

**SUMMARY OF MATERIAL MODIFICATION  
AND  
AMENDMENT #5  
TO THE  
CITY OF FORT SMITH  
GROUP BENEFIT PLAN  
GROUP NO. 14283**

This Summary of Material Modification and Amendment describes changes to the City of Fort Smith Group Benefit Plan effective January 1, 2014. These changes are effective as of **January 1, 2016** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

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City of Fort Smith (the "Plan Sponsor") is amending the City of Fort Smith Group Benefit Plan (the "Plan") as follows:

**Patient Protection and Affordable Care Act (the "Affordable Care Act")**

*This Summary of Material Modification and Amendment to the City of Fort Smith Group Benefit Plan (the "Plan") is adopted to comply with certain provisions of the Patient Protection and Affordable Care Act (the "Affordable Care Act").*

**Annual Out-of-Pocket Maximum**

*The **Out-of-Pocket Maximum** section under **General Overview of the Plan** is hereby deleted and replaced with the following:*

**GENERAL OVERVIEW OF THE PLAN**

**Out-of-Pocket Maximum**

An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

- (1) Dental benefits, other than those dental expenses paid under the major medical component of the Plan.
- (2) Charges over Usual and Customary Charges for Non-Participating Providers.
- (3) Charges this Plan does not cover, including precertification penalties.
- (4) Charges in excess of the established Plan maximums or limitations.

Reimbursement for these non-accumulating expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

## RENEWAL CHANGES

1. *All references to the [www.myMeritain.com](http://www.myMeritain.com) web address are hereby deleted and replaced with [www.meritain.com](http://www.meritain.com).*
2. *The following paragraph is hereby added as the second paragraph to the **General Overview of the Plan** section:*

### GENERAL OVERVIEW OF THE PLAN

If a Covered Person receives goods or services from a Participating Provider whose contract between the provider and the provider's Network provides for reimbursement to the provider for those goods or services of amounts not otherwise reimbursable under this Plan, the Plan benefit payable shall be the amount specified in the contract between the provider and the Network, rather than the amount otherwise reimbursable under this Plan.

3. *The **Deductible** section under **General Overview of the Plan** is hereby deleted and replaced with the following:*

### GENERAL OVERVIEW OF THE PLAN

#### Deductible

**NOTE: This provision only applies to medical benefits under the Plan. Please refer to the Dental Expenses section of the Plan for the Deductible, if any, applicable to those benefits.**

A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan, except as otherwise shown in the Medical Schedule of Benefits.

The family Deductible maximum, as shown in the Medical Schedule of Benefits, is the maximum amount of Deductibles which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

If 2 or more covered family members suffer Injuries from the same Accident, only one Deductible will be applied to all charges Incurred for the treatment of those Injuries during the Calendar Year.

4. *The **Health and Wellness Program** is hereby deleted and replaced as shown in **Exhibit A**.*

5. The **Medical Schedule of Benefits** and **Prescription Drug Schedule of Benefits** are hereby deleted and replaced as shown in **Exhibits B and C**.

The **Medical Schedule of Benefits – Plan 2, Prescription Drug Schedule of Benefits – Plan 2, Medical Schedule of Benefits – Plan 3 and Prescription Drug Schedule of Benefits – Plan 3** are hereby added to the Plan as shown in **Exhibits D-G**.

6. Item (G) under (a)-(iv) under number (41) - **Preventive Services and Routine Care** in the **Eligible Medical Expenses** section of the Plan is hereby deleted and replaced with the following:

### ELIGIBLE MEDICAL EXPENSES

- (41) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:
- (G) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:
- (1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.
  - (2) Breastfeeding equipment will be covered, subject to the following:
    - (i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and
    - (ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last 3 Calendar Years and provided the Covered Person remained continuously enrolled in the Plan following the birth of the Child.
  - (3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, City of Fort Smith has caused this Amendment to take effect, be attached to, and form a part of their Group Benefit Plan.

Wanda McBride 1-5-16  
Authorized Signature Date

Human Resources Coordinator  
\_\_\_\_\_  
Title

Amber Jones 1-5-16  
Witness Date

Production Assistant  
\_\_\_\_\_  
Title

## EXHIBIT A

### HEALTH AND WELLNESS PROGRAM

The Health and Wellness Program is a wellness benefit offered by the Employer to reduce the health risks of an Employee and his or her Spouse. The Health and Wellness Program is made up of several different components and is designed to provide an Employee with the tools and personal support they need to make positive lifestyle changes. Participation in this program is completely voluntary; however, in order to obtain and receive any program incentive and be compliant, you must complete the CHRA and the biometric lab screening.

This program focuses on four key lifestyle choices:

- (1) Nutrition habits – helping Covered Persons adopt healthy, balanced eating behaviors.
- (2) Exercise habits – assisting Covered Persons with identifying ways to become more physically active.
- (3) Weight Management – promoting safe, effective weight loss and weight management.
- (4) Tobaccos cessation – helping Covered Persons make a quit plan and take action that is most likely to result in successful cessation.

One component of our Health and Wellness Program is the Clinical Health Risk Assessment (CHRA). This program identifies and stratifies populations based on current medical conditions and future risk, and also assesses the Covered Person's readiness to change. Program participants are asked general questions relating to nutrition, activity and exercise, alcohol and tobacco use, psychosocial, personal/family history, and personal health management. Covered Persons are also asked about existing medical conditions, including arthritis, asthma, back pain, Chronic Obstructive Pulmonary Disease (COPD), depression, diabetes, heart disease, heart failure and hypertension. The CHRA includes questions to assess the impact of the condition on daily life and the ability to self-manage the condition. The CHRA can also identify members who would benefit from health and wellness coaching.

Other Health and Wellness Program components include biometric screening and an incentive program. Each component has a direct impact on program participation, outcomes and success. Satisfactory completion of the CHRA and biometric lab screening are necessary in order to receive any program incentives. Results must be within the City of Fort Smith Goals.

Upon completion of the biometric evaluation, the Covered Employee will receive a confidential, individual report that identifies any potential health risk factors and other valuable health information for making positive lifestyle changes. The information contained in this individual report provides general health information only and does not constitute medical advice. You should review this individual report with your health care provider

#### **Incentive**

The Employer offers the covered Employee that participates in the Plan an additional incentive if he or she elects to participate in the Healthy Merits Program. The amount of the incentive is determined by the Employer and also communicated in the program welcome materials.

**EXHIBIT B**

**MEDICAL SCHEDULE OF BENEFITS – PLAN 1**

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited	
<b>CALENDAR YEAR MAXIMUM BENEFIT</b>	Unlimited	
<b>CALENDAR YEAR DEDUCTIBLE</b>		
Single	\$2,000	\$4,000
Family	\$4,000	\$8,000
<b>CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM</b> (includes medical Deductible, medical Copays, medical Coinsurance and Precert Penalties)		
Single	\$5,000	Unlimited
Family	\$10,000	Unlimited
<b>TOTAL OVERALL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Copays and Coinsurance - combined with Prescription Drug Card)		
Single	\$6,850	N/A
Family	\$13,700	N/A
<b>MEDICAL BENEFITS UNLIMITED</b>		
<b>Allergy Serums and Injections</b>	100% (Deductible waived)	50% after Deductible
<b>Allergy Testing and Treatment</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
<b>Ambulance Services</b>	80% after Deductible	50% after Deductible
<b>Ambulatory Surgical Center</b>	80% after Deductible	50% after Deductible
<b>Chemotherapy (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Chiropractic Care/Spinal Manipulation</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
Calendar Year Maximum Benefit	20 visits	
<b>Diabetic Education</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
<b>Diabetic Supplies</b>	100% (Deductible waived)	Not Covered
NOTE: Diabetic Supplies must be purchased through Edgepark Medical Supplies (TIN 34-1650951) after a one month supply at the pharmacy.		
<b>Diagnostic Testing, X-Ray and Lab Services (Outpatient)</b>	80% after Deductible	50% after Deductible

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Durable Medical Equipment (DME)</b>	80% after Deductible	50% after Deductible
<b>Emergency Services – Emergency Medical Condition</b>	80% after Deductible	Paid at the Participating Provider level of benefits
<b>Emergency Room - Non-Emergency Medical Condition</b>	80% after Deductible	50% after Deductible
<b>Home Health Care</b>	80% after Deductible	50% after Deductible
<b>Hospice Care</b>	100% (Deductible waived)	50% after Deductible
Respite Care Lifetime Maximum Benefit	5 days	
<b>Hospice Bereavement Counseling</b> (within six (6) months of Covered Person's death)	100% (Deductible waived)	50% after Deductible
<b>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</b>		
Inpatient	80% after Deductible	50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	80% after Deductible ICU/CCU Room rate	50% after Deductible ICU/CCU Room rate
Miscellaneous Services & Supplies	80% after Deductible	50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
<b>IMWell Health Clinic - All services rendered during a visit to the IMWell Health Clinic, including diagnostic x-ray and lab services</b> NOTE: Services billed by a separate provider will be subject to the applicable benefit as specified elsewhere in the Medical Schedule of Benefits.	100% (Deductible waived)	Not Covered
<b>Mastectomy Bra</b>	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	1 bra	
<b>Maternity (Professional Fees)*</b>		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% (Deductible waived)	50% after Deductible
Lactation Consultations	100% (Deductible waived)	100% (Deductible waived)
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Mental Disorders and Substance Use Disorders</b>		
Inpatient	80% after Deductible	50% after Deductible
Outpatient Office Visits	\$35 Copay then 100% (Deductible waived)	50% after Deductible
All Other Items and Services	100% (Deductible waived)	100% (Deductible waived)
<b>NOTE:</b> Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
<b>Morbid Obesity</b>	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 surgical procedure	
<b>Nutritional Counseling</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
<b>Outpatient Therapies</b> (e.g., physical, speech, occupational)	80% after Deductible	50% after Deductible
Combined Calendar Year Maximum Benefit	60 visits	
<b>Nystagmus</b> (rapid eye movement)	80% (Deductible waived)	60% after Deductible
Calendar Year Maximum Benefit	\$5,000*	
* Calendar Year Maximum Benefit does not apply to Covered Persons age 19 and under.		
<b>Physician's Services</b>		
Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
Office Visits	\$35 Copay* then 100% (Deductible waived)	50% after Deductible
Physician Office Surgery	\$35 Copay* then 100% (Deductible waived)	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
<b>Pre-Admission Testing (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Preventive Services and Routine Care</b>		
Preventive Services  (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100% (Deductible waived)	100% (Deductible waived)
Preventive/Routine Colonoscopy, Sigmoidoscopy and Similar Routine Surgical Procedures  (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% (Deductible waived)	50% after Deductible
<b>Radiation Therapy (Outpatient)</b>	80% after Deductible	50% after Deductible

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Skilled Nursing Facility and Rehabilitation Facility</b>	80% after Deductible	50% after Deductible
<b>Sparks Regional Medical Center</b> (preventive/routine comprehensive exams) See the Human Resources Department for further details.	100% (Deductible waived)	100% (Deductible waived)
Maximum Benefit	1 exam every 5 Calendar Years	
<b>Temporomandibular Joint Dysfunction (TMJ)</b>	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	\$1,500	
<b>Transplants</b>	80% after Deductible (Aetna IOE Program)*	50% after Deductible
Lodging Daily Maximum Benefit	\$50 per day per person (\$100 per day maximum) per transplant *	\$50 per day per person per transplant
Transportation and Lodging Maximum Benefit	\$10,000 per transplant*	N/A
Maximum Benefit per Transplant	\$500,000 per transplant	\$200,000 per transplant
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit.		
<b>Urgent Care Facility</b>	\$35 Copay* then 100% (Deductible waived)	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
<b>Wig (see Eligible Medical Expenses)</b>	80% after Deductible	80% after Participating Provider Deductible
Lifetime Maximum Benefit	1 wig	
<b>All Other Eligible Medical Expenses</b>	80% after Deductible	50% after Deductible

## EXHIBIT C

### PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PLAN 1

BENEFIT DESCRIPTION	BENEFIT
<b>NOTE:</b> There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
<b>CALENDAR YEAR PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Prescription Drug Copays)	
Single	\$1,850
Family	\$3,700
<b>TOTAL OVERALL CALENDAR YEAR MAJOR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Copays, and Coinsurance - combined with major medical)	
Single	\$6,850
Family	\$13,700
BENEFIT DESCRIPTION	BENEFIT
<b>Retail Pharmacy: 30-day supply</b>	
Generic Drug	20% Copay (\$15 minimum/\$150 maximum)
Generic Drug – Align Pharmacy	10% Copay (\$5 minimum/\$75 maximum)
Preferred Drug	30% Copay (\$30 minimum/\$150 maximum)
Non-Preferred Drug	40% Copay (\$50 minimum/\$150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
<b>Align Retail Pharmacy: 90-day supply</b>	
Generic Drug	20% Copay (\$25 minimum/\$275 maximum)
Preferred Drug	30% Copay (\$75 minimum/\$275 maximum)
Non-Preferred Drug	40% Copay (\$150 minimum/\$275 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

**NOTE:** *Diabetic supplies must be purchased through Edgepark Medical Supplies after a one month supply at the pharmacy.*

#### **Dispense as Written**

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

#### **Specialty Pharmacy Program**

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Manager.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator.

**EXHIBIT D**

**MEDICAL SCHEDULE OF BENEFITS – PLAN 2**

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited	
<b>CALENDAR YEAR MAXIMUM BENEFIT</b>	Unlimited	
<b>CALENDAR YEAR DEDUCTIBLE</b>		
Single	\$1,250	\$4,000
Family	\$2,500	\$8,000
<b>CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM</b> (includes medical Deductible, medical Copays, and medical Coinsurance)		
Single	\$5,000	Unlimited
Family	\$10,000	Unlimited
<b>TOTAL OVERALL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Copays and Coinsurance - combined with Prescription Drug Card)		
Single	\$6,850	N/A
Family	\$13,700	N/A
<b>MEDICAL BENEFITS UNLIMITED</b>		
<b>Allergy Serums and Injections</b>	100% (Deductible waived)	50% after Deductible
<b>Allergy Testing and Treatment</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
<b>Ambulance Services</b>	80% after Deductible	50% after Deductible
<b>Ambulatory Surgical Center</b>	80% after Deductible	50% after Deductible
<b>Chemotherapy (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Chiropractic Care/Spinal Manipulation</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
Calendar Year Maximum Benefit	20 visits	
<b>Diabetic Education</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
<b>Diabetic Supplies</b>	100% (Deductible waived)	Not Covered
NOTE: Diabetic Supplies must be purchased through Edgemark Medical Supplies (TIN 34-1650951) after a one month supply at the pharmacy.		
<b>Diagnostic Testing, X-Ray and Lab Services (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Durable Medical Equipment (DME)</b>	80% after Deductible	50% after Deductible

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Emergency Services – Emergency Medical Condition</b>	80% after Deductible	Paid at the Participating Provider level of benefits
<b>Emergency Room - Non-Emergency Medical Condition</b>	80% after Deductible	50% after Deductible
<b>Home Health Care</b>	80% after Deductible	50% after Deductible
<b>Hospice Care</b>	100% (Deductible waived)	50% after Deductible
Respite Care Lifetime Maximum Benefit	5 days	
<b>Hospice Bereavement Counseling</b> (within six (6) months of Covered Person's death)	100% (Deductible waived)	50% after Deductible
<b>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</b>		
Inpatient	80% after Deductible	50% after Deductible
Room and Board Allowance*	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	80% after Deductible ICU/CCU Room rate	50% after Deductible ICU/CCU Room rate
Miscellaneous Services & Supplies	80% after Deductible	50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
<b>IMWell Health Clinic - All services rendered during a visit to the IMWell Health Clinic, including diagnostic x-ray and lab services</b> NOTE: Services billed by a separate provider will be subject to the applicable benefit as specified elsewhere in the Medical Schedule of Benefits.	100% (Deductible waived)	Not Covered
<b>Mastectomy Bra</b>	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	1 bra	
<b>Maternity (Professional Fees)*</b>		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% (Deductible waived)	50% after Deductible
Lactation Consultations	100% (Deductible waived)	100% (Deductible waived)
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Mental Disorders and Substance Use Disorders</b>		
Inpatient	80% after Deductible	50% after Deductible
Outpatient Office Visits	\$35 Copay then 100% (Deductible waived)	50% after Deductible
All Other Items and Services	100% (Deductible waived)	100% (Deductible waived)
<b>NOTE:</b> Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
<b>Morbid Obesity</b>	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 surgical procedure	
<b>Nutritional Counseling</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
<b>Nystagmus</b> (rapid eye movement)	80% (Deductible waived)	60% after Deductible
Calendar Year Maximum Benefit *	\$5,000	
* Calendar Year Maximum Benefit does not apply to Covered Persons age 19 and under.		
<b>Outpatient Therapies</b> (e.g., physical, speech, occupational)	80% after Deductible	50% after Deductible
Combined Calendar Year Maximum Benefit	60 visits	
<b>Physician's Services</b>		
Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
Office Visits	\$35 Copay* then 100% (Deductible waived)	50% after Deductible
Physician Office Surgery	\$35 Copay* then 100% (Deductible waived)	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
<b>Pre-Admission Testing (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Preventive Services and Routine Care</b>		
Preventive Services  (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100% (Deductible waived)	100% (Deductible waived)
Preventive/Routine Colonoscopy, Sigmoidoscopy and similar routine surgical procedures  (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% (Deductible waived)	50% after Deductible
<b>Radiation Therapy (Outpatient)</b>	80% after Deductible	50% after Deductible

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Skilled Nursing Facility and Rehabilitation Facility</b>	80% after Deductible	50% after Deductible
<b>Sparks Regional Medical Center</b> (preventive/routine comprehensive exams) See the Human Resources Department for further details.	100% (Deductible waived)	100% (Deductible waived)
Maximum Benefit	1 exam every 5 Calendar Years	
<b>Temporomandibular Joint Dysfunction (TMJ)</b>	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	\$1,500	
<b>Transplants</b>	80% after Deductible (Aetna IOE Program)*	50% after Deductible
Lodging Daily Maximum Benefit	\$50 per day per person (\$100 per day maximum) per transplant *	\$50 per day per person per transplant
Transportation and Lodging Maximum Benefit	\$10,000 per transplant*	N/A
Maximum Benefit per Transplant	\$500,000 per transplant	\$200,000 per transplant
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit.		
<b>Urgent Care Facility</b>	\$35 Copay* then 100% (Deductible waived)	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
<b>Wig (see Eligible Medical Expenses)</b>	80% after Deductible	80% after Participating Provider Deductible
Lifetime Maximum Benefit	1 wig	
<b>All Other Eligible Medical Expenses</b>	80% after Deductible	50% after Deductible

## EXHIBIT E

### PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PLAN 2

BENEFIT DESCRIPTION	BENEFIT
<b>NOTE:</b> There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
<b>CALENDAR YEAR PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Prescription Drug Copays)	
Single	\$1,850
Family	\$3,700
<b>TOTAL OVERALL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Copays, and Coinsurance - combined with major medical)	
Single	\$6,850
Family	\$13,700
BENEFIT DESCRIPTION	BENEFIT
<b>Retail Pharmacy: 30-day supply</b>	
Generic Drug	20% Copay (\$15 minimum/\$150 maximum)
Generic Drug – Align Pharmacy	10% Copay (\$5 minimum/\$75 maximum)
Preferred Drug	30% Copay (\$30 minimum/\$150 maximum)
Non-Preferred Drug	40% Copay (\$50 minimum/\$150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
<b>Align Retail Pharmacy: 90-day supply</b>	
Generic Drug	20% Copay (\$25 minimum/\$275 maximum)
Preferred Drug	30% Copay (\$75 minimum/\$275 maximum)
Non-Preferred Drug	40% Copay (\$150 minimum/\$275 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

**NOTE:** Diabetic supplies must be purchased through Edgepark Medical Supplies after a one month supply at the pharmacy.

#### **Dispense as Written**

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

#### **Specialty Pharmacy Program**

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Manager.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator.

**EXHIBIT F**

**MEDICAL SCHEDULE OF BENEFITS – PLAN 3**

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited	
<b>CALENDAR YEAR MAXIMUM BENEFIT</b>	Unlimited	
<b>CALENDAR YEAR DEDUCTIBLE</b>		
Single	\$500	\$4,000
Family	\$1,000	\$8,000
<b>CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM</b> (includes medical Deductible, medical Copays, and medical Coinsurance)		
Single	\$5,000	Unlimited
Family	\$10,000	Unlimited
<b>TOTAL OVERALL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Copays and Coinsurance - combined with Prescription Drug Card)		
Single	\$6,850	N/A
Family	\$13,700	N/A
<b>MEDICAL BENEFITS UNLIMITED</b>		
<b>Allergy Serums and Injections</b>	100% (Deductible waived)	50% after Deductible
<b>Allergy Testing and Treatment</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
<b>Ambulance Services</b>	80% after Deductible	50% after Deductible
<b>Ambulatory Surgical Center</b>	80% after Deductible	50% after Deductible
<b>Chemotherapy (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Chiropractic Care/Spinal Manipulation</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
Calendar Year Maximum Benefit	20 visits	
<b>Diabetic Education</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
<b>Diabetic Supplies</b>	100% (Deductible waived)	Not Covered
NOTE: Diabetic Supplies must be purchased through Edgepark Medical Supplies (TIN 34-1650951) after a one month supply at the pharmacy.		
<b>Diagnostic Testing, X-Ray and Lab Services (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Durable Medical Equipment (DME)</b>	80% after Deductible	50% after Deductible

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Emergency Services – Emergency Medical Condition</b>	80% after Deductible	Paid at the Participating Provider level of benefits
<b>Emergency Room - Non-Emergency Medical Condition</b>	80% after Deductible	50% after Deductible
<b>Home Health Care</b>	80% after Deductible	50% after Deductible
<b>Hospice Care</b>	100% (Deductible waived)	50% after Deductible
Respite Care Lifetime Maximum Benefit	5 days	
<b>Hospice Bereavement Counseling</b> (within six (6) months of Covered Person's death)	100% (Deductible waived)	50% after Deductible
<b>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</b>		
Inpatient	80% after Deductible	50% after Deductible
Room and Board Allowance	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	80% after Deductible ICU/CCU Room rate	50% after Deductible ICU/CCU Room rate
Miscellaneous Services & Supplies	80% after Deductible	50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
<b>IMWell Health Clinic - All services rendered during a visit to the IMWell Health Clinic, including diagnostic x-ray and lab services</b> NOTE: Services billed by a separate provider will be subject to the applicable benefit as specified elsewhere in the Medical Schedule of Benefits.	100% (Deductible waived)	Not Covered
<b>Mastectomy Bra</b>	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	1 bra	
<b>Maternity (Professional Fees)*</b>		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% (Deductible waived)	50% after Deductible
Lactation Consultations	100% (Deductible waived)	100% (Deductible waived)
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Mental Disorders and Substance Use Disorders</b>		
Inpatient	80% after Deductible	50% after Deductible
Outpatient Office Visits	\$35 Copay then 100% (Deductible waived)	50% after Deductible
All Other Items and Services	100% (Deductible waived)	100% (Deductible waived)
<b>NOTE:</b> Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
<b>Morbid Obesity</b>	80% after Deductible	50% after Deductible
Lifetime Maximum Benefit	1 surgical procedure	
<b>Nutritional Counseling</b>	\$35 Copay then 100% (Deductible waived)	50% after Deductible
<b>Nystagmus</b> (rapid eye movement)	80% (Deductible waived)	60% after Deductible
Calendar Year Maximum Benefit	\$5,000*	
* Calendar Year Maximum Benefit does not apply to Covered Persons age 19 and under.		
<b>Outpatient Therapies</b> (e.g., physical, speech, occupational)	80% after Deductible	50% after Deductible
Combined Calendar Year Maximum Benefit	60 visits	
<b>Physician's Services</b>		
Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
Office Visits	\$35 Copay* then 100% (Deductible waived)	50% after Deductible
Physician Office Surgery	\$35 Copay* then 100% (Deductible waived)	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
<b>Pre-Admission Testing (Outpatient)</b>	80% after Deductible	50% after Deductible
<b>Preventive Services and Routine Care</b>		
Preventive Services  (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100% (Deductible waived)	100% (Deductible waived)
Preventive/Routine Colonoscopy, Sigmoidoscopy and similar routine surgical procedures  (includes any routine care item or service not otherwise covered under the preventive services provision above)	100% (Deductible waived)	50% after Deductible
<b>Radiation Therapy (Outpatient)</b>	80% after Deductible	50% after Deductible

	<b>PARTICIPATING PROVIDERS</b>	<b>NON-PARTICIPATING PROVIDERS</b> (Subject to Usual and Customary Charges)
<b>Skilled Nursing Facility and Rehabilitation Facility</b>	80% after Deductible	50% after Deductible
<b>Sparks Regional Medical Center</b> (preventive/routine comprehensive exams) See the Human Resources Department for further details.	100% (Deductible waived)	100% (Deductible waived)
Maximum Benefit	1 exam every 5 Calendar Years	
<b>Temporomandibular Joint Dysfunction (TMJ)</b>	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	\$1,500	
<b>Transplants</b>	80% after Deductible (Aetna IOE Program)*	50% after Deductible
Lodging Daily Maximum Benefit	\$50 per day per person (\$100 per day maximum) per transplant *	\$50 per day per person per transplant
Transportation and Lodging Maximum Benefit	\$10,000 per transplant*	N/A
Maximum Benefit per Transplant	\$500,000 per transplant	\$200,000 per transplant
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit.		
<b>Urgent Care Facility</b>	\$35 Copay* then 100% (Deductible waived)	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
<b>Wig (see Eligible Medical Expenses)</b>	80% after Deductible	80% after Participating Provider Deductible
Lifetime Maximum Benefit	1 wig	
<b>All Other Eligible Medical Expenses</b>	80% after Deductible	50% after Deductible

## EXHIBIT G

### PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PLAN 3

BENEFIT DESCRIPTION	BENEFIT
<b>NOTE:</b> There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
<b>CALENDAR YEAR PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Prescription Drug Copays)	
Single	\$1,850
Family	\$3,700
<b>TOTAL OVERALL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Copays, and Coinsurance - combined with major medical)	
Single	\$6,850
Family	\$13,700
BENEFIT DESCRIPTION	BENEFIT
<b>Retail Pharmacy: 30-day supply</b>	
Generic Drug	20% Copay (\$15 minimum/\$150 maximum)
Generic Drug – Align Pharmacy	10% Copay (\$5 minimum/\$75 maximum)
Preferred Drug	30% Copay (\$30 minimum/\$150 maximum)
Non-Preferred Drug	40% Copay (\$50 minimum/\$150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
<b>Align Retail Pharmacy: 90-day supply</b>	
Generic Drug	20% Copay (\$25 minimum/\$275 maximum)
Preferred Drug	30% Copay (\$75 minimum/\$275 maximum)
Non-Preferred Drug	40% Copay (\$150 minimum/\$275 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

**NOTE:** *Diabetic supplies must be purchased through Edgepark Medical Supplies after a one month supply at the pharmacy.*

#### **Dispense as Written**

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

#### **Specialty Pharmacy Program**

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Manager.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator.

**SUMMARY OF MATERIAL MODIFICATION  
AND  
AMENDMENT #6  
TO THE  
CITY OF FORT SMITH  
GROUP BENEFIT PLAN  
GROUP NO. 14283**

This Summary of Material Modification and Amendment describes changes to the City of Fort Smith Group Benefit Plan effective January 1, 2014. These changes are effective as of **January 1, 2016** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

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City of Fort Smith (the "Plan Sponsor") is amending the City of Fort Smith Group Benefit Plan (the "Plan") as follows:

***The Prescription Drug Schedule of Benefits – Plan 1, Prescription Drug Schedule of Benefits – Plan 2 and Prescription Drug Schedule of Benefits – Plan 3 are hereby deleted and replaced as shown in Exhibits A-C.***

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, City of Fort Smith has caused this Amendment to take effect, be attached to, and form a part of their Group Benefit Plan.

Wanda McBride      4-25-16  
Authorized Signature      Date

H.R. Coordinator  
Title

Lindsay Kaelin      4/25/16  
Witness      Date

HR Coordinator  
Title

## EXHIBIT A

### PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PLAN 1

BENEFIT DESCRIPTION	BENEFIT
<b>NOTE:</b> There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
<b>CALENDAR YEAR PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Prescription Drug Copays)	
Single	\$1,850
Family	\$3,700
<b>TOTAL OVERALL CALENDAR YEAR MAJOR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Copays, and Coinsurance - combined with major medical)	
Single	\$6,850
Family	\$13,700
BENEFIT DESCRIPTION	BENEFIT
<b>Retail Pharmacy: 30-day supply</b>	
Generic Drug	20% Copay (\$15 minimum/\$150 maximum)
Generic Drug – Align Pharmacy	10% Copay (\$10 minimum/\$75 maximum)
Preferred Drug	30% Copay (\$30 minimum/\$150 maximum)
Non-Preferred Drug	40% Copay (\$50 minimum/\$150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
<b>Align Retail Pharmacy: 90-day supply</b>	
Generic Drug	20% Copay (\$25 minimum/\$275 maximum)
Preferred Drug	30% Copay (\$75 minimum/\$275 maximum)
Non-Preferred Drug	40% Copay (\$125 minimum/\$275 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

**NOTE:** Diabetic supplies must be purchased through Edgepark Medical Supplies after a one month supply at the pharmacy.

#### **Dispense as Written**

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

#### **Specialty Pharmacy Program**

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Manager.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

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## EXHIBIT B

### PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PLAN 2

BENEFIT DESCRIPTION	BENEFIT
<b>NOTE:</b> There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
<b>CALENDAR YEAR PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Prescription Drug Copays)	
Single	\$1,850
Family	\$3,700
<b>TOTAL OVERALL CALENDAR YEAR MAJOR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Copays, and Coinsurance - combined with major medical)	
Single	\$6,850
Family	\$13,700
BENEFIT DESCRIPTION	BENEFIT
<b>Retail Pharmacy: 30-day supply</b>	
Generic Drug	20% Copay (\$15 minimum/\$150 maximum)
Generic Drug – Align Pharmacy	10% Copay (\$10 minimum/\$75 maximum)
Preferred Drug	30% Copay (\$30 minimum/\$150 maximum)
Non-Preferred Drug	40% Copay (\$50 minimum/\$150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
<b>Align Retail Pharmacy: 90-day supply</b>	
Generic Drug	20% Copay (\$25 minimum/\$275 maximum)
Preferred Drug	30% Copay (\$75 minimum/\$275 maximum)
Non-Preferred Drug	40% Copay (\$125 minimum/\$275 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

**NOTE:** Diabetic supplies must be purchased through Edgepark Medical Supplies after a one month supply at the pharmacy.

#### **Dispense as Written**

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

#### **Specialty Pharmacy Program**

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Manager.

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## EXHIBIT C

### PRESCRIPTION DRUG SCHEDULE OF BENEFITS – PLAN 3

BENEFIT DESCRIPTION	BENEFIT
<b>NOTE:</b> There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
<b>CALENDAR YEAR PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Prescription Drug Copays)	
Single	\$1,850
Family	\$3,700
<b>TOTAL OVERALL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</b> (includes Deductible, Copays, and Coinsurance - combined with major medical)	
Single	\$6,850
Family	\$13,700
BENEFIT DESCRIPTION	BENEFIT
<b>Retail Pharmacy: 30-day supply</b>	
Generic Drug	20% Copay (\$15 minimum/\$150 maximum)
Generic Drug – Align Pharmacy	10% Copay (\$10 minimum /\$75 maximum)
Preferred Drug	30% Copay (\$30 minimum/\$150 maximum)
Non-Preferred Drug	40% Copay (\$50 minimum/\$150 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)
<b>Align Retail Pharmacy: 90-day supply</b>	
Generic Drug	20% Copay (\$25 minimum/\$275 maximum)
Preferred Drug	30% Copay (\$75 minimum/\$275 maximum)
Non-Preferred Drug	40% Copay (\$125 minimum/\$275 maximum)
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	\$0 Copay (100% paid)

**NOTE:** Diabetic supplies must be purchased through Edgepark Medical Supplies after a one month supply at the pharmacy.

#### **Dispense as Written**

The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

#### **Specialty Pharmacy Program**

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Manager.

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