.

B. Binding Effect. All Dentists and Eligible Persons, by performing or receiving services under this Contract, are bound by all its terms.

C. Payment Limitations. Delta Dental will make no payment for services or supplies if a claim for such has not been received by Delta Dental within one year following the date the services or supplies were furnished.

D. Marketing Materials. No materials will be published or distributed by the Contractor concerning this Contract until Delta Dental approves the materials.

E. Legal Action. No action on a legal claim arising out of or related to this Contract will be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose, or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude the Contractor or an Eligible Person from seeking a decision from a jury trial or pursuing other available legal remedies.

F. Indemnification. To the extent permitted by law, Delta Dental and Contractor agree to defend, indemnify, and hold harmless the other and its directors, officers, and employees (who are acting in the course of their employment, but not as claimants) from any loss, cost, or expense (including reasonable attorney fees and court costs) resulting from or arising out of or in connection with its breach of this Contract, or any negligent act or omission of any of its directors, officers, or employees, unless liability for such act or omission is expressly assigned elsewhere in this Contract.

G. Required Information. While an Eligible Person is covered by Delta Dental, that person agrees to provide Delta Dental with any information it needs to process claims and administer Benefits. This includes allowing Delta Dental to have access to his or her dental records.

H. Dispute Resolution. Delta Dental will establish procedures for resolving all questions raised by a Dentist, a Contractor, or an Eligible Person in regard to claims for Benefits allowed or denied under the terms of this Contract. These procedures will be used both for the initial determination of those questions and for the resolution of appeals made on the basis of those initial determinations. To the extent the benefit plan sponsored by the Contractor is governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the procedures established for determining the Benefits to which an Eligible Person is entitled will comply with the requirements set forth in ERISA Section 503 as applicable to a limited scope dental benefit plan, and the regulations thereunder, for providing a "full and fair review" of all benefit claims. The ERISA-required claims procedures will be set forth in detail in the certificate that is to be distributed to Subscribers and that describes the Benefits under this Contract. All determinations made according to this procedure will be final and binding on the Dentist, the Contractor, and the Eligible Person; provided, however, that the Eligible

Person may exercise his or her legal rights after this determination as described in the Claims Appeal Procedure contained in the certificate.

I. Statements. In the absence of fraud, all statements made by the Contractor or Eligible Persons shall be deemed to be representations and not warranties.

J. Severability. If any provision of this Contract is in violation of the laws of the State in which this Contract was issued, that provision shall be deemed to be void, but the invalidation of that provision will not otherwise impair or affect the rest of the Contract. When any provision in this Contract is in conflict with such laws, the rights, duties and obligations of Delta Dental, the Contractor and all Eligible Persons shall be governed by such laws.

K. Compliance with Applicable Law. This Contract is subject to change if, in the future, federal and state laws and regulations require Delta Dental or the Contractor to comply with such laws and regulations. Should any such change to this Contract be necessary by law, the Contractor will receive written notice from Delta Dental informing the Contractor of the reasons for any change to the Contract and the process by which the Contractor will receive an amended Contract.

L. Additional Services. Delta Dental may from time to time provide additional services or coverage by rider or other notice. Delta Dental may withdraw those services or coverage at any time after giving notice.

M. Notices. Any notice required or permitted to be given by this Contract will be considered given if in writing and personally delivered, or if in writing and deposited in the United States mail with postage prepaid, addressed to the person at their last address of record.

N. Amendment and Assignment. No agent has authority to change any part of this Contract. No changes to this Contract will be valid unless Delta Dental approves them in writing. Delta Dental shall have the discretion to assign its rights and responsibilities under this Contract to an affiliated entity. If Delta Dental chooses to assign its rights and responsibilities, it shall assign them to an appropriately licensed entity capable of performing similar functions at similar levels as Delta Dental. Delta Dental shall serve written notice of the assignment to Contractor and said notice shall provide the name and address of the assignee. Neither this Contract nor any part of it shall be assigned by Contractor without the prior written consent of Delta Dental, and any attempt at assignment by Contractor without such consent by Delta Dental shall be null and void. Subject to the foregoing limitation, this Contract shall be binding upon the parties and their respective successors and assigns.

O. Subrogation and Right of Reimbursement. To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right the Subscriber may have to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions. The Subscriber or his or her legal representative must do whatever is necessary to enable Delta Dental to exercise its rights and do nothing to prejudice them. If the Subscriber recovers damages from any party or through any coverage named above, the Subscriber must reimburse Delta Dental from that recovery to the extent of payments made under the Plan.

P. Right of Recovery Due to Fraud. If Delta Dental pays for services or supplies that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to the acts of the Contractor, Subscriber, and/or Eligible Dependent, it may recover that payment from the person or entity that committed such fraud. Contractor, Subscriber, and/or Eligible Dependent authorizes Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to the Contractor, Subscriber, and/or Eligible Dependent. Delta Dental will provide an explanation of the payment being recovered at the time the deduction is made.

Q. Force Majeure. Neither Delta Dental (including its agents, directors, officers, and employees) nor Contractor shall be liable for delays in performance due to circumstances beyond their reasonable control. Each party shall be excused from performance under this Contract and shall have no liability to the other party for any period during which it is prevented from performing any of its obligations (other than payment obligations), in whole or in part, as a result of delays caused by the other party or by an act of God, war, terrorism, civil unrest, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including failures or fluctuations in electrical power, heat, light, or telecommunications, and such nonperformance shall not be a

default under or grounds for termination of this Contract. In the event Contractor is unable to make payment due to circumstances beyond its reasonable control as identified in this Force Majeure section, Delta Dental will accept delayed payment from Contractor within a reasonable period of time. A reasonable period of time shall not exceed 30 days.

R. Assignment of Benefits. Benefits to Eligible Persons are for the personal benefit of those people and cannot be transferred or assigned; provided, however, that Delta Dental may pay Participating Dentists directly on behalf of Eligible Persons.

S. Governing Laws. This Contract and corresponding certificate for Subscribers will be governed by and interpreted under the laws of the State of Indiana.

T. Legally Mandated Benefits. If any applicable law requires broader coverage or more favorable treatment for the Subscriber or an Eligible Dependent than is provided by this Contract, that law shall control over the language of this Contract.

U. Right of Recovery Due to Overpayment. If Delta Dental determines that it has, for any reason, paid a Dentist more for dental services than is provided for under this Contract (the "Overpayment Amount"), Delta Dental has the right to recover the Overpayment Amount from the Dentist to whom the Overpayment Amount was made. Delta Dental will provide the Dentist with notice of the Overpayment Amount and the basis on which Delta Dental believes that the payment made was in excess of the amount properly due under the Contract. Should the Dentist return the Overpayment Amount, Delta Dental's right of recovery will have been satisfied. Should the Dentist fail to return the Overpayment Amount, Delta Dental reserves the right to offset the Overpayment Amount from any future payments due that Dentist for services covered by Delta Dental. Where Overpayment Amounts are recovered by means of an offset, the Overpayment and offset amounts will be properly credited to, or debited from, the affected dental Plan(s) so that all involved dental Plans will have been administered according to their terms and will have paid only the amount that is properly payable for the services provided.

V. Entire Agreement. This Contract and the certificate constitute the entire agreement between the parties.

W. Effect of Errors on Coverage. Typographical or administrative errors shall not deprive an Eligible Person of Benefits. Neither shall such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of this Contract.

X. Bankruptcy or Insolvency. Contractor shall notify Delta Dental immediately in the event of bankruptcy or other insolvency. In such an instance, Delta Dental shall not have any obligation to continue paying claims, but may choose to continue doing so, at its discretion. Delta Dental reserves all rights and remedies with respect to the Contractor's bankruptcy or other insolvency, including but not limited to, the right to automatically terminate or modify performance under this Contract to the extent permitted by applicable law.

Section VIII - Coordination of Benefits

All Benefits under this Contract are subject to a coordination of benefits provision, if applicable, that is designed to provide maximum coverage, but not result in payment of more than 100 percent of the total fee for a given treatment.

A. Applicability

1. This Coordination of Benefits ("COB") provision applies to This Plan when a person has dental benefits under more than one Plan.
2. If this COB provision applies, the Order of Benefit Determination Rules below determine whether the Benefits of This Plan are determined before or after those of another Plan. This Plan's Benefits:
   a. Will not be reduced when This Plan determines its Benefits before another Plan; but
   b. May be reduced when another Plan determines its benefits first. This reduction is described in Section VIII.D, "Effect on the Benefits of This Plan".

c. In the event that the below provisions of this Section VIII do not determine whether or to what extent Delta Dental coordinates benefits with another Plan, Delta Dental shall follow its internal policies and procedures, unless otherwise prohibited by applicable law.

B. Definitions

1. A Plan is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

   a. Nongroup and group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage; or

   b. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

   Each policy or other arrangement for coverage under a. or b. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. This Plan is the dental coverage established for Eligible Persons pursuant to this Contract.

3. The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or a Secondary Plan when a person is covered by more than one Plan.

   When This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's benefits.

   When This Plan is a Secondary Plan, its Benefits are determined after those of the other Plan's benefits and may be reduced because of the other Plan's benefits.

   When a person is covered under more than two Plans, This Plan may be a Primary Plan as to one or more of those Plans and may be a Secondary Plan as to the other Plans.

4. Allowable Expenses are necessary, reasonable, and customary items of expense for health care when they are covered by This Plan. However, This Plan is not required to pay for an item, service, or benefit which is not a part of This Plan's Contract.

   When a Plan provides payment for services, the reasonable cash value of each service will be considered both an Allowable Expense and a benefit paid.

5. The Claim Determination Period is the Benefit Year. It does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

C. Order of Benefit Determination Rules

1. **When there is a basis for a claim under This Plan and another Plan,** This Plan is a Secondary Plan whose Benefits are determined after those of other Plans, unless:

   a. The other Plan has rules coordinating its benefits with those of This Plan; and

   b. Both those rules and This Plan's rules, in Section VIII.C(2) below, require that This Plan's Benefits be determined before those of the other Plan.

2. This Plan determines its order of Benefits using the first of the following rules that applies:

   a. The benefits of the Plan that covers a person as an employee or subscriber (that is, as other than a dependent) are determined before the benefits of the Plan that covers the person as a dependent. However, this rule does not apply if the person is also a Medicare beneficiary and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

      (i) Secondary to the Plan covering him or her as a dependent; and

(ii) Primary to the Plan covering him or her as other than a dependent (for example, a retired employee), then the order of benefits determination is reversed so that the Plan covering the person as an employee, subscriber or retiree is secondary and the other Plan is primary.

b. Except as stated in Section VIII.C(2)(c) below, when This Plan and another Plan cover a dependent Child of parents who are not separated or divorced:

(i) The benefits of the Plan of the parent whose birthday falls earlier in the year are determined before those of the Plan of the parent whose birthday falls later in the year; but

(ii) If both parents have the same birthday, the benefits of the Plan that covered the parents longer are determined before those of the Plan that covered them for a shorter period of time.

However, if the other Plan does not have the rule described in (i) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the other Plan's rule will determine the order of benefits.

c. If more than one Plan covers a dependent Child of separated or divorced parents, benefits for the Child are determined in this order:

(i) First, the Plan of the parent with custody of the Child;

(ii) Then, the Plan of the spouse of the parent with custody of the Child;

(iii) Then, the Plan of the parent without custody of the Child; and

(iv) Then, the Plan of the spouse of the parent without custody of the Child.

If the other Plan does not have this Section VIII.C(2)(c), and if, as a result, the Plans do not agree on the order of benefits, this Section VIII.C(2)(c) will be ignored.

However, if the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses, and the entity obligated to pay or provide the benefits of that parent's Plan has actual knowledge of those terms, that Plan's benefits are determined first. The other parent's Plan will be the Secondary Plan. This Section VIII.C(2)(c) does not apply with respect to any Claim Determination Period during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of a court decree state that the parents will share custody, without stating that one of the parents is responsible for the Child's health care expenses, the Plans covering the Child will be subject to the order of benefit determination contained in Section VIII.C(2)(b) above.

d. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Section VIII.C(2)(d) is ignored.

e. If a person whose coverage is provided under a right of continuation pursuant to federal law (that is, COBRA) or state law also is covered under another Plan, the benefits of the Plan covering the person as an employee or a subscriber (or as that person's dependent) will be determined before the benefits under the continuation coverage. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Section VIII.C(2)(e) will be ignored.

f. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee or a subscriber longer are determined before the benefits of the Plan that covered him or her for the shorter term.

D. Effect on the Benefits of This Plan

1. This Section VIII.D applies when, in accordance with Section VIII.C, "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to another Plan. In that event, This Plan's Benefits may be reduced under this Section VIII.D.

2. This Plan's Benefits will be reduced when the sum of:

   a. The Benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and

   b. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of similar provisions, whether or not claim is made, exceeds those Allowable Expenses. In that case, This Plan's Benefits will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses under This Plan.

   When This Plan's Benefits are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

E. Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from, or give them to, any other organization or person, subject, in all events, to all provisions of applicable law. Delta Dental need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Delta Dental any facts it needs to pay the claim.

F. Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Delta Dental may pay that amount to the organization that made the payment. That amount will be treated as though it were a Benefit paid under This Plan, and Delta Dental will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery

If the amount of the payment made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

1. The people it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The amount of the "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Section IX - Term and Termination

This Contract shall remain in full force and effect for the initial term commencing on the Effective Date and continuing until the First Renewal Date, as specified in the Declarations Section. Thereafter, the Contract may be renewed for subsequent terms as specified in the Declarations Section or in a renewal letter. Delta Dental shall have the option of terminating this Contract if:

A. The Contractor fails to make a required payment before expiration of the Grace Period specified; or

B. Delta Dental cancels pursuant to Section VI.B.1 of this Contract; or

C. The Contractor fails to furnish Delta Dental with accurate enrollment data pursuant to Section VI.B.2 of this Contract; or

D. The Contractor permits voluntary enrollment of Subscribers and/or their Eligible Dependents unless otherwise specified in the Summary of Dental Plan Benefits; or

E. The Contractor refuses to allow Delta Dental (by Delta Dental's auditors or other authorized representatives) to inspect the Contractor's records to verify the accuracy of Subscribers and Eligible Dependents pursuant to Section VI.B.4 of this Contract; or

F. The Contractor has otherwise breached this Contract.

The Contractor may voluntarily cancel this Contract if the Contractor provides Delta Dental with 30 days written notice of intent to cancel.

The Contractor is entitled to a grace period of 31 days (the "Grace Period") for the payment of any Rate installment due, except the first, during which period the Contract will remain in force. Delta Dental is not obligated to pay claims incurred during the Grace Period until it receives the Rate due.

Upon termination of this Contract, the Contractor is liable to Delta Dental for any Rate that was then due and unpaid. In the event this Contract terminates mid-month, such amount shall include a pro rata fee for any period the Contract was in force during the Grace Period.

DELTA DENTAL

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 0505-0007, 0100, 0110, 0135, 0150, 0160, 0200, 0210, 0211, 0222, 0272, 0300, 0460, 0485, 0500, 0600, 0750, 0760, 0770, 0790, 0900
City of Greenwood

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Indiana

Benefit Year – April 1 through March 31

Covered Services –

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Extractions – removal of teeth	80%	80%	80%
Major Restorative Services – crowns	80%	80%	80%
***Other Basic Services** – misc. services*	80%	80%	80%
Major Services			
Emergency Palliative Treatment – to temporarily relieve pain	50%	50%	50%
Periodontal Maintenance – cleanings following periodontal therapy	50%	50%	50%
Other Oral Surgery – dental surgery other than extractions	50%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per benefit year.
- Prophylaxes (cleanings) are payable twice per benefit year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per benefit year with no age limit.
- Space maintainers are payable once per area per lifetime for people up to age 13.
- Bitewing X-rays are payable once per benefit year and full mouth X-rays (which include bitewing X-rays) are payable once in any four-year period.
- Sealants are payable once per tooth per lifetime for the occlusal surface of first and second permanent molars up to age 15. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per person total per Benefit Year on all services, except oral exams, preventive services, X-rays, brush biopsy, sealants, and orthodontic services. $1,000 per person total per lifetime on orthodontic services.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered on the first day of the month following 30 days of employment.

Eligible People – Any employee of the Contractor working at least 37.5 hours per week: Retiree (0007), Mayor's Office (0100), Fleet Maintenance (0110), Community Development Services (0135), Information Technology (0150), Human Resources (0160), Clerk (0200), Finance (0210), Airport (0211), Parks and Recreation (0222), Adult Probation (0272), City Court (0300), Fire Department (0460), Motor Vehicle Highway (0485), Board of Works (0500), Police Department (0600), Sanitation Billing (0750), Sanitation Field (0760), Waste Management (0770), Stormwater (0790), Law (0900) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees, if applicable. The Contractor pays the full cost of this plan.

Also eligible are your legal spouse and your children under age 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract.

Benefits will cease on the last day of the month in which the employee is terminated.