PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
BARTHOLOMEW CONSOLIDATED SCHOOL CORPORATION

TABLE OF CONTENTS

INTRODUCTION 1

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS 3

SCHEDULE OF MEDICAL BENEFITS 10

MEDICAL BENEFITS 18

PLAN EXCLUSIONS 27

PRESCRIPTION DRUG BENEFITS 30

MEDICAL MANAGEMENT SERVICES 33

DEFINED TERMS 36

HOW TO SUBMIT A CLAIM 43

COORDINATION OF BENEFITS 47

THIRD PARTY RECOVERY PROVISION 50

CONTINUATION COVERAGE RIGHTS UNDER COBRA 52

RESPONSIBILITIES FOR PLAN ADMINISTRATION 59

GENERAL PLAN INFORMATION 64

INTRODUCTION

This document is a description of Bartholomew Consolidated School Corporation (BCSC) Employee Benefit Trust (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason unless covered under existing union contract.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like unless covered under existing union contract.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other Medical Management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in this document.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits provides an outline of the Plan reimbursement formulas as well as payment limits on certain services. The BCSC Employee Benefit Trust offers 2 plan options for Employees to choose from. Please note: there are 2 schedules of benefits- one for each plan option. The rest of the information in this SPD applies to both plan options.

Benefit Descriptions explains when the benefit applies and the types of charges covered.

Plan Exclusions shows what charges are **not** covered.

Medical Management Services explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms defines those Plan terms that have a specific meaning.

Claim Provisions explains the rules for filing claims and the claim appeal process.

Coordination of Benefits shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights under COBRA explains when a person's coverage under the Plan ceases and the continuation options which are available.

Patient Protection and Affordable Care Act

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

I. ELIGIBILITY

A. Eligible Classes of Employees: All Active and Retired Employees of the Employer.

B. Eligibility Requirements for Employee Coverage: A person is eligible for Employee coverage from the first day that he or she:

1. is a Full-time, Active Employee of the Employer. A certified Employee, Administrator or Director is considered to be Full-time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer for that work. Non-certified Employees must work at least 30 hours per week in order to be eligible for coverage under this Plan. Grandfathered non-certified Employees including, but not limited to, bus drivers and food services Employees who were required to work 20 hours per week as of December 31, 1996 are only required to work 20 hours per week to be eligible for coverage under this Plan.

2. is a Retired Employee of the Employer and meets the eligibility requirements outlined below.

3. is in a class eligible for coverage.

4. For non-certified Employees: completes the employment Waiting Period of **60 days** as an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. The waiting period is waived for certified Employees, Administrators and Directors; these Employees are effective on the date of hire.

C. Eligible Classes of Dependents: A Dependent is any one of the following persons:

1. The Employee's legal spouse who is a resident of the same country in which the Employee resides. The term "Spouse" shall also include any individuals who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages. The Plan Administrator may require documentation proving a legal marital relationship.

2. A covered Employee's children from birth up to and including the limiting age of 25 years. When the child reaches the limiting age, coverage will end on the child's birthday.

   a. The term "children" shall include natural children of the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

   b. If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

   c. The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of

adoption of the child. The child must be available for adoption and the legal process must have commenced.

d. Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

3. A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

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

4. These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

   If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

   If both mother and father are Employees, their children will be covered as Dependents of the mother or father but not of both.

D. **Eligibility Requirements for Dependent Coverage:** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

   At any time, the Plan may require proof that a Spouse, or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

E. **Working Spouse Exclusion:** The purpose of the Working Spouse Rule is to share the costs of the medical expenses with other plans or insurance carriers when the spouse of an Employee is eligible for medical coverage where the spouse is employed. It is the Employer's responsibility to determine who is eligible for this coverage on a non-discriminatory basis.
   1. If a spouse of an eligible Employee is employed with a company which offers group medical insurance coverage and that spouse is eligible for that plan, that spouse will not be eligible for this Plan.
   2. If the spouse is employed with a company that does not offer group medical coverage and is eligible to be enrolled, the spouse may be enrolled in this Plan as primary at the family rate which is currently in effect. (A statement from the spouse's employer that verifies they have no coverage available with that employer will be required).

   Note: Medicare does not count as an employer sponsored plan for the purposes of this rule.

F. **Eligibility Requirements for Retiree Coverage:** A retired Employee will be eligible to continue coverage upon retirement from employment with Bartholomew Consolidated School Corporation if the following has been met:

1. Must qualify for retirement benefits with the retirement plan of which the Employee is a member; and
2. For certified Employees, Administrators and Directors: Must be employed with BCSC for at least 5 years in order to continue coverage.
3. For non-certified Employees: Must be employed with BCSC for at least 20 years in order to continue coverage.

Coverage is available to all retired Employees who meet the defined criteria listed above and to all eligible Dependents of the retired Employee. The retired Employee is required to pay 100% of the cost of coverage as set by the Plan Administrator.

Coverage will terminate for the retired Employee and any eligible Dependents when the retired Employee turns 65 and is eligible for Medicare.

II. FUNDING

The Employer shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions unless covered under existing union contract.

III. ENROLLMENT

A. **Enrollment Requirements:** An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also if Dependent coverage is elected.

B. **Enrollment Requirements for Newborn Children:** A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 60 days of birth, he/she will not be eligible for coverage under this Plan except under a Special Enrollment Period.

IV. TIMELY ENROLLMENT

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 60 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees who are legally married are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

Employees and their Dependents who do not enroll within 60 days of initially becoming eligible for coverage will not be eligible except under a Special Enrollment Period.

V. EFFECTIVE DATE

A. **Effective Date of Employee Coverage:** An Employee will be covered under this Plan as of the first day following the date that the Employee satisfies all of the following:

1. The Eligibility Requirement.
2. The Active Employee Requirement.
3. The Enrollment Requirements of the Plan.

B. **Active Employee Requirement:** An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

C. **Effective Date of Dependent Coverage:** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

VI. SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under the following circumstances:

A. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 60 days after the coverage ends (or after the employer stops contributing towards the other coverage).

B. In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the birth, marriage, adoption or placement for adoption.

C. If an eligible Employee or Dependent has health coverage under Medicaid or a state children's health plan ("CHIP") , and that coverage is lost due to a loss of eligibility of the coverage, or if an eligible Employee or Dependent becomes eligible for premium assistance with respect to the Plan under Medicaid or CHIP, then such individual shall be a Special Enrollee provided such person makes application for coverage hereunder within sixty (60) days of either the loss of Medicaid or CHIP coverage or the eligibility for premium assistance. In no event may an Employee enroll a Dependent under this provision if the Employee is not already a Participant or if the Employee is not contemporaneously enrolling himself or herself as a Participant under this provision. Coverage under this provision shall be effective as of the first day of the month beginning after the date the completed enrollment form is received by the Plan Administrator.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

VII. SPECIAL ENROLLMENT PERIODS

An Employee or Dependent may be eligible for coverage if one of the following events occurs: Employee or Dependent loses coverage under another plan; or an Employee acquires Dependents due to marriage, birth, adoption or placement for adoption.

A. Loss of Coverage

If an eligible Employee or Dependent declined coverage hereunder at the time of initial eligibility but subsequently loses coverage under the other health plan and makes application for coverage under this Plan within 60 days of the loss, such individual shall be a Special Enrollee provided such person:

1. was under a COBRA continuation provision and the coverage under such provision was exhausted;
2. was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment);
3. loses coverage because Employer contributions toward such coverage were terminated; or
4. loses coverage due to reaching the Calendar Year Maximum for all benefits under another health plan.

Individuals who lose other coverage due to nonpayment of premium or for cause (e.g., filing fraudulent claims) shall not be Special Enrollees.

Coverage under Special Enrollment due to a loss of coverage under another plan will be effective on the first day following the date coverage was lost.

B. Dependent Acquisition

An eligible Employee, whether enrolled in this Plan or not, may add himself, if applicable, and any new Dependents upon marriage, birth, adoption or placement for adoption. If the Employee requests coverage and completes the application for enrollment within 60 days of the event, the effective date of coverage will be:

1. in the case of marriage, the date of the marriage;
2. in the case of a Dependent's birth, the date of such birth;
3. in the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

VIII. TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

A. When Employee Coverage Terminates: Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

1. The date the Plan is terminated.

2. The date in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

3. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

4. The earliest date the Employee has a claim that is denied in whole or in part because the Employee has met or exceeded a calendar year limit on all benefits.

B. **Continuation during Periods of Employer-Certified Leave of Absence:** A person may remain eligible for a limited time if Active, full-time work ceases due to a leave of absence or layoff. This continuance will end as follows:

For certified Employees, Administrators and Directors: the School Board may grant an unpaid leave of absence of 1 school year.

For non-certified Employees: a supervisor may approve a leave of absence not to exceed 6 months.

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

An Employee who continues coverage during an approved leave of absence or layoff will be required to pay 100% of the cost of coverage as set by the Plan Administrator.

For leave of absences due to disability, the Employee and Eligible Dependents may remain on the plan until the Employee becomes Medicare eligible. The disabled employee is responsible for 100% of the cost of coverage and benefits will terminate on the last day of the month if the premium contribution has not been paid.

The Plan Sponsor may require proof of continued disability from the employee as needed.

C. **Continuation During Family and Medical Leave:** Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

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

D. **Rehiring a Terminated Employee:** A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

E. **Employees on Military Leave:** Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and

Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

   a. The 24 month period beginning on the date on which the person's absence begins; or

   b. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

2. A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

   If you wish to elect this coverage or obtain more detailed information, contact the Plan Administrator. You may also have continuation rights under USERRA. In general, you must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

F. **When Dependent Coverage Terminates:** A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

   1. The date the Plan or Dependent coverage under the Plan is terminated.

   2. The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

   3. The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

   4. The date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

   5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

   6. The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a calendar year limit on all benefits.

SCHEDULE OF MEDICAL BENEFITS

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

Note: The following services must be pre-certified. Failure to obtain pre-certification will result in a 30% penalty per claim.

Inpatient Admissions
Skilled Nursing Facility stays
Home Health Care
Hospice Care
Durable Medical Equipment purchases over $200 and all rentals
Speech Therapy

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the Medical Management section in this booklet for details.

This Plan contains a Network Provider Organization.

PPO name: Landmark / SIHO / Encore
Address: PO Box 1787
Columbus, IN 47202
Telephone: (812) 378-7070
Toll free: (800) 443-2980
Website: www.siho.org
Website: www.encoreconnect.com
Telephone: (888) 446-5844

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

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

1. If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

2. If a Covered Person has a Medical Emergency requiring immediate care.

3. If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an In-Network facility.

4. If a Covered Person utilizes a PHCS Healthy Directions Provider. To locate PHCS Healthy Directions participating Providers, visit the website at www.phcs.com or call toll free 1-888-779-7427. Dependents and Retired Employees living outside the PPO service area must utilize a PHCS Healthy Directions Provider in order for Covered Charges to be paid at the In-Network level.

Deductibles/Co-payments payable by Plan Participants

Deductibles/Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. However, for the PPO Plan, Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year.

A co-payment is the amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments.

HIGH DEDUCTIBLE HEALTH PLAN		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
ANNUAL MAXIMUM	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$1,500	
Per Covered Family	$3,000	
The deductible is **"non-embedded"** meaning the entire family deductible must be met before any money is paid by the Plan for any covered charge.		
COINSURANCE STOP LOSS AMOUNT, PER CALENDAR YEAR (DOES NOT INCLUDE DEDUCTIBLE)		
Per Covered Person	$2,500	
Per Covered Family	$5,000	
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$4,000	
Per Covered Family	$8,000	
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Precertification Penalties.		
COVERED CHARGES		
Hospital Services		
Room and Board	80% after deductible	60% after deductible
Intensive Care Unit	80% after deductible	60% after deductible
Physician Services	80% after deductible	60% after deductible
Pre-Admission Testing	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible (the facility's semi private room rate)	60% after deductible (the facility's semi private room rate)
Calendar Year maximum: 180 days		
Emergency Room Services		
Emergency Room Physician Charges	80% after deductible	80% after deductible
Emergency Room Facility Charges	80% after deductible	80% after deductible
Physician Services		
Office visits		
Primary Care & Specialist Physicians	$20 copay* after deductible	$20 copay* after deductible
Urgent Care Facilities	$40 copay* after deductible	$40 copay* after deductible
*Copay applies to office visit only; services performed in the office are covered as follows:		
Lab tests & x-rays	80% after deductible	60% after deductible
Surgery performed in office	80% after deductible	60% after deductible
Allergy testing	80% after deductible	60% after deductible

HIGH DEDUCTIBLE HEALTH PLAN		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
Allergy serum and injections	80% after deductible	60% after deductible
Radiation & Chemotherapy	80% after deductible	60% after deductible
Other Benefits		
Outpatient Surgery	80% after deductible	60% after deductible
Second Surgical Opinion	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Calendar Year maximum: 60 visits		
Hospice Care	80% after deductible	60% after deductible
Calendar Year maximum: 3 months outpatient and 6 months inpatient		
Bereavement Counseling	100% after deductible	100% after deductible
Bereavement services must be furnished within nine months after the patient's death.		
Ambulance Service	80% after deductible	60% after deductible
Occupational Therapy	80% after deductible	60% after deductible
Speech Therapy	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Spinal Manipulation Chiropractic	80% after deductible	60% after deductible
Calendar Year maximum: 6 visits		
Mental Disorders		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Substance Abuse		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Preventive Care		
Routine Well Exams	100%; deductible waived	100%; deductible waived
Preventive Care benefits are subject to the SIHO Preventive Health Benefits ***Comprehensive*** Guidelines Sports physicals are covered under this benefit		
Organ Transplants	80% after deductible	60% after deductible
Infertility Benefit	80% after deductible	60% after deductible
Lifetime maximum: $5,000		

HIGH DEDUCTIBLE HEALTH PLAN		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
Bariatric Benefit	Not Covered	Not Covered
**Grandfathered members	80% after deductible	60% after deductible
NOTE: Members who had Bariatric surgery prior to 7.1.2010, will be grandfathered for follow-up and complications up to $50,000 lifetime maximum.		
X-rays & Lab tests	80% after deductible	60% after deductible
Wigs (following chemotherapy)	80% after deductible	60% after deductible
Calendar Year maximum: 1 wig		
Clinical Trials	80% after deductible	60% after deductible
Pregnancy	80% after deductible	60% after deductible
Dependent daughters are covered for this benefit.		
Prescription Drug Benefits		
Retail (up to a 30 day supply)		
Generic	$12 copayment after deductible has been met	
Brand Name Formulary	$36 copayment after deductible has been met	
Brand Name Non-Formulary	$60 copayment after deductible has been met	
Mail Order (up to a 90 day supply)		
Generic	$24 copayment after deductible has been met	
Brand Name Formualry	$60 copayment after deductible has been met	
Brand Name Non-Formulary	$100 copayment after deductible has been met	
Prescription Drugs on the High Deductible Health Plan –Health Savings Account Preventive Therapy Drug List will be covered at the appropriate copay and not subject to deductible.		
Diabetic testing supplies are covered under the prescription drug benefit.		
Specialty medications are covered under the prescription drug benefit. These medications require prior authorization by SIHO Medical Management.		
Smoking cessation medications are also covered under the prescription drug benefit.		

PPO PLAN		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
ANNUAL MAXIMUM	Unlimited	
Note: The maximums listed below are the total for Network and Non-Network expenses.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$750	
Per Covered Family	$1,500	
COINSURANCE STOP LOSS AMOUNT, PER CALENDAR YEAR (DOES NOT INCLUDE DEDUCTIBLE)		
Per Covered Person	$2,000	
Per Covered Family	$4,000	
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$2,750	
Per Covered Family	$5,500	
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: precertification penalties.		
COVERED CHARGES		
Hospital Services		
Room and Board	90% after deductible	60% after deductible
Intensive Care Unit	90% after deductible	60% after deductible
Physician Services	90% after deductible	60% after deductible
Pre-Admission Testing	90% after deductible	60% after deductible
Skilled Nursing Facility	90% after deductible (the facility's semiprivate room rate)	60% after deductible (the facility's semiprivate room rate)
Calendar Year maximum: 180 days		
Emergency Room Services		
Emergency Room Physician Charges	80% after deductible	80% after deductible
Emergency Room Facility Charges	$100 copay* then 80% after deductible	$100 copay* then 80% after deductible
*Copay is waived if admitted directly to the Hospital from the ER.		
Physician Services		
Office visits		
Primary Care & Specialist Physicians	80% after deductible	60% after deductible
Urgent Care Facilities	80% after deductible	60% after deductible
Lab tests & x-rays	80% after deductible	60% after deductible
Surgery performed in office	80% after deductible	60% after deductible
Allergy testing	80% after deductible	60% after deductible

PPO PLAN		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
Allergy serum and injections	80% after deductible	60% after deductible
Radiation & Chemotherapy	80% after deductible	60% after deductible
Other Benefits		
Outpatient Surgery	90% after deductible	60% after deductible
Second Surgical Opinion	80% after deductible	60% after deductible
Home Health Care	90% after deductible	60% after deductible
Calendar Year maximum: 60 visits		
Hospice Care	90% after deductible	60% after deductible
Calendar Year Maximum: 3 months outpatient and 6 months inpatient		
Bereavement Counseling	100% up to a maximum of $25 per visit	100% up to a maximum of $25 per visit
Bereavement services must be furnished within nine months after the patient's death.		
Ambulance Service	80% after deductible	60% after deductible
Occupational Therapy	80% after deductible	60% after deductible
Speech Therapy	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Prosthetics	80% after deductible	60% after deductible
Spinal Manipulation Chiropractic	80% after deductible	60% after deductible
Calendar Year maximum: 20 visits		
Mental Disorders		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Substance Abuse		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
Preventive Care		
Routine Well Exams	100%; deductible waived	100%; deductible waived
Preventive Care benefits are subject to the SIHO Preventive Health Benefits ***Comprehensive*** Guidelines Sports physicals are covered under this benefit.		
Organ Transplants	90% after deductible	60% after deductible
Infertility Benefit	80% after deductible	60% after deductible

PPO PLAN		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
Lifetime maximum: $5,000		
Bariatric Benefit	Not Covered	Not Covered
**Grandfathered members	90% after deductible	60% after deductible
NOTE: Members who had Bariatric surgery prior to 7.1.2010, will be grandfathered for follow-up and complications up to $50,000 lifetime maximum.		
X-rays & Lab tests	80% after deductible	60% after deductible
Wigs (following chemotherapy)	80% after deductible	60% after deductible
Calendar Year maximum: 1 wig		
Clinical Trials	90% after deductible	60% after deductible
Pregnancy	90% after deductible	60% after deductible
Dependent daughters are covered for this benefit.		
Prescription Drug Benefits		
Retail (up to a 30 day supply)		
Generic	100% after $12 copayment	
Brand Name Formulary	100% after $24 copayment	
Brand Name Non-Formulary	100% after $48 copayment	
Mail Order (up to a 90 day supply)		
Generic	100% after $24 copayment	
Brand Name Formualry	100% after $48 copayment	
Brand Name Non-Formulary	100% after $80 copayment	
Diabetic testing supplies are covered under the prescription drug benefit.		
Specialty medications are covered under the prescription drug benefit. These medications require prior authorization by SIHO Medical Management.		
Smoking cessation medications are also covered under the prescription drug benefit.		

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

I. DEDUCTIBLE

Deductible Amount: This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will not accrue toward the Coinsurance Stop-loss Amount.

Deductible Three Month Carryover for PPO Plan: Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

Covered Family Limit PPO Plan: When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Covered Family toward their Calendar Year deductibles, the deductibles of all members of that Covered Family will be considered satisfied for that year. An individual only needs to satisfy the individual deductible; once one family member has met his/her individual deductible in whole, the rest of the family deductible can be met by any number of family members.

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

II. BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any co-payments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

III. COINSURANCE STOP LOSS AMOUNT

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

IV. OUT-OF-POCKET LIMIT

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

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

V. MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person. The Maximum Benefit applies to all plans and benefit options offered under the BCSC Employee Benefit Trust, including the ones described in this document.

VI. COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

A. **Hospital Care:** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at the Hospital's lowest private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

B. **Coverage of Pregnancy:** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Illness for any Covered Person including Dependent daughters.

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

C. **Skilled Nursing Facility Care:** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

1. the patient is confined as a bed patient in the facility; and

2. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

3. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

D. **Physician Care:** The professional services of a Physician for surgical or medical services. Charges for **multiple surgical procedures** will be a Covered Charge subject to the following

provisions:

1. If two (2) or more surgical procedures are performed during the same operative session, the maximum benefit is as follows:
   a. If all procedures are performed through the same incision or in the same natural body orifice; the amount for the procedure with the highest Maximum Eligible Charge.
   b. If the procedures are performed in remote operative fields and through separate incisions; the amount for the procedure with the highest Maximum Eligible Charge plus 50% of the Maximum Eligible Charges for each other procedure.
2. If bilateral procedures are performed in separate operative fields, they are treated as one (1) procedure; the Plan will pay 1-1/2 times the Maximum Eligible Charge for the unilateral procedure.
3. If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

E. **Private Duty Nursing Care:** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

1. **Inpatient Nursing Care:** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

2. **Outpatient Nursing Care:** Outpatient private duty nursing care is not covered.

F. **Home Health Care Services and Supplies:** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Illness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

G. **Hospice Care Services and Supplies:** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children) is covered. Bereavement services must be furnished within nine months after the patient's death.

H. **Human organ and tissue transplants:**
1. Pre-certification Requirement for Transplant Evaluation - Expenses incurred in connection with the evaluation of a Covered Person for any human organ or tissue transplant will be covered, but only after Referral and Pre-certification through the Benefit Administrator has occurred. The Covered Person or his Physician should contact the Benefit Administrator for Pre-certification of an evaluation prior to the Referral to a transplant Physician. The Benefit Administrator will assign a Case Manager to work with the Covered Person closely through the transplant process.
2. Pre-certification Requirement for Transplant Procedure - After the evaluation by a Plan-designated transplant Physician has occurred; the Covered Person or the transplant Physician should contact the Case Manager. Medical information about the Covered Person's condition and the proposed transplant protocol will be requested for review. The

Case Manager will coordinate the review of the medical information for Medical Necessity and coverage determination. The Case Manager will communicate the determination to the Covered Person and transplant Physician.

3. Definitions
   a. Covered Transplant Procedures - Covered Transplant Procedures are any of the following adult or pediatric human organ and tissue transplant procedures determined to be Medically Necessary:
      i. Heart
      ii. Liver
      iii. Bone Marrow (related or unrelated)
      iv. Lung
      v. Kidney
      vi. Pancreas
      vii. Simultaneous Pancreas/Kidney
      viii. Simultaneous Heart/Lung
   b. Transplant Services - Transplant Services means any services directly related to a Covered Transplant Procedure including, but not limited to, Inpatient and Outpatient Hospital services, Physician services for diagnosis, treatment, and Surgery for a Covered Transplant Procedure, diagnostic services, and procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, as well as surgical, storage and transportation costs incurred and directly related to the successful acquisition of an organ or tissue used in an eligible and covered organ transplant. Transplant Services also includes, but is not limited to, Durable Medical Equipment rental outside of the Hospital, prescription drugs including immunosuppressives, surgical supplies and dressings, and home health care.
4. Maximums
   a. Organ and/or Tissue Procurement - The payments for procurement expenses for a donor organ or tissue are covered at 100% when the Covered Transplant Procedure is performed by a specialty care Network Provider.
5. Specific Exclusions for Organ/Tissue Transplants
   There are no benefits for:
   a. Services and supplies of any Provider located outside the United States of America, except for procurement services (subject to the amounts shown in the Maximums Section), which will be limited to those nations which share the same protocols, standards and registry with the United States.
   b. Services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received.
   c. Implant of an artificial or mechanical heart or part thereof unless used as a bridge for heart transplants. This does not include replacement of a heart valve.
   d. Services for non-human organ transplants.
   e. All other exclusions, limitations or conditions set forth in this Plan shall apply to Transplant Services unless otherwise provided in this Transplant Services Section.
   f. Services or supplies, including rehabilitation services, which are provided in a non-continuous chronology related to an actual transplantation performed within the effective eligibility of the Covered Person under this Plan.
   g. Charges for organ transplant surgery, other than those procedures described under the Human Tissue and Organ Transplant Section or that are in excess of the Maximum Benefit for Organ Transplants shown in the Schedule of Benefits are not covered; nor are charges for harvesting incurred by any organ donor covered except as shown in the Schedule of Benefits.

I. Second and/or Third Opinion:

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as shown in the Schedule of Benefits.

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

J. Preadmission Testing:

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

1. performed on an outpatient basis within seven days before a Hospital confinement;

2. related to the condition which causes the confinement; and

3. performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable as shown in the Schedule of Benefits even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

K. Covered Services for Clinical Trials:

1. Routine patient care costs that are covered:
   a. Those that would be covered for a patient not enrolled in a clinical trial
   b. Services required for the provision of the investigational item or service
   c. Services needed for reasonable and necessary care arising from the provision of the investigational item or service.
2. Routine patient care costs that are not covered:
   a. Investigational item, device, or service, itself;
      (i) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
      (ii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
3. In order to be considered a Covered Service the following criteria must be met:
   a. A physician must determine and document that the member is appropriate for the clinical trial; and
   b. The member must meet the eligibility criteria of the trial.
   c. The trial must be:
      (i) Conducted for the prevention, detection or treatment of cancer or other life threatening disease or condition; **and is**
      (ii) Federally funded; or
      (iii) Sponsored by FDA; or
      (iv) A Drug trial exempt from Investigational New Drug (IND) requirements.
   4. A trial is considered federally funded if it is approved and funded by one or more of these agencies:
   a. National Institutes of Health
   b. Centers for Disease Control
   c. Agency for Healthcare Research Quality
   d. Centers for Medicare and Medicaid Services
   e. Department of Defense
   f. Veterans Administration; or the
   g. Department of Energy
   h. If the Covered Person is eligible to participate in a clinical trial that is offered by both a network provider and a non-network provider, only the trial offered by the

network provider (and otherwise meeting the criteria of this section) will be considered a Covered Benefit.

L. **Other Medical Services and Supplies:** these services and supplies not otherwise included in the items above are covered as follows:

1. **Abortions**, including elective abortions, are covered if the pregnancy is a result of rape or incest or if continuing the pregnancy is life-threatening to the mother.

2. Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

3. **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

4. The diagnosis and treatment (including medication) for **Attention Deficit Disorder** (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).

5. The diagnosis and treatment of pervasive developmental disorders such as **Autism** and Asperger's syndrome are covered.

6. Follow up care and complications due to **Bariatric Surgery** for members who had surgery prior to 7.1.2010 will be grandfathered for the lifetime maximum of $50,000. This benefit includes medications and surgery. All expenses related to Bariatric treatment, including complications following a surgical procedure, are subject to the maximum of $50,000.

7. **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered:
   a. under the supervision of a Physician;
   b. in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
   c. initiated within 12 weeks after other treatment for the medical condition ends; and
   d. in a Medical Care Facility as defined by this Plan.

8. Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

9. Initial **contact lenses** or glasses required following cataract surgery.

10. **Contraceptive Devices:** All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered under the Preventive Health Benefit as required by the Affordable Care Act.

11. **Diabetic and asthma education** and management training.

12. **Diabetic supplies** not purchased through the pharmacy will be covered under major medical.

13. Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

14. Treatment of the **feet** including treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia and bunions (including open cutting operations), and Medically Necessary treatment of corns, calluses and toenails for individuals with metabolic or peripheral-vascular disease.

15. The diagnosis and treatment of **infertility** including artificial insemination, gamete intra fallopian transfer (GIFT), or in vitro fertilization up to the maximum shown in the Schedule of Benefits.

16. **Laboratory studies.**

17. Treatment of **Mental Disorders and Substance Abuse**. Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:
    a. All treatment is subject to the benefit payment shown in the Schedule of Benefits.
    b. Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

    The BCSC Plan also offers an Employer Assistance Program (EAP). This EAP is offered through Solutions. The EAP provides assessment and brief consultation services up to five (5) sessions per episode, including emergency evaluations. There is no annual or lifetime maximum. These EAP services are free to the Employee and eligible Dependents. Referral to therapy or consultation services may be made to Providers within the PPO Network when warranted.

18. Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:
    a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth
    b. Emergency repair due to Injury to sound natural teeth.
    c. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
    d. Excision of benign bony growths of the jaw and hard palate.
    e. External incision and drainage of cellulitis.
    f. Incision of sensory sinuses, salivary glands or ducts.
    g. Removal of impacted teeth.
    h. Reduction of dislocations and excision of temporomandibular joints (TMJs).

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

19. The initial purchase, fitting and repair of **Orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness.

20. **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

21. **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

22. **Prescription** Drugs (as defined).

23. Covered Charges under Medical Benefits are payable for routine **Preventive Care** as described in the Schedule of Benefits. Routine care is care by a Physician that is not for an Injury or Illness. Please refer to the SIHO Preventive Health Guidelines for a complete listing of Covered Preventive Charges.

24. The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

25. Charges for **Reconstructive Surgery** or **cosmetic procedures** for the following:
    a. Restoration of bodily function or correction of a deformity resulting from disease, accidental Injury, functional birth defects of a child or a previous therapeutic process; or
    b. reconstructive mammoplasties including:
        i. reconstruction of the breast on which a mastectomy has been performed,
        ii. surgery and reconstruction of the other breast to produce a symmetrical appearance, and
        iii. coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas.

26. Diagnosis of **sleep disorders**. Treatment will be covered only if it is Medically Necessary.

27. **Smoking Cessation:** Programs, counseling and medication are covered under the Preventive Health Benefit as required by the Affordable Care Act.

28. **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either:
    a. surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person;
    b. an Injury; or
    c. an Illness that is other than a learning or Mental Disorder.

29. **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. Chiropractic Therapy is intended to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interfaces from or related to distortion, misalignment or subluxation of the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Chiropractic Therapy. All services ordered and performed by the chiropractor will accumulate toward the chiropractic maximum.

30. **Sterilization** procedures.

31. **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

32. Coverage of **Well Newborn Nursery/Physician Care**.

    Charges for Routine Nursery Care: Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

    This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

    The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn.

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

Charges for Routine Physician Care: The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn.

33. Charges associated with the initial purchase of a **wig after chemotherapy** up to the limits shown in the Schedule of Benefits.

34. Diagnostic **x-rays**.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

A. **Abortion:** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

B. **Acupuncture:** unless performed by a licensed Physician as an alternative to anesthesia prior to surgery.

C. **Alcohol:** Services, supplies, care or treatment to a Covered Person for an Injury or Illness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

D. **Complications of non-covered treatments:** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

E. **Cosmetic procedures:** Care, services or treatment of cosmetic procedures except for the following reconstructive procedures:
   1. Restoration of bodily function or correction of a deformity resulting from disease, accidental Injury, functional birth defects of a child or a previous therapeutic process; or
   2. Reconstructive mammoplasties as specified in the Medical Benefit section.

F. **Custodial care:** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

G. **Educational or vocational testing:** Services for educational or vocational testing or training.

H. **Excess charges:** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Usual and Reasonable Charge.

I. **Exercise programs:** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

J. **Experimental or not Medically Necessary:** Care and treatment that is either Experimental / Investigational or not Medically Necessary.

K. **Eye care:** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to the initial purchase of glasses or contacts following cataract surgery.

L. **Foreign travel:** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

M. **Government coverage:** Services or supplies of an Injury sustained or Illness contracted while on active duty in military service, unless payment is legally required.

N. **Hair loss:** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.

O. **Hearing aids and exams:** Charges for services or supplies in connection with hearing aids or exams for their fitting. This exclusion does not apply to the initial purchase and fitting of hearing aids if the loss of hearing is caused by a surgical procedure performed while covered under this Plan.

P. **Hospital employees:** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Q. **Illegal acts:** Charges for services received as a result of Injury or Illness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

R. **Illegal drugs or medications:** Services, supplies, care or treatment to a Covered Person for Injury or Illness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

S. **Impotence:** Care, treatment, services, supplies or medication in connection with treatment for impotence unless the impotence is caused by an underlying medical condition. Treatment of impotence requires a letter of Medical Necessity be sent to SIHO Medical Management.

T. **Marital or pre-marital counseling:** Care and treatment for marital or pre-marital counseling. Please note: benefits for marital or pre-marital counseling may be covered by the Employee Assistance Program (EAP).

U. **Never Events:** Not medically necessary "never events" as defined by the Centers of Medicare and Medicaid Services (CMS) errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients; conditions that indicate a real problem in the safety and credibility of a health care facility.

V. **No charge:** Care and treatment for which there would not have been a charge if no coverage had been in force.

W. **Non-compliance:** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

X. **Non-emergency Hospital admissions:** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

Y. **Non-traditional medical services:** Complementary or alternative medicine treatments and supplies which are not specified as covered under this Plan.

Z. **No obligation to pay:** Charges incurred for which the Plan has no legal obligation to pay.

AA. **No Physician recommendation:** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

BB. Obesity: Care and treatment of obesity, morbid obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness.

CC. Occupational: Care and treatment of an Injury or Illness that is occupational -- that is, arises from work for wage or profit including self-employment.

DD. Personal comfort items: Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

EE. Private duty nursing: Charges in connection with care, treatment or services of an outpatient private duty nurse.

FF. Relative giving services: Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

GG. Replacement braces: Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

HH. Routine care: Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Illness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

II. Self-Inflicted: Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

JJ. Services before or after coverage: Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

KK. Sex changes: Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

LL. Sleep disorders: Care and treatment for sleep disorders unless deemed Medically Necessary.

MM. Surgical sterilization reversal: Care and treatment for reversal of surgical sterilization.

NN. Travel or accommodations: Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

OO. War: Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

I. PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

II. COPAYMENTS

The co-payment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

III. MAIL ORDER DRUG BENEFIT OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

IV. COVERED PRESCRIPTION DRUGS

A. All drugs prescribed by a Physician that require a prescription either by federal or state law. This excludes any drugs stated as not covered under this Plan.

B. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

C. Insulin and other diabetic supplies when prescribed by a Physician.

D. **Contraceptive Devices:** All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity are covered under the Preventive Health Benefit as required by the Affordable Care Act.

E. Specialty medications with prior authorization by SIHO Medical Management.

F. Infertility medications.

G. Growth hormones with prior authorization by SIHO Medical Management.

H. Retin-A for Covered Persons age 30 or under.

I. **Smoking Cessation:** Programs, counseling and medication are covered under the Preventive Health Benefit as required by the Affordable Care Act.

J. Anabolic steroids.

V. EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following:

A. **Administration:** Any charge for the administration of a covered Prescription Drug.

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

C. **Devices:** Devices of any type (excluding birth control devices), even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

D. **Drugs used for cosmetic purposes:** Charges for drugs used for cosmetic purposes including medications for hair growth or removal.

E. **Experimental:** Experimental drugs and medicines, even though a charge is made to the Covered Person.

F. **FDA:** Any drug not approved by the Food and Drug Administration.

G. **Growth hormones:** Charges for drugs to enhance physical growth or athletic performance or appearance.

H. **Immunization:** Immunization agents or biological sera. Note: certain immunizations are covered under the Preventive Health Benefit. Please refer to the PHB Guidelines for a complete listing of Covered Charges.

I. **Impotence:** A charge for impotence medication unless impotency is due to an underlying medical condition. A letter of Medical Necessity is required.

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

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

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

M. **Medical exclusions:** A charge excluded under Medical Plan Exclusions.

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

O. **Non-legend drugs:** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

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

Q. **Refills:** Any refill that is more than the number of refills ordered by the Physician.

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

VI. ExtraCare ® Health Discount Card

Effective: October 1, 2008 – Caremark will provide Plan Participants with an ExtraCare® Health discount card ("ExtraCare® Card"). The ExtraCare® Card provides the ability to earn rewards for purchases at CVS/pharmacy store or online at CVS.com and to receive a 20% discount on all CVS branded health care-related items at CVS/pharmacy stores; provided that no rewards or discounts are available for the purchase of prescription drugs.

MEDICAL MANAGEMENT SERVICES

Medical Management Services Phone Number

SIHO Medical Management
(812) 378-7050 (Columbus)
(800) 553-6027 (Toll-free)

This number is also located on the Employee ID card.

The patient or family member must call this number to receive pre-certification of certain Medical Management Services. This call must be made as soon as possible but no later than 48 hours or the next business day in advance of services being rendered or within 48 or the next business day after an emergency.

Pre-certification is the responsibility of the Covered Person.

Any reduced reimbursement due to failure to follow pre-certification procedures will not accrue toward the 100% maximum out-of-pocket payment.

I. UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

A. Pre-certification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
1. Inpatient Admissions
2. Skilled Nursing Facility stays
3. Home Health Care
4. Hospice Care
5. Durable Medical Equipment purchases over $200 and all rentals
6. Speech Therapy

B. Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

C. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

D. Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what services are medically necessary and appropriate to help ensure cost-effective care. **Certification of medical necessity and appropriateness of care by SIHO Medical Management does not establish eligibility under the Plan nor guarantee benefits.**

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Pre-certification does not have to be obtained for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

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

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

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

If the procedures for pre-certification are not followed, Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by 30% per claim.

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

Concurrent review, discharge planning: Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. SIHO Medical Management will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services. Concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving continued services. All services extended beyond the initial pre-certification will require concurrent review.

II. CASE MANAGEMENT

In cases where the covered person's condition is expected to be or is of a serious nature, case management services are available. The use of case management is a voluntary program to the covered person; however these services will generally provide a greater benefit to the covered person by participating in the program. The case manager will review the medical care provided to covered persons and may recommend alternative, cost-efficient programs of treatment. Such programs will be implemented only with the consent of the covered person, his physician, and the Plan Supervisor and may, in appropriate cases, provide for payment of benefits that would not otherwise be covered by the Plan, if payment of such benefits is expected to accelerate recovery or reduce overall expenses. A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

A. personal support to the patient;

B. contacting the family to offer assistance and support;

C. monitoring Hospital or Skilled Nursing Facility;

D. determining alternative care options; and

E. assisting in obtaining any necessary equipment and services.

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

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

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

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Acute Rehabilitation Hospital is licensed and accredited to provide professional services to those needing intensive therapies to regain normal body function. Services included, but not limited to, Physical, Occupational and Speech therapies by a licensed therapist, a minimum of 3 hours of therapies, 24 hour nursing by a licensed nurse under the direction of a full-time RN, complete medical record for each patient, Utilization review and discharge plan, a physiatrist or licensed physician overseeing the care on staff.

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

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

The Benefit Administrator of the Plan is **Southeastern Indiana Health Organization (SIHO)**.

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

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

Brand Name means a trade name medication.

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

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

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Family is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employee Assistance Program (EAP) is a program designed to help Employees and their dependents with issues such as mental health, behavioral health matters, drug and alcohol counseling, family counseling, and grief and loss. The EAP provides assessment and brief consultation services up to five (5) sessions, per episode including emergency evaluations. These EAP services are free to the Employee and eligible dependents. Referral to therapy or consultation services is made to providers within the PPO Network when warranted.

Employer is Bartholomew Consolidated School Corporation (BCSC).

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

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

A. 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

B. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

C. if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

D. if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Genetic Information Nondiscrimination Act of 2008 means notwithstanding anything in this Plan to the contrary, in accordance with the Genetic Information Nondiscrimination Act of 2008 ("GINA"), as amended, and any regulations issued there under, the Plan will not:

1. adjust Plan contributions amounts or premiums on the basis of genetic information;
2. request or require any individual to undergo a genetic test, or
3. request, require, or purchase genetic information for underwriting purposes, or with respect to any individual prior to such individual's enrollment in the Plan.

Under this section, "genetic information" includes an individual's genetic tests, the genetic tests of an individual's family members, and an individual's family medical history.

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

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that

the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

A. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

B. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical Illness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

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

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

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

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

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

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

Participating Provider Organization (PPO) is a group of contracted Providers that provide services at negotiated rates. A complete listing of participating providers can be obtained at no cost from the Plan Administrator.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor

of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Bartholomew Consolidated School Corporation (BCSC) Employee Benefit Trust, which is a benefits plan for certain Employees of BCSC and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

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

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

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

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

Skilled Nursing Facility is a facility that fully meets all of these tests:

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

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Specialty Drugs are Prescription Legend Drugs which are only approved to treat limited patient populations, indications or conditions; are normally injected, infused or required close monitoring by a physician or clinically trained individual; or have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

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

Sub Acute Inpatient Facility is licensed and accredited to provide professional services to a person needing extended intensive care services. Services would include, but not limited to, continuous care for multiple dysfunctions involving multiple body systems constant monitoring with 10-12 hours of critical care, complete medical record for each patient, complex care of ventilator/dialysis/extensive wound care.

Utilization review, 24-hr in-house monitoring of respiratory therapy, registered dietician, licensed pharmacist (24-hr coverage) and specialized wound care team.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

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

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

I. WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the plan within 12 months of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be declined.

The Benefit Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Benefit Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

A. the specific reason or reasons for the denial;

B. specific reference to those Plan provisions on which the denial is based;

C. a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

D. appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Benefit Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

II. CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

A. Request from the Benefit Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

B. File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Benefit Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Benefit Administrator and will provide the Participant with a written response within 60 days of the date the Benefit Administrator receives the Participant's written request for review and if not notified, the Participant may deem the claim denied. If, because of extenuating circumstances, the Benefit Administrator is unable to complete the review process within 60 days, the Benefit Administrator shall notify the Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Benefit Administrator received the Participant's written request for review.

The Benefit Administrator's written response to the Participant shall cite the specific Plan provision(s) upon which the denial is based.

If the Benefit Administrator denies the appeal, the request will then be heard by the Health Trust Committee. This committee will review the information relating to the appeal and the Benefit Administrator's reasons for denying the appeal. If the Health Trust Committee upholds the decision of the appeal, you will be notified by letter stating the committee agreed with the denial. If the Health Trust Committee disagrees with the decision of the Benefit Administrator's appeal committee, you will be notified by letter and the claim will be reprocessed.

You will be notified of the decision not later than 60 days after the appeal is received.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

III. APPEAL PROCEDURES

The claimant has a right to appeal any decision that denies claim payment or a request for coverage of health care services or treatment. Appeals must be submitted within 180 days of the notification of denial. Appeals may be submitted verbally or in writing. Verbal appeals may be started by contacting Member Services. All verbal requests will be documented by the SIHO associate who is assisting the claimant, with a copy forwarded to the claimant for signature and acknowledgement. Upon return of the form with claimant signature the appeal will be forwarded to an appeals coordinator. Written appeals received will be forwarded to an appeals coordinator. An acknowledgement notice will be sent to the claimant within 3 business days of receipt of a written or verbal appeal request.

Claimants Rights on Appeal

The claimant will have the opportunity to submit written comments, documents, medical information, or any other pertinent information relating to the appeal. Upon request and free of charge, the claimant will be provided with reasonable access to and copies of; all documents, records and other information relevant to the appeal. A full and fair review of your claim by associates of the Appeals Department will be conducted. The review will be conducted by a person different from the person who made the initial determination and who is not the original decision-maker's subordinate. If the decision is made on the grounds of a medical judgment, a health care professional with appropriate training and experience will be consulted. This health care professional will not be the individual who was consulted during the initial determination or that person's subordinate. The review will take into account all comments, document, records and other information the claimant submits, whether or not presented or considered in the initial determination. No deference will be afforded to the initial determination.

Notification of Resolution of Appeal

Urgent care Claims-In the case of an Urgent Care Claim; decision notification will be made within 72 hours after it is received for review.

Pre-Service Claims-In the case of a Pre-Service claim not involving urgent care; decision notification will be made within 30 days after the request for review.

Other Claims-In the case of all other Claims, decision notification will be made within 30 days after the request for review.

Expedited Appeals (Urgent Care Claims)
If a medical condition exists that may seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function if treatment is delayed the claimant may request an expedited appeal. The expedited appeal process is considered a stand-alone procedure and is in lieu of the standard appeal procedure. An expedited appeal can be requested either verbally or in writing. All information for review may be submitted by telephone, facsimile, or other available similar method. Resolution of the expedited appeal will be made as expeditiously as the appellant's health warrants but will occur no later than 48 hours after the filing of the appeal.

Notice of Decisions on Appeal
If an appeal is denied, the claimant will be notified in writing or electronically. The notice will contain the following information:

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

External Review of Appeals Process
If the claimant is dissatisfied with the outcome of the appeal, he or she may file a written or verbal request to initiate an External Review Appeal. This request must be filed no later than 4 months after the claimant is notified of the resolution of the prior appeal. The claimant may not file more than one External Review Appeal request on the same appeal. Upon receipt of the request for External Review Appeal, the appeals coordinator will select an independent review organization that is certified and approved to perform external reviews by URAC (Utilization Review Accreditation Commission) and the State of Indiana.

The external review organization will assign a medical review professional who is board certified in the applicable specialty for resolution of the appeal.

The external review organization and the medical review professional conducting the external review may not have a material professional, familial, or financial, or other affiliation with SIHO; any officer, director, or management employee of SIHO; the physician or the physician's medical group that is proposing the service; the facility at which the service would be provided; or the development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating physician.

A claimant may be required to pay not more than $25 of the costs associated with the services of an external review organization. All additional costs must be paid by SIHO.

A claimant who files an appeal under this final alternative is not subject to retaliation for exercising his

or her right to an appeal by an external review organization. The claimant may be permitted to utilize the assistance of other individuals, including physicians, attorneys, friends, and family members throughout the external review process. The claimant shall be permitted to submit additional information relating to the proposed service throughout the review process and may cooperate with the external review organization by providing any requested medical information or authorizing the release of necessary medical information.

SIHO shall cooperate with the external review organization by promptly providing any information requested by the external review organization.

The external review organization shall make a determination to uphold or reverse SIHO's appeal resolution based on information gathered from the claimant, SIHO, the treating physician, or any additional information that the external review organization considers necessary and appropriate. For standard appeals, the determination shall be made within 15 business days from the filing date of the request for external review. For expedited appeals, the determination shall be made within 72 hours after the external review request is filed.

When making the determination of the resolution of the appeal, the external review organization shall apply the standards of decision making that are based on objective clinical evidence and the terms of the appellant's benefit contract.

The external review organization shall notify SIHO and the claimant of the determination made under this section within 72 hours after making the determination. For expedited appeals, the notification will occur within 24 hours of the determination. The result of the determination is binding on SIHO.

If at any time during the external review process the claimant submits information to SIHO that is relevant to SIHO's previous appeal resolution and was not considered by SIHO during the appeals hearing phase, SIHO shall reconsider the previous resolution under the appeals hearing process. The external review organization shall cease the external review process until the reconsideration by SIHO is completed.

If additional information from the claimant results in SIHO's reconsideration of the appeal at the hearing level, SIHO will notify the claimant of its decision within 15 days after the information is received. If the appeal is related to an Urgent Care Claim, SIHO will make a determination within 72 hours of receipt of the additional information.

If the reconsideration determination made by SIHO is adverse to the claimant, the claimant may request that the external review organization resume the external review.

COORDINATION OF BENEFITS

I. COORDINATION OF THE BENEFIT PLANS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan. The balance due, if any, is the responsibility of the Covered Person.

II. BENEFIT PLAN

This provision will coordinate the medical of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

A. Group or group-type plans, including franchise or blanket benefit plans.

B. Blue Cross and Blue Shield group plans.

C. Group practice and other group prepayment plans.

D. Federal government plans or programs. This includes Medicare.

E. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

F. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

III. ALLOWABLE CHARGE

For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of a HMO or network Provider.

IV. AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

V. BENEFIT PLAN PAYMENT ORDER

When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

A. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

B. Plans with a coordination provision will pay their benefits up to the Allowable Charge:

1. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

2. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

3. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

4. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

    a. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

    b. If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

5. When a child's parents are divorced or legally separated, these rules will apply:

    a. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

    b. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

    c. This rule will be in place of items (a) and (b) above when it applies. A court decree may state which parent is financially responsible for medical of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

    d. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

    e. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

6. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

7. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

8. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

VI. CLAIMS DETERMINATION PERIOD

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

VII. RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

VIII. FACILITY OF PAYMENT

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

IX. RIGHT OF RECOVERY

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

I. WHEN THIS PROVISION APPLIES

The Covered Person may incur medical charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical charges. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

A. automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

B. must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

II. AMOUNT SUBJECT TO SUBROGATION OR REFUND

The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Illness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

III. CONDITIONS PRECEDENT TO COVERAGE

The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Illness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

IV. DEFINED TERMS

A. **"Covered Person"** means anyone covered under the Plan, including minor dependents.

B. **"Recover," "Recovered," "Recovery"** or **"Recoveries"** means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Illness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

C. **"Refund"** means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury or Illness.

D. **"Subrogation"** means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical charges against the other person.

E. **"Third Party"** means any Third Party including another person or a business entity.

V. RECOVERY FROM ANOTHER PLAN UNDER WHICH THE COVERED PERSON IS COVERED

This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

VI. RIGHTS OF PLAN ADMINISTRATOR

The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the Bartholomew Consolidated School Corporation Employee Benefit Trust (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Bartholomew Consolidated School Corporation COBRA continuation coverage for the Plan is administered by SIHO Insurance Services. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

I. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

II. Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

A. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

B. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

C. A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her

performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

III. What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e. cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

A. The death of a covered Employee.

B. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

C. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

D. A covered Employee's enrollment in any part of the Medicare program.

E. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

F. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage

date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

IV. What factors should be considered when determining to elect COBRA continuation coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

V. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

VI. What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

VII. Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

A. the end of employment or reduction of hours of employment,

B. death of the employee,

C. commencement of a proceeding in bankruptcy with respect to the employer, or

D. enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Bartholomew Consolidated School Corporation
1200 Central Avenue
Columbus, IN 47201

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

VIII. Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

IX. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

X. When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage

that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

A. The last day of the applicable maximum coverage period.

B. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

C. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

D. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

E. The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

F. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

1. 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

2. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

XI. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

A. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

B. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

1. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

2. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

C. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

D. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

E. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

XII. Under what circumstances can the maximum coverage period be expanded?
If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

XIII. How does a Qualified Beneficiary become entitled to a disability extension?
A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

XIV. Does the Plan require payment for COBRA continuation coverage?
For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

XV. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

XVI. What is Timely Payment for payment for COBRA continuation coverage?
Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is

allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

XVII. Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

XVIII. If you have Questions:

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

XIX. Keep Your Plan Administrator Informed of Address Change

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

XX. COBRA Extended Enrollment and Subsidy

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended, provides for premium reductions on involuntary terminations for health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. The premium assistance is also available for continuation coverage under certain State laws.

This plan will comply with all current dates, extensions and amendments provided by the Department of Labor (DOL) concerning ARRA and COBRA.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

I. PLAN ADMINISTRATOR

Bartholomew Consolidated School Corporation (BCSC) Employee Benefit Trust is the benefit plan of BCSC, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, the Employer shall appoint a new Plan Administrator as soon as reasonably possible.

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

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

II. DUTIES OF THE PLAN ADMINISTRATOR

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

B. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

C. To decide disputes which may arise relative to a Plan Participant's rights.

D. To prescribe procedures for filing a claim for benefits and to review claim denials.

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

F. To appoint a Benefit Administrator to pay claims.

G. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

III. PLAN ADMINISTRATOR COMPENSATION

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

IV. BENEFIT ADMINISTRATOR IS NOT A FIDUCIARY

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

V. COMPLIANCE WITH HIPAA PRIVACY STANDARDS

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

A. General

The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

B. Permitted Uses and Disclosures

Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

C. Authorized Employees

The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

1. **Updates Required**
   The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

2. **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

3. **Resolution of Issues of Noncompliance**
   In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

   a. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

   b. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

   c. Mitigating any harm caused by the breach, to the extent practicable; and

d. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

D. Certification of Employer

The Employer must provide certification to the Plan that it agrees to:

1. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

4. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

5. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

6. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

7. Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

9. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

10. Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f) (2) (iii) of the Privacy Standards.

The following members of Bartholomew Consolidated School Corporation's workforce are designated as authorized to receive Protected Health Information from the Plan in order to perform their duties with respect to the Plan:

Health Trust Committee
Director of Accounting/Deputy Tresurer
Assistant Superintendent of Financial Services
Benefits Coordinator

VI. COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

1. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

VII. FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Benefit Administrator.

VIII. THE TRUST AGREEMENT

If this Plan is established under a Trust agreement, that agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee, Retiree or Dependent:

A. A copy of the Trust agreement.

B. A complete list of employers and employee organizations sponsoring the Plan.

Service of legal process may be made upon a Plan trustee.

IX. PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

X. CLERICAL ERROR

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION
The Plan is a self-funded group health Plan and the administration is provided through a Third Party Benefit Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME: Bartholomew Consolidated School Corporation (BCSC) Employee Benefit Trust

NAME OF GROUP: Bartholomew Consolidated School Corporation (BCSC)

TAX ID NUMBER: 35-1113190

PLAN EFFECTIVE DATE: January 1

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Bartholomew Consolidated School Corporation
1200 Central Avenue
Columbus, IN 47201

PLAN ADMINISTRATOR

Bartholomew Consolidated School Corporation
1200 Central Avenue
Columbus, IN 47201

BENEFIT ADMINISTRATOR

SIHO Insurance Services
PO Box 1787
Columbus, IN 47202

TRUSTEE(S)
Sharon Tower
Health Trust Committee Chairperson

John Green
Assistant Principal

Jim Sheridan
Dean

Rebecca Schwantes
Student Services Coordinator

Jeff Caldwell
School Board Member

BY THIS AGREEMENT, Bartholomew Consolidated School Corporation (BCSC) Employee Benefit Trust is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Bartholomew Consolidated School Corporation (BCSC) on or as of the day and year first below written.

By Sharon Power

Date 1/17/14

Witness _____

Date _____