



"Securing Your Tomorrow Today"

DOE-2000A
STICKER 11 10 3:10

**Woods &
Grooms, Inc.**

Insurance - Third Party Administrators

March 7, 1997

2520032031774

SMM
PWBA Room N-5644
U.S. Department of Labor
200 Constitution Dr., N.W.
Washington, DC 20210

RE: Ruxer Ford Lincoln Mercury Employee Benefit Plan
Employer I.D. #35-1048138
Plan Number 502

Gentlemen:

Enclosed is a signed copy of Amendment II to the Ruxer Ford Lincoln Mercury Employee Benefit Plan Master Plan Document.

Amendment II was effective March 1, 1997 and it revised the Patoka Valley Regional Health Care Cooperative wording and changed some maximums as shown in the Schedule of Benefits.

By contract agreement, Woods & Grooms, Inc. is responsible for all Trust reports and filing requirements. Trust records are kept at this office. Please address any correspondence concerning this information to my attention at the address below.

Sincerely,

Rita Baker
Plan Supervisor
Ruxer Ford Lincoln Mercury Employee Benefit Plan

Enclosure

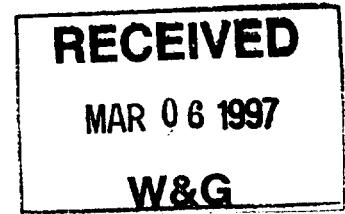
Amendment II
RUXER FORD LINCOLN MERCURY EMPLOYEE BENEFIT PLAN
MASTER PLAN DOCUMENT

Effective March 1, 1997, the Plan Sponsor/Plan Administrator of the Ruxer Ford Lincoln Mercury Employee Benefit Trust makes the following changes to Ruxer Ford Lincoln Mercury Employee Benefit Plan Master Plan Document. These changes are applicable to all eligible employees and dependents covered by the Trust

Patoka Valley Regional Health Care Cooperative (page 1) is deleted and replaced with the following:

For those employees residing within the service area of the Cooperative (see listing provided below), this employer has an agreement with the Patoka Valley Regional Health Care Cooperative (PVRHCC) and their Medical Management Department to provide the following services for covered employees and dependents who have enrolled for benefits under this Employer:

- A. Preferred Provider Program
- Credentialed providers
 - Submission of claims by Network provider
 - Fee schedule followed by Network providers
 - Patient questionnaires to determine satisfaction with the Cooperative
 - Contracted discounts with providers
 - Case Management
- B. Pre-certification of selected outpatient treatments/procedures
- Completion of all paperwork by Cooperative staff
 - Submission of all paperwork by Cooperative staff to Third Party Administrator
 - Determination of Medical appropriateness and effectiveness
 - Assistance with second medical/surgical opinions
- C. Referrals
- Provider completes referral
 - Cooperative staff process the completed physician referral letters
 - Copies of referral letter sent to physicians, patient and Plan Supervisor within one day of receipt of referral
 - Completion of referral letter the day received from the physician
 - Responsibility of the patient to inform the physician that a referral letter is needed
 - Referral letter must be received 24 hours prior to the visit
- D. Utilization Review
- Length of stay determination by Cooperative UR nurse(s)
 - Clinical reviews while patient is in the hospital
 - Retrospective reviews on selected patients
 - Clinical denials coordinated by the Cooperative nurse(s)
- E. Case Management
- Local coordination of services
 - Cost savings to employee
 - Cost savings to employer



5710 117 10 3:10

Preferred Provider Program

Your employer has joined the Patoka Valley Regional Health Care Cooperative. The Cooperative has contracted with hospitals, physicians, facilities and other health care providers to provide medical services for

covered employees and dependents. Each physician provider is credentialed by the Cooperative to insure that quality providers are selected for the Cooperative members. Each physician agrees to a pre-determined fee schedule. For covered services, you are not responsible for paying an amount above what is contracted for between the Cooperative and the Provider. You are protected from such balance billing when you utilize the Cooperative's In-Network providers. A list of the In-Network providers is available to all employees from the Human Resources department of each company.

Your provider will file the claim form for you if you use an In-Network provider. If you use an Out-of-Network provider you may be responsible for filing your claim form.

You will receive a questionnaire from the Cooperative's office to determine your satisfaction with the Cooperative. The questionnaire is optional and completely confidential.

When an employee or his covered dependents uses the services of a network provider (hospital, physician, health care professional) who is listed in the Provider Directory, then that portion of the employee cost for covered services or supplies will be processed at in-network rates unless stated otherwise in the Schedule of Benefits. Services from providers who are not network providers (Out-of-network) will be covered at out-of-network rates unless stated otherwise in the Schedule of Benefits.

Medical costs incurred by you or your covered dependents while traveling outside of the service area or attending school in an area where there are no PVRHCC providers will be reimbursed according to the referral benefit listed in the Schedule of Benefits.

If you reside outside the PVRHCC service area, refer to your individual company plan for provisions.

The service area of the Cooperative is:

Full Counties Crawford, Dubois, Martin, Orange, Perry, Pike, Spencer

Partial Counties Daviess (zip code 47501 and 47558), Gibson (zip code 47660) and Warrick (zip code 47637)

Pre-Certification

All employees residing within the Cooperative's service area and their dependents covered under this Plan are under a pre-certification program coordinated by the Cooperative's Medical Management Department. The following services, wherever performed, must be pre-certified by the Cooperative's UR nurse(s) to receive maximum plan benefits:

1. Adenoidectomy
2. Angiogram, coronary
3. Arthroscopy (all joints)
4. Breast biopsy
5. Breast reduction
6. Bunionectomy with or without hammertoe corrections
7. Coronary Artery Bypass Graft (CABG)
8. Cancer Care (chemotherapy, radiation, etc.)
9. Cardiac Catheterization (outpatient only)
10. Cardiac rehabilitation greater than six (6) weeks
11. Carpal tunnel release
12. Durable medical equipment (DME) costing more than \$200/month total (includes prosthetic devices)
13. Foot Surgeries (all)
14. Growth Hormone
15. Home Health (nurses, therapists, aides, etc.)

16. Hysterectomy, abdominal or vaginal
17. Implant of any kind exceeding \$200 (Morphine, insulin infusion, spinal cord stimulator, etc.)
18. Laminectomy/discectomy with or without fusion
19. Mammoplasty, reduction
20. Mandibular or maxillary osteotomy
21. Mastectomy, subcutaneous/prophylactic
22. MRI (any body parts) (OUTPATIENT ONLY)
23. Myelogram
24. Myringotomy with or without insertion of ventilating tubes
25. Organ transplants
26. Physical therapy
27. Pregnancy
28. Septoplasty/submucous resection with or without rhinoplasty
29. Sleep studies
30. Speech Therapy
31. TMJ therapies and surgeries
32. Tonsillectomy
33. Tympanoplasty and Tympanotomy
34. Uvuolpalatopharyngoplasty
35. Vein Stripping

NOTE: The procedures/treatments listed above are medically managed by the Cooperative. This Plan, however, may exclude from coverage some of the items listed. Please refer to Covered Medical Expenses and Medical Expense Exclusions to determine treatments/procedures covered or excluded by this plan.

Before any treatment/procedure listed above is performed, the following process must be followed:

1. For an emergency admission, procedure or treatment, the employee must call the Cooperative's UR nurse within 48 hours after the procedure/treatment is performed to receive certification for the procedure.
2. For a non-emergency procedure or treatment, the employee must call the Cooperative's UR nurse within 7-10 days before the scheduled procedure to receive certification for the procedure.
3. When you call the Cooperative's UR nurse you will need to provide the following information:
 - Employee Name
 - Employee's Social Security Number
 - Employee's Address
 - Employee's Phone Number
 - Employer
 - Patient's Name
 - Date of Hospital Admission
 - Name of Hospital
 - Location of Hospital

If the procedures for pre-certification are not followed, all covered expenses incurred for that/those procedure(s) will be subject to a separate \$250 penalty. Such penalty amount shall not count toward deductible or co-insurance maximums. The employee should always verify receipt of information related to precertifications by speaking directly to the Cooperative's UR nurse(s).

Referrals

If care cannot be received from any of the providers within the network, a network physician may refer you to an out-of-network provider. The network physician must complete the appropriate referral form and fax it or mail it to the Cooperative at least twenty-four (24) hours prior to you seeing the out-of-network doctor. You will receive in-network benefits only if the referral is received by the PVRHCC office at least one working day

before the out-of network care occurs and only for medically necessary services or treatment not available in-network unless stated otherwise in the Schedule of Benefits.

Remember, follow these steps when a referral is needed:

- A participating In-network physician must initiate the referral
- The in-network physician is responsible for sending the referral letter to the Cooperative at least twenty-four (24) hours prior to the visit to the out-of-network physician
- It is the employee's responsibility to check with the Cooperative to assure that the referral letter has been received by the physician
- The Cooperative nurse(s) will forward the approval for the referral to the TPA, the physician and to you, the employee

If these steps are not followed all out-of-network services or treatments will be reimbursed according to the out-of-network percentages shown in the Schedule of Benefits.

Utilization Review

Admissions to any hospital, wherever located, requires notification. Admission to a hospital is any confinement over eighteen (18) hours. This means you or someone representing you must notify or inform the Cooperative that you or your covered dependent have been admitted to the hospital. If you call the office after normal business hours or on the weekend you may leave the information on the Cooperative's confidential phone line message manager. The following information is needed:

- Employee name
- Employee's Social Security Number
- Employee's address
- Employee's Phone Number
- Employer
- Patient's name
- Date of hospital admission
- Name of hospital
- Location of hospital

The Cooperative will determine medical necessity for all inpatient stays based upon the information received from the hospital UR nurses.

The hospital UR nurse(s) will work directly with the Cooperative's UR nurse(s) to receive the clinical information required to determine the length of stay. Unauthorized days will be considered not medically necessary. If, in the opinion of the patient's physician, the patient remains in the hospital longer than the time certified by the Cooperative's nurse(s), the hospital UR nurse will request an extension to the length of stay. If the Cooperative determines that an extension is warranted, it will be granted. If the Cooperative does not grant an extension and the patient remains in the hospital, the Cooperative will process the length of stay as the days certified. This information will be sent to the TPA. No payment will be made by the employer or the employee for any services rendered by in-network providers on the day(s) that were deemed to be not medically necessary. The employee is not responsible to the provider for any bills that were incurred on the day(s) that were deemed not medically necessary if services were provided at an in-network facility. The employer, employee and physician have the opportunity to appeal any determination of medical necessity. If an appeal is made, the employer and the employee are not responsible for any payment of in-network services rendered on the day(s) deemed not medically necessary until a final determination is made of the day(s) in question. It is the responsibility of the employee to contact the Cooperative if any payment requests are made of the employee when a length of stay is in question.

If services obtained from an out-of network provider are considered not medically necessary, all charges incurred will be subject to a separate \$250 penalty. Such penalty amount shall not count toward deductible or co-insurance maximums.

The Cooperative sends all complete and final determinations of length of stay to the Plan Supervisor within one business day of the patient being discharged from the hospital.

Case Management

The Cooperative nurse(s) work(s) directly with the physicians and patients to coordinate catastrophic and high cost case management. The employee may receive phone calls from the Cooperative nurse(s) to assist in providing cost effective, quality care outside of the hospital environment. The Cooperative nurse(s) does/do not contact the patient while he is in the hospital. Local coordination of care coupled with participation by the company's reinsurer will benefit the employee and the employer.

The plan may elect to offer benefits for services furnished by any provider pursuant to an alternative treatment plan for a covered person whose condition would otherwise require hospital care or other intensive or long term care. Expenses which are normally not covered under this plan, but which are recommended by case management and approved by the plan sponsor and any re-insurance carrier will be reimbursable under this provision.

The plan shall provide such alternative benefits at its sole discretion and only when and for so long as it is determined that alternative services are medically necessary and cost effective, and that the total benefits paid for such services will not exceed the total benefits to which the covered person would otherwise be entitled under this plan in the absence of such alternative benefits.

If the plan elects to provide alternative benefits for a covered person in one instance, it shall not be obligated to provide the same or similarly benefits for other covered persons under this plan in another instance, nor shall it be construed as a waiver of the right to administer this plan thereafter in strict accordance with its express terms.

Reminders

- Call the Cooperative's UR nurse(s) 7-10 days before going into the hospital for a planned admission.
- Call the Cooperative's UR nurse(s) before having any of the listed treatment/procedures that require precertification.
- In an emergency, the Employee still needs to let the Cooperative's UR nurse(s) know within 48 hours that a covered person has been admitted to a hospital or has had a procedure/treatment listed on the precertification list
- The Cooperative review the patient hospital stay and determined medical necessity
- The Cooperative handles all referrals from physicians; it is ultimately the employee's responsibility to determine if the Cooperative received a referral within 24 hours of the service being rendered
- The Cooperative does not approve employee or dependent eligibility
- The Cooperative does not process claims
- The Cooperative does not determine that all charges are covered

Special Conditions Coverage under **The Schedule of Benefits** (page 10) is amended as follows:

Voluntary Second Surgical Opinion

with Patoka Provider or Non-Patoka Provider 100% no deductible

Mental Health Care and/or Substance Abuse Care

Outpatient Services

with Patoka Provider 80% after deductible
up to annual and lifetime maximums

with Non-Patoka Provider 60% after deductible
up to annual and lifetime maximums

Mental Health Care and/or Substance Abuse Care (con't)

Maximum payment per visit \$50

Calendar Year Individual maximum \$2,500

Home Health Care Expenses

with Patoka Provider 80% after deductible

with Non-Patoka Provider 60% after deductible

Maximum payment per visit \$100

Calendar Year Individual Maximum 75 visits

Chiropractic Care

with Patoka Provider 80% after deductible

with Non-Patoka Provider 60% after deductible

Calendar Year Individual Maximum \$750

Preventive Care

with Patoka Provider 80% after deductible

with Non-Patoka Provider 60% after deductible

Letter "q" under **Covered Medical Expenses** is deleted and included in the following provision under Special Conditions (page 31).

PREVENTIVE CARE - Expenses *incurred* for the following services will be reimbursed as shown in the Schedule of Benefits:

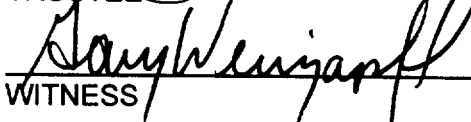
- a. routine pap smears and the office visit associated with the test, but not more than one every twelve (12) months;
- b. immunizations and flu shots and the office visit associated with the immunization or flu shot;
- c. lab work for prostate screening and the office visited associated with the test;;
- d. routine mammography examinations for asymptomatic women based on the following guidelines of the American Cancer Society:
 - 1. one baseline mammogram for women age 35 to 39;
 - 2. one mammogram for women age 40 to 49 every two years or more frequently based on the woman's physician's recommendation; and
 - 3. one mammogram every year for women age 50 and over.

This amendment is effective March 1, 1997 and it does comply with Federal Civil rights legislation involving benefits for employees and dependents.

RUXER FORD LINCOLN MERCURY


TRUSTEE

2/27/97
DATE


WITNESS