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DUNN & Associates

BENEFIT ▪ ADMINISTRATORS ▪ INC.

EMPLOYEE BENEFIT TRUST: Southeast Dubois County Schools

AMENDMENT #: 2

SUMMARY PLAN DESCRIPTION ISSUED: January 1, 2018

AMENDMENT EFFECTIVE DATE: September 1, 2019

The following changes are effective for the page(s) indicated of the Employee Benefit Trust/Plan Summary Plan Description /Master Plan Document for all eligible participants covered by the Trust. All other portions of this document remain as stated in the document.

Page: 5-6
Section: Preferred Provider Organization
Description: The section has been updated:

Preferred Provider Organizations (PPO's) are networks of health care professionals that are contracted to accept a negotiated reasonable and customary fee as the covered amount for specific services. These preferred providers will file claims directly with the Plan Supervisor and have agreed not to "balance bill" an eligible insured for the amount of the charge above the negotiated fee schedule.

- The Primary PPO for this Plan is **Patoka Valley Health Care Cooperative** (PVHCC).
- The Wrap Network (in Indiana) for this Plan is **Encore Combined Network**
- The National Wrap Network (Out of Indiana) for this Plan is **Cigna.**

FOR COVERED PERSONS LIVING WITHIN THE PVHCC SERVICE AREA

All providers contracted with the primary PPO will be considered "In-Network" providers. Covered expenses incurred by an "In-Network" provider (hospital or physician) will be covered at a higher rate than "Out-of-Network" Providers (providers **not** listed as a participating provider of the primary PPO Network). See the Schedule of Benefit within this Summary Plan Description booklet for additional information and exceptions to this payment process.

When services are not available within the primary PPO Service Area, an "In-Network" physician may refer the patient to a provider in the Indiana "Wrap" Network (wrap-around network). If such a referral is needed, PVHCC (the primary PPO) MUST be notified PRIOR to the visit to the "Out-of-Network" provider. If the referral is approved by the primary PPO, covered expenses will be paid at the "In-Network" rate. If the referral is not requested and/or not approved by the primary PPO, the covered expenses will be paid at the "Out-of-Network "rate.

FOR COVERED PERSONS LIVING OUTSIDE OF THE PRIMARY PPO SERVICE AREA

WRAP NETWORK (In Indiana)

All providers contracted with the **Encore Combined Network** "wrap" network will be considered "In-Network" providers. The covered person will not be required to get a referral approval from PVHCC if participant lives outside of the primary PPO service area. Covered expenses incurred by an "In-Network" provider (hospital or physician) will be covered at a higher rate than "Out-of-Network" Providers (providers **not** listed as a participating provider of the wrap network). See the Schedule of Benefit within this Summary Plan Description booklet for additional information and exceptions to this payment process.

NATIONAL WRAP NETWORK (Out of Indiana)

All providers contracted with the **Cigna** "national wrap" network will be considered "In-Network" providers. The covered person will not be required to get a referral approval from the primary PPO if participant lives outside of the primary PPO service area. Covered expenses incurred by an "In-Network" provider (hospital or

physician) will be covered at a higher rate than "Out-of-Network" Providers (providers **not** listed as a participating provider of the national wrap network). See the Schedule of Benefit within this Summary Plan Description booklet for additional information and exceptions to this payment process.

Primary PPO Service Area:
Full County – Crawford, Daviess, Dubois, Martin, Orange, Perry, Pike and Spencer.
Partial County – Gibson zip code 47660 (Oakland City) and Warrick zip code 47673 (Tennyson)

An updated list of PVHCC providers can be obtained free of charge from the Human Resources Department of this Employer, the Plan Supervisor, or by contacting the network(s) directly:

PPO Network	Website	Phone
PVHCC	www.pvcooperative.com	(812) 683-3332 or (800) 318-1590
Encore Combined	www.encoreconnect.com	(888) 574–8180
Cigna	www.MyCigna.com	

Additional Preferred Provider Organizations may be utilized in order to optimize coverage areas. When this occurs, and the services are received outside the network areas with a referral, the covered charges will be paid at the "In-Network" rate. It should not be assumed that covered expenses incurred by these providers will always be paid at the "In-Network" rate since providers could be free to become non-participating providers at any time.

Referrals

Referrals to an Out-of-Network provider are covered as Out-of-Network services, supplies and treatment. It is the responsibility of the covered person to assure services to be rendered are performed by In-Network providers in order to receive the In-Network provider level of benefits. PVHCC may only make a referral to an out-of-network provider if there is not a specialist provider within any network.

Note that providers are free to become non-participating providers at any time; therefore, it is the covered person's responsibility to ensure providers are still in the appropriate network prior to having services rendered.

Services received at Riverview Surgery Center located in Rockport, Indiana. Tax ID# 45-2951941 will be considered a non-covered benefit under this plan. Payment for all expenses billed by this facility will be the responsibility of the participant.

Exceptions

The following listing of exceptions represents services, supplies or treatments rendered by an Out-of-Network provider where covered expenses shall be payable at the In-Network level of benefits:

a. a covered person is outside of the state of Indiana for business or personal reasons for a short duration when expenses were incurred. "Short duration", for the purposes of the plan is defined as four (4) weeks or less. When travel is for business, "short duration" does not apply.

b. a covered person temporarily residing outside of the network area to attend school or training.

c. Indiana, dialysis claims are processed utilizing 150% of Medicare equivalent allowance. Claims are not subject to PPO network negotiated rates.

   Out of Indiana, dialysis claims, are processed according to the national wrap network requirements. National wrap network rates will apply in determining allowable amounts. Call (800) 880-9960 to initiate pre-certification.

Page: 7-9
Section: Pre-Utilization Program
Description: The following has been updated as follows:

PRE-UTILIZATION IN INDIANA

Employees and dependents are under a pre-utilization review program coordinated by Clinix, a utilization review/case management company. Pre-utilization review includes utilization review, concurrent stay review, and discharge planning.

SERVICES REQUIRING PRE-UTILIZATION REVIEW

Hospital Admissions – All inpatient hospital admissions over 18 hours require pre-utilized review. Maternity stays are excluded from this requirement unless the mother or baby remains in the Hospital for more than 48 hours following a normal delivery or for more than 96 hours following a cesarean section.

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

Outpatient Surgical Procedures – Any outpatient surgical procedure that takes place in an operating room or surgery center have a pre-utilization review prior to the procedure. In addition, the following outpatient procedures also require pre-utilization review:

a. Outpatient Chemotherapy
b. Outpatient Radiation Therapy
c. Outpatient Dialysis

Cancer Care – Cancer care includes but is not limited to chemotherapy, radiation, and surgical removal.

Dialysis – Home and Facility Outpatient Dialysis.

Durable Medical Equipment (DME) – Medical equipment which is not disposable (i.e. is used repeatedly and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth.

Home Health Care – Items and services provided as needed in patients' homes by a home health agency (HHA) or by other ~~under~~ arrangement made by a Home Health Agency.

Hospice Care – Services provided by a health care facility or program providing medical care and support services, such as counseling, to terminally ill persons and their families.

Infusions – Home and Facility Infusions.

MRI's (outpatient only) – Outpatient Magnetic Resonance Imaging (MRI) procedures.

Outpatient Surgical Procedures – Any outpatient procedures requiring the use of an operating room or surgery center.

Pregnancies – Clinix should be notified when you become pregnant. Inpatient maternity stays of no more than 48 hours following a vaginal delivery or 96 hours following a cesarean section are excluded as mentioned above.

Scans (outpatient only) – Outpatient Positron Emission Tomography (PET) scans and CT scan or computed tomography scan;

Skilled Nursing Care – Around-the-clock nursing and rehabilitative care, that can only be provided by, or under the supervision of, skilled medical personnel.

Sleep Studies – Contact Clinix prior to scheduling sleep study procedures.

Therapy – Physical, Occupational and Speech Therapy (outpatient basis only).

HOW TO OBTAIN PRE-UTILIZATION REVIEW

Call Clinix 1-800-227-2298 and provide the following information to the case manager:

a. name of the covered person being treated
b. social security number or other identifying number of the Employee
c. recommended procedure
d. proposed date of procedure

For planned (elective) inpatient admissions, call at least 7 days prior to admission, for emergency admissions, call within 48 hours following admission, and for obstetrical care, call during the 1st trimester. For all other services requiring pre-utilization review, call prior to scheduling the procedure/care or obtaining equipment. Confidential voice mail is available 24 hours per day. If voice mail left, remember to leave information above. If the covered person believes this request is "urgent" (see "Urgent Claim" in Definitions section), he should indicate this to the case manager. A health care provider may call on behalf of the covered person, and the provider also may indicate urgency to the case manager. A covered person (or the parent or guardian of a covered person who is a minor or otherwise legally incapacitated) may designate an authorized representative for purposes of requesting pre-utilization review of services or appealing a denial involving Care Management in writing. Except that in the case of a claim involving urgent care, a health care professional with knowledge of condition may always act as an authorized representative.

NOTIFICATION OF PRE-UTILIZATION DETERMINATION

If a request for pre-utilization review is "urgent", the case manager will advise whether the request is approved or denied within 72 hours. If a request for pre-utilization review is not "urgent", the case manager will advise whether the request is approved or denied within 15 days. The case manager will approve a requested procedure, service or supply only if it finds it to be medically necessary and medically appropriate, based on the severity and complexity of the covered person's illness or injury, the covered person's age and general health, and medical necessity/appropriateness guideline. However, a determination by the case manager that a requested procedure, service or supply is medically necessary and/or medically appropriate does NOT mean that the procedure, service or supply is a covered expense under this Plan.

CONTINUED CONFINEMENT

If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already certified, the Employee, the physician, or the hospital may get more days certified by calling Clinix. This must be done no later than on the last day that has already been certified. Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to the Employee and to the physician.

CONCURRENT REVIEW

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extended beyond the initial pre-utilization will require concurrent review.

DISCHARGE PLANNING

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during pre-utilization or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

CASE MANAGEMENT
Clinix 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.

DISEASE MANAGEMENT
This Plan includes a disease management program. This is a program that targets Covered Persons identified as needing assistance with the management of their chronic illness. The identified Covered Persons are assigned to a Nurse Educator who will work with them in the areas of participation education, medication compliance, targeting risk factors, potential complication identification, specialist physician follow-up, disease triggers, and appropriate medical follow-up care. Disease management participants are also educated about modifying certain lifestyle factors in order to improve their overall health.

IF THERE IS A DISAGREEMENT / APPEALS
The decision to hospitalize, perform a procedure or use a particular vendor at all times rest with the covered person and his physician. A covered person (or the authorized representative of the covered person) may appeal any whole or partial denial of pre-utilization review of services as described under the "Claims Appeal and Review Procedure" section of this booklet. Note that since pre-utilization review is performed by Clinix and not the Plan Supervisor, appeals related to adverse pre-utilization review decisions should be directed to Clinix and **not** Dunn and Associates.

BENEFIT REDUCTION
If the procedures for Pre-utilization Review of Hospital Admissions are not followed, covered charges will be subject to a $250 per admission penalty. This penalty will not count toward any deductible or co-insurance maximums.

REMEMBER
- ✓ *Call* Clinix *BEFORE receiving care mentioned above.*
- ✓ *In emergencies, the Employee still needs to let* Clinix *know that a covered person has been admitted to the hospital within 48 hours of the admittance.*
- ✓ *An Employee should check his coverage under this Plan.* Clinix *reviews and approves the hospitalization. It does not approve Employee or dependent eligibility or that all charges are covered. An Employee must check his Plan for eligible procedures and charges.*
- ✓ *If the Employee does not follow procedures as required for hospital admissions, a $250 per admission penalty will apply to the covered charges.*

PRE-UTILIZATION OUTSIDE OF INDIANA
For Eligibility and Pre-certifications outside of Indiana call **(800) 880-9960**.

Page: 12-16
Section: Schedule of Benefits
Description: The following has been updated as follows:

COMPREHENSIVE MEDICAL BENEFITS (Employee and Dependents)

	PLAN A Traditional Plan		PLAN B High Deductible Health Plan (HDHP) may be elected with or without a Health Savings Account (HSA)		PLAN A & B
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Deductible (per calendar yr) Individual Family	$850 $1,700	$1,700 $3,400	$3,000 $6,000	$3,000 $6,000	Deductible applies to all covered expenses unless otherwise stated under Special Conditions.
	Common in- and out-of-network deductible.		In & Out-of-network deductibles do not apply towards each other.		
Coinsurance Limit Medical Individual Medical Family Rx Individual Rx Family Total Coinsurance Limit Individual Family	 $1,650 $3,300 $1,500 $3,000 $3,150 $6,300	 $3,300 $6,600 $1,500 $3,000 $4,800 $9,600	 $3,000 $6,000 $3,000 $6,000 $6,000 $12,000		Per calendar year; In- and out-of-network coinsurance limits do NOT include deductibles and do NOT apply toward each other. After the coinsurance limit has been met, most covered expenses are payable at 100% of reasonable and customary for the remainder of that calendar year. Coinsurance limits include applicable copays.
Total Out-of-Pocket (per calendar yr) Individual Family	 $4,000 $8,000	 $6,500 $13,000	 $9,000 $18,000		
Physician Office Visit (Primary Care Physician Only)	$50.00 copay then 100% no deductible	50% after deductible	80% after deductible	50% after deductible	

	PLAN A Traditional Plan		PLAN B High Deductible Health Plan (HDHP) may be elected with or without a Health Savings Account (HSA)		PLAN A & B
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Mental Health/Substance Abuse Care (In and Outpatient)	$50.00 copay then 100% no deductible	50% after deductible	80% after deductible	50% after deductible	
Emergency (Accident/Illness)	$150 copay then 80% after deductible	$150 copay then 80% after deductible	80% after deductible	80% after deductible	
Dialysis	80% after deductible	50% after deductible	80% after deductible	50% after deductible	Maximum allowable amount is 150% of the Medicare allowable for incurred expenses. Limited to 40 treatments per episode of care. Treatment will be considered a separate episode of care if more than 180 days have lapsed since the last outpatient treatment.

	PLAN A Traditional Plan		PLAN B High Deductible Health Plan (HDHP) may be elected with or without a Health Savings Account (HSA)		PLAN A & B
BENEFIT DESCRIPTION	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**PLAN LIMITATIONS**
Prescription Drug Benefit					
	Copay Employee Pays		Copay Employee Pays		Plan A: Deductible waived and copays do not apply toward deductible and coinsurance limits. Embedded out of pocket maximum, if a member has family coverage, any combination of covered family members can help meet the family out of pocket maximum up to each person's individual out of pocket maximum. Plan B: Embedded deductible/out of pocket maximum, if a member has family coverage, any combination of covered family members can help meet the family deductible/out of pocket maximum up to each person's individual deductible/out of pocket maximum. * If an insured elects not to purchase a generic drug when available and approved by the physician, the employee will be responsible for the brand copay plus the difference in the cost of the generic and the brand name drug purchased. Discounts are available through pharmacies participating in Preferred network. Only the copay will need to be paid by the covered person up front. Reimbursement Program If a participant purchases a drug from the $4/$10 generic listing (not running the script through the drug program) the employee will need to submit a claim to Dunn & Associates and the Trust will reimburse the participant at 100% of cost.
Retail Store (30-day supply)					
Generic Drugs	$10		20% after deductible		
Brand Preferred	$40 or 20% (greater of) maximum of $50		20% after deductible		
Brand Non-Preferred	$60 or 30% (greater of) maximum of $150		20% after deductible		
Fluoxentine/Lovastatin	$0				
Retail Store (90-day supply)	Copay Employee Pays		Copay Employee Pays		
Generic Drugs	$12		20% after deductible		
Brand Preferred	$60 or 20% (greater of) maximum of $100		20% after deductible		
Brand Non-Preferred	$100 or 30% (greater of) maximum of $200		20% after deductible		
Fluoxentine/Lovastatin	$0				
Specialty Program (30-day supply)					
Tier 1	10%		10% after deductible		
Tier 2	20% (max $550)		20% (max $550) after deductible		
Tier 3	20%		20% after deductible		
Tier 4	50%		50% after deductible		
Rx Reimbursement					
Generic Drugs 30-day	$4 (100% of cost)		$4 (100% of cost)		
Generic Drugs 90-day	$10 (100% of cost)		$10 (100% of cost)		
	Plan A: Deductible waived and copays do not apply toward deductible and coinsurance limits. Embedded out of pocket maximum, if a member has family coverage, any combination of covered family members can help meet the family out of pocket maximum up to each person's individual out of pocket maximum.		Plan B: Embedded deductible/out of pocket maximum, if a member has family coverage, any combination of covered family members can help meet the family deductible/out of pocket maximum up to each person's individual deductible/out of pocket maximum.		

These higher copays will apply if you have a prescription filled at a CVS/Walgreens or Rite Aid pharmacy.			
Prescription Drug Benefit		Copays listed above apply.	
	Copay Employee Pays		
Retail Store (30-day supply)			
Generic Drugs	$25		
Brand Preferred	$55 or 25% (greater of) maximum of $65		
Brand Non-Preferred	$75 or 35% (greater of) maximum of $165		
Retail Store (90-day supply)	Copay Employee Pays		
Generic Drugs	$27		
Brand Preferred	$75 or 25% (greater of) maximum of $115		
Brand Non-Preferred	$115 or 35% (greater of) maximum of $215		

Page: 26-34
Section: Comprehensive Medical Benefits/Prescription Drug Benefit
Description: The following language has been added to this section as follows:

Tiered Pharmacy Network
A tiered pharmacy network will be implemented. This will increase your prescription drug copay for generic or brand name medications if you have them filled at a CVS, Walgreens or Rite-Aid Pharmacy. Also, a narrow formulary will be implemented. The Pharmacy Benefit Manger will notify all members that are or may be affected by this implementation.

Signed this 23rd day of March, 2020

TRUSTEE

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WITNESS