PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

CAMDENTON R-III SCHOOL DISTRICT
EMPLOYEE HEALTH CARE PLAN

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INTRODUCTION

This document is a description of Camdenton R-III School District Employee Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

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

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

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

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

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

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

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

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

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

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

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

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

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

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

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

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

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

Responsibilities for Plan Administration. Explains the responsibilities for the Plan Administrator and includes information about the Plan’s obligations with respect to Participants’ privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) and the Plan’s compliance with the HIPAA Electronic Security Standards.

SCHEDULE OF BENEFITS

Verification of Eligibility: Contact the Claims Supervisor to verify eligibility for Plan benefits **before** the charge is incurred. (Refer to General Plan Information section for contact information.)
PREADMISSION CERTIFICATION (also referred to as **PRECERTIFICATION**) means the review of all Hospital admissions prior to the admission date. This program is designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital stay is proposed. For example, based on the information provided by the Physician, the Pre-certification Nurse (contact information on the Health Care Plan ID card) will make an initial assessment of the condition to determine, among other things: if a second surgical opinion is required or recommended; if the admission is to an In-Network facility; if concurrent review by Utilization Review Coordinator is to be initiated; and if Medical Case Management is applicable.

PRECERTIFICATION REQUIREMENT: If any part of a Hospital or other Inpatient stay is not precertified per the instructions in the Cost Management Section, the benefit payment will be reduced by $200.

The Plan may not, under state or Federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean delivery. (The Hospital stay begins at the time of delivery, or admission if the delivery occurred outside the Hospital.) The attending Physician does not have to obtain precertification from the Plan; however the Covered Person is still required to precertify the Hospital stay to avoid the above precertification penalty. (Refer to the Cost Management Services Section and Medical Benefits Section for complete details.)

PREAUTHORIZATION of certain services is requested and may expedite the adjudication of the claim. (For items marked with "*" in the table, refer to the Cost Management Services Section for complete details.)

All Organ Transplant services, including evaluation, **must** be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator (Refer to General Plan Information section for contact information.) when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization.

TIMELY FILING OF CLAIMS: Claims must be filed with the Claims Supervisor within 12 months of the date charges for the service were incurred. If the Plan should terminate, all claims must be filed within 90 days of the Plan's termination date. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined. (Refer to the section entitled "How to Submit a Claim".)

MEDICAL BENEFITS

To be considered a Covered Charge under this Plan, treatment, services and/or supplies must meet all of the following criteria:

(1) Medically Necessary;
(2) Ordered by an appropriate Physician;
(3) Not excluded under the Plan; and
(4) Meets the standards of care for the diagnosis.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the above. Charges will be allowed at the Usual and Customary Allowance, contracted rate, negotiated rate or billed amount, whichever is less unless specifically stated elsewhere in this Plan. Notwithstanding these allowances, all charges from all providers will be subject to a review for Reasonable allowance.

The meanings of these capitalized terms are in the Defined Terms section of this document.

The Plan is a plan which contains multiple Participating Provider Organizations.

PPO names: HealthLink, Freedom Network Select and PHCS
Telephones: (800) 624-2356
Web sites: www.HealthLink.com

PPO name: A national wrap network is available. A separate ID card is provided to the Employee for this network access. Must meet one of the exceptions listed on the next page to be considered at the "Participating Providers" benefit level.

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

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will better benefits from the Plan than when a Non-Participating Provider is used. It is the Covered Person's choice as to which Provider to use.

Additional information about this network is available at the Human Resources office. A list of Participating Providers is available by calling the PPO at the above phone number or searching for a provider on the PPO's web site. The phone number and web site are also listed on your ID card. In order to obtain benefits at the higher level, it is the Covered Person's responsibility to make sure the provider is participating in the network prior to seeking services. Call the PPO to verify the current status of the provider before each visit.

The Claims Supervisor may also contract directly with certain Hospitals and Physicians. These providers will be considered Participating Providers.

Services, as used in this Plan document, means a recognized or standard medical service; it does not mean a specific technique, procedure, or equipment. For example, hip replacement surgery would be considered a recognized or standard medical service; however, the specific technique used by the Physician, e.g., the manner of performing the surgery, is not considered as a service such as to qualify the Covered Person for an exception to the Non-network reimbursement percentage.

Under the following circumstances, the higher "Participating Providers" benefit will be applied for certain Non-Participating Provider services:

SERVICES OUTSIDE THE NETWORK AREA: *(Recommend utilizing the wrap network.)*

If a Covered Person is outside the PPO network area and requires services Incidental in nature. A referral is not required.

If the Covered Person resides outside the network area. A referral is not required.

SERVICES WITHIN OR OUTSIDE THE NETWORK AREA:

If a Covered Person is seeking services by a Non-Participating Provider when the services are available in the network area by a Participating Provider. Prior to seeking services, the Participating Provider in that specialty must submit a referral to the Utilization Review Coordinator to determine if the services will be considered under the Participating Provider benefit and the time period for which the services will be approved under this exception.

If a Covered Person has no choice of Participating Providers in the specialty required to treat the Illness or Injury within the PPO network area. Verification of the availability, or lack thereof, of a Participating Provider must be submitted to the Utilization Review Coordinator by the Covered Person or the Physician to review for authorization of payment at the Participating Provider benefit level prior to seeking services.

If a Covered Person has an Emergency Medical Condition (on an Inpatient or Outpatient basis) evidenced by acute symptoms of sufficient severity so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy or seriously impair bodily functions, bodily organs or parts. This applies to ambulance transport, facility and Physician charges. For an Inpatient admission, in order to continue to receive the higher benefit once the Covered Person's condition has been stabilized following admission to a Non-Participating facility, the Covered Person must be transferred to a Participating facility.

If a Covered Person is admitted to a Participating Provider facility on an Inpatient or Outpatient basis and receives Physician, diagnostic or anesthesia services by a Non-Participating Provider when a Participating Provider in that specialty is not available .

If a Covered Person has a specimen for a lab test drawn or an x-ray taken by a Participating Provider but a Non-Participating Provider performs the lab test or reads the x-ray.

If a Covered Person receives treatment, services or supplies by a Non-Participating Provider and the charges for the services were negotiated and/or approved by the Utilization Review Coordinator. (Refer to General Plan Information section for contact information. (Precertification is not an approval of the services or a guarantee of payment for the services.) *However, charges for services with discounts accessed through a repricing network in absence of any other exception listed above will be considered at the Non-Participating Provider benefit level.*

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that the Covered Person must pay once a Calendar Year before the Plan pays on any incurred Covered Charges. Beginning in January of each year, the deductible must again be met before Plan benefits are paid.However, Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year. Some services may have the deductible waived. Refer to the Schedule of Benefits for details.

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

MEDICAL BENEFITS SCHEDULE

(Refer to Medical Benefits Section for further details on each item listed. Refer to the Cost Management Services Section for preauthorization on items marked with "*".)

	OPEN ACCESS PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Note: The maximums listed below are the total for Open Access, Participating and Non-Participating Provider expenses. For example, if a maximum of 60 days is listed three times under a service (once in each column), the Calendar Year maximum is 60 days total which may be used for any combination of providers.			
***DEDUCTIBLE*, PER CALENDAR YEAR**			
Per Covered Person	$1,500	$1,500	$5,000
Per Family Unit	$4,500	$4,500	$15,000
The Calendar Year deductible is waived for the following Covered Charges: - Preventive Care- as listed - Allergy serum & injections in a network Physician's office			
COPAYMENTS			
Telemedicine visit:	$15; only services through (855) 717-6800		
Primary Care Physician's & urgent care office visits:	$30		N/A
Specialist's office visit:	$40		N/A
Note: The copayment only applies to the office visit charge, urgent care physician office visit charge and after hours visit charge. Regular Plan benefits apply to other charges. The copayment does not apply to preventive care services. Primary Care Physicians are general practitioners, family medicine, gynecologists, pediatricians and internists when providing general health services.			
Prescriptions @ Pharmacy	Refer to Prescription Benefits.		
MAXIMUM *COINSURANCE AND COPAY (MEDICAL and PRESCRIPTION)* AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$4,850	$4,850	$5,000
Per Family Unit	$8,200	$8,200	$15,000
MAXIMUM *OVERALL OUT-OF-POCKET* AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$6,350	$6,350	$10,000
Per Family Unit	$12,700	$12,700	$30,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.			
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Cost containment penalties Amounts in excess of Usual and Customary Charge Charges excluded as ineligible			
Note: The maximum amounts an individual can contribute to the in-network deductible and coinsurance family maximums are amounts up to the in-network "Per Covered Person" maximums. Therefore, if the individual has out-of-network services, only the amount up to the in-network maximum will be counted toward reaching the family's in-network maximum.			
COVERED CHARGES			
Ambulance Service			
Emergent	80% after deductible	70% after deductible	50% after deductible
Eligible non-emergent	80% after deductible	70% after deductible	50% after deductible
***Applied Behavior Analysis for Autism Spectrum Disorders**	80% after deductible	70% after deductible $40,000 Calendar Year maximum	50% after deductible
Note: This benefit is for Dependent Children up to age 19. Refer to the Medical Benefit section for further details of this benefit.			
Contact lenses or glasses (following eye surgery)	80% after deductible	70% after deductible $300 maximum per surgery	50% after deductible
Note: When required following eye surgery, except surgeries to correct refractive disorders. Refer to the Medical Benefit section for further details of this benefit.			
Diagnostic Testing (X-rays & Labs, including Pre-Admission Testing)	80% after deductible	70% after deductible	50% after deductible
Note: Includes mammograms and colonoscopies required for the treatment of an Illness. Refer to Preventive Care benefits for coverage of diagnostic tests when there is a family history of an Illness.			
***Durable Medical Equipment**	80% after deductible	70% after deductible	50% after deductible
Emergency Room Visit			
Medical Emergency	80% after deductible	70% after deductible	50% after deductible
Medical Non-Emergency Care	80% after deductible	70% after deductible	50% after deductible

	OPEN ACCESS PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
***Home Health Care**	80% after deductible	70% after deductible	50% after deductible
	100 visits Calendar Year maximum		
Hospice Care	80% after deductible	70% after deductible	50% after deductible
Bereavement Counseling	80% after deductible	70% after deductible	50% after deductible
Hospital Services			
Room and Board	80% after deductible the semiprivate room rate	70% after deductible the semiprivate room rate	50% after deductible the semiprivate room rate
Intensive Care Unit	80% after deductible Hospital's ICU Charge	70% after deductible Hospital's ICU Charge	50% after deductible Hospital's ICU Charge
Well Newborn Nursery & Physician Care (initial Hospital confinement)	80% after deductible	70% after deductible	50% after deductible
Other Outpatient Services not listed herein	80% after deductible	70% after deductible	50% after deductible
Jaw Joint/TMJ	80% after deductible	70% after deductible	50% after deductible
	$1,000 orthodontic appliances Lifetime maximum		
Note: Orthodontic treatment is limited to the maximum listed above. Surgical treatment is covered up to the Plan Lifetime maximum.			
Mental Disorders			
Inpatient	80% after deductible	70% after deductible	50% after deductible
Outpatient	80% after deductible	70% after deductible	50% after deductible
Physician office visit and Counseling visit charge:	100% after Specialist copayment	100% after Specialist copayment	50% after deductible
***Organ Transplants**	Designated Transplant Facility: 80% after deductible		Non-Designated Transplant Facility: 50% after deductible
Note: Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational". All Organ Transplant services, including evaluation, must be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization. Non-authorized services rendered by a non-designated transplant facility will be excluded by this Plan.			
***Orthotics**	80% after deductible	70% after deductible	50% after deductible
***Outpatient Private Duty Nursing**	80% after deductible	70% after deductible	50% after deductible
Physician Services			
Inpatient visits	80% after deductible	70% after deductible	50% after deductible
Office & urgent care visits	100% after copayment on the office/ urgent care visit & after hours charge.	100% after copayment on the office/ urgent care visit & after hours charge.	50% after deductible
Specialist office visits	100% after copayment on the office visit charge.	100% after copayment on the office visit charge.	50% after deductible
Surgery	80% after deductible	70% after deductible	50% after deductible
Allergy testing	80% after deductible	70% after deductible	50% after deductible
Allergy serum and injections	80%, deductible waived	70%, deductible waived	50% after deductible
All other non-listed charges	80% after deductible	70% after deductible	50% after deductible
Pregnancy	80% after deductible	70% after deductible	50% after deductible
Note: Dependent daughters not covered. Two ultrasounds will be considered eligible expenses for a routine Pregnancy for the following: to determine gestational age and for routine screening.			
Prescription Drugs (Inpatient, Outpatient & Physician's office)	80% after deductible	70% after deductible	50% after deductible
Note: Any ***Specialty Drug*** billed by a provider when available through the Participating Pharmacy will be covered at 70% after deductible. However, the Covered Person will remain responsible for 20% even after the maximum coinsurance amount has been met for the Calendar year. To avoid this penalty, fill the Specialty Drug through a Participating Pharmacy. Refer to Prescription Drug Benefits following this Schedule. Contact the PBM at the number on your ID card.			

	OPEN ACCESS PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Preventive Care (ACA AND NON-ACA SERVICES)			
Routine Well Adult Care	100%, deductible waived.	100%, deductible waived.	50% after deductible
Benefit restricted to services performed in conjunction with preventive services such as routine physical examination. Benefit also includes services currently recommended by the United States Preventive Services Task Force categories A and B, such as certain laboratory tests and cancer screenings. A current listing of required preventive care can be accessed at www.HealthCare.gov/center/regulations/ prevention.html. Revised recommendations by the Task Force will be made applicable to the Plan when required by law.			
Additional preventive care services for women are covered with no cost-sharing when rendered by Participating Providers/Pharmacies. View a current listing of required preventive services at http://www.hrsa.gov/womensguidelines/. Contact the Pharmacy Benefit Manager at the phone number on your health care plan ID card for specific information about medications which qualify for this benefit.			
Check with your local Health Department to see if immunizations are available free of charge.			
Frequency limits for mammogram Ages 35 through 39 ..... single Baseline mammogram Ages 40 and over ..... annually			
Routine Well Child Care	100%, deductible waived.	100%, deductible waived.	50% after deductible
Benefit restricted to services performed in conjunction with preventive services such as routine physical examination. Benefit also includes services currently recommended by the Health Resources and Services Administration (HRSA) for Infants, Children, and Adolescents. Revised recommendations by the HRSA will be made applicable to the Plan when required by law.			
Benefit restricted to services recommended by the Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention or as required by other federal or Missouri state law.			
Check with your local Health Department to see if immunizations are available free of charge.			
***Prosthetics**	80% after deductible	70% after deductible	50% after deductible
Second Surgical Opinion, Voluntary	80% after deductible	70% after deductible	50% after deductible
	Refer to Cost Management Services section for further information.		
***Skilled Nursing Facility**	80% after deductible	70% after deductible	50% after deductible
	The facility's semiprivate room rate; Within 14 days of a 3 day stay; 60 days Calendar Year maximum		
Spinal Manipulation/ Chiropractic Services	80%after deductible	70%after deductible	50% after deductible
	26 visits allowed per Calendar Year with a maximum allowed of $45 per visit		
Note: All services rendered by a chiropractor are subject to these maximums.			
Substance Abuse			
Inpatient	80% after deductible	70% after deductible	50% after deductible
Outpatient	80% after deductible	70% after deductible	50% after deductible
Physician office visit and Counseling visit charge:	100% after Specialist copayment	100% after Specialist copayment	50% after deductible
Replacement of **teeth** removed for the medical management of a hazardous medical condition	80% after deductible	60% after deductible	50% after deductible
	$1,500 Lifetime maximum		
Therapies			
***Cardiac**	80% after deductible	70% after deductible	50% after deductible
***Occupational**	80% after deductible	70% after deductible	50% after deductible
***Physical**	80% after deductible	70% after deductible	50% after deductible
***Pulmonary**	80% after deductible	70% after deductible	50% after deductible
***Speech**	80% after deductible	70% after deductible	50% after deductible
Vision	80% after deductible	70% after deductible	50% after deductible
Weight Management	80% after deductible	70% after deductible	50% after deductible
Wigs	80% after deductible	70% after deductible	50% after deductible
	One wig Lifetime maximum		
Note: Refer to Medical Benefits section for coverage criteria.			
All other Covered Charges not excluded or limited in this Plan Document:	80% after deductible	70% after deductible	50% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT		
	PARTICIPATING	**NON-PARTICIPATING**
Prescription Drug Deductible, per Calendar Year		
Per Covered Person	$50	$50
Retail Prescriptions- (Per 30-day supply)		
Generic Drugs	$10 copayment	See below.
Formulary Brand Name Drugs	$30 copayment then 20% of the balance	See below.
Non-Formulary Brand Name Drugs	$50 copayment then 20% of the balance	See below.
Specialty Drugs	10% copayment; Person responsible for a total out-of-pocket of $1,500 per Calendar Year then Plan pays 100%.	See below.
Note: **Specialty Drugs** treat multi-faceted chronic diseases. They typically require unique clinical, administration, distribution and handling requirements. They are more expensive than traditional prescriptions and there are limited generics and biosimilars available. Biosimilars are a potential future opportunity that will provide therapeutic options for already approved specialty brand drugs at potentially lower costs. A list of these drugs is available by contacting the Claims Supervisor or Pharmacy Benefit Manager as stated on your health plan ID card. Only available through network specialty pharmacy or retail location.		
Participating MedTrak 90 Pharmacy Option- (Per 90-day supply)		
Generic Drugs	$20 copayment	Not Applicable
Formulary Brand Name Drugs	$60 copayment	Not Applicable
Non-Formulary Brand Name Drugs	$100 copayment	Not Applicable
Prior authorization is required for any prescription over $1,000 (30-day) or $2,000 (90-day).		
Generic Incentive: Covered Expenses will be limited to the cost of a Generic drug if a Generic drug is available. However, the brand name drug will be considered a covered expense if a Generic drug is not available, or if the Physician writes "DAW" (dispense as written) on the prescription. If not, then in addition to the copayment, the Covered Person must pay the difference between the cost of the Generic drug and the Brand Name drug.		
Filing receipts when PBM card is not used at Participating Pharmacy or when prescription is filled at a Non-Participating Pharmacy: If this is your primary plan and if the Prescription Drug is not processed through this Plan's Pharmacy Benefit Manager (PBM), the Covered Person must submit the receipt along with the PBM's claim form. If the Pharmacy charges less than the Pharmacy's discount price through the PBM, purchase the prescription without the card and submit the receipt with the claim form to the PBM and state the situation on the form. The claim will be repriced according to the Plan's network discount with the pharmacy. A reimbursement check will be sent to the Employee for any amount above the copayment listed above less any services charges. The difference between the allowed amount and the billed amount will be the Covered Peron's responsibility. Some exceptions to the network allowance may be made for extenuating circumstances. Typically, a pharmacy can refile a claim in 14 days if a problem existed in filing the claim electronically. The PBM's help desk is available to assist with rejected claims. *If this is your secondary plan,* submit your receipt and/or explanation of benefits from your primary plan to Med-Pay. The coordination of benefits provision applies and benefits are payable under the medical benefits of this Plan. The billed amount will be the amount listed on the receipt (total amount allowed or copayment, if total allowed is not listed). The Med-Pay claim form may be obtained from www.med-pay.com. Search the PBM's web site to obtain a prescription claim form.		
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.		

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

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

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage once he or she satisfies all of the following (refer to the EFFECTIVE DATE section):

(1) New Employee

(a) Non-variable Hour Employee

(i) is a Full-time, Active Employee of the Employer (has begun working for the Employer). An Employee is considered to be Full-time if he or she works at least 30 Hours of Service per week and is on the regular payroll of the Employer for that work.

(ii) is in a class eligible for coverage.

(iii) completes the employment Waiting Period of 45 days for "classified" Employees and until the first of the month after date of hire for "certified" Employees as an Active Employee. A "Waiting Period" is the time beginning on the first day of employment as an Active Employee eligible for coverage and ends at midnight on the 45th day (classified) or last day of the month (certified) (as long as remaining eligible). For example, an Active Employee who has met all eligibility requirements will have coverage beginning on the 46th day (classified) of first of the following calendar month (certified).

(b) Variable Hour Employee, Part-time Employee or Seasonal Employee

(i) based on Hours of Service during the Initial Measurement Period, has been determined, during the New Employee Administrative Period to be a Full-time Employee of the Employer. An Employee is considered to be Full-time if he or she averaged 30 or more Hours of Service per week (130 Hours of Service or more in a month) during the Initial Measurement Period.

(ii) is in a class eligible for coverage.

(c) Variable Hour Employee, Part-time Employee or Seasonal Employee experiencing a change in employment status to Full-time

(i) is in a class eligible for coverage.

(ii) completes the employment Waiting Period of 45 days for "classified" Employees and until the first of the month after date of hire for "certified" Employees as an Active Employee. A "Waiting Period" is the time beginning on the first day of employment as an Active Employee eligible for coverage and ends at midnight on the 45th day (classified) or last day of the month (certified) (as long as remaining eligible). For example, an Active Employee who has met all eligibility requirements will have coverage beginning on the 46th day (classified) of first of the following calendar month (certified). If earlier, coverage will be effective the 1st day of the New Employee Stability Period, if the Employee averaged 30 Hours of Service or more per week (130 Hours of Service or more in a Month) during the Initial Measurement Period.

(2) Ongoing Employee

(a) based on Hours of Service during the Standard Measurement Period, has been determined, during the Ongoing Employee Administrative Period to be a Full-time Employee of the Employer. An Employee is considered to be Full-time if he or she averaged 30 or more Hours of Services per week (130 Hours of Service or more in a month) during the Standard Measurement Period.

(b) is in a class eligible for coverage.

(3) Ongoing Employee experiencing a change in employment status from non-Full-time to Full-time Employee during the Ongoing Employee Stability Period

(a) is a Full-Time, Active Employee of the Employer (has begun working for the

Employer). An Employee is considered to be Full-time if he or she works at least 30 Hours of Service per week and is on the regular payroll of the Employer for that work.

(b) is in a class eligible for coverage.

(c) completes the employment Waiting Period of 45 days for "classified" Employees and until the first of the month after date of hire for "certified" Employees as an Active Employee. A "Waiting Period" is the time beginning on the first day of employment as an Active Employee eligible for coverage and ends at midnight on the 45th day (classified) or last day of the month (certified) (as long as remaining eligible). For example, an Active Employee who has met all eligibility requirements will have coverage beginning on the 46th day (classified) of first of the following calendar month (certified). If earlier, coverage will be effective the 1st day of the New Employee Stability Period, if the Employee averaged 30 Hours of Service or more per week (130 Hours of Service or more in a Month) during the Initial Measurement Period.

(4) Retired Employee of the Employer and Surviving Spouses of Retired Employees who are eligible for and receiving a retirement pension from the Employer's public retirement plan and who have maintained continuous coverage under the Employer's Group Medical Insurance Plan immediately prior to retirement. A Retired Employee must have been an Active Employee (as defined by this Plan) and have elected to pay for the continuation of that coverage (either single or dependent) which was in effect at the time of his/her retirement. Retirees shall have one year from the date of retirement to elect Retiree coverage for themselves, spouses and unmarried eligible Dependent children. If coverage is not elected during that one-year period, the Employer has no obligation under state law to make health care coverage available to these persons following that period.

Capitalized terms used above that are not included in the Defined Terms section of the Plan Document can be found in the Plan's Eligibility Appendix. If you wish to review a copy of the Appendix, please contact the Plan Administrator.

Note: Coverage under this Plan is available to Employees age sixty-five (65) and over and to spouses age sixty-five (65) and over of Employees under the same conditions as coverage is available to Employees and their spouses under age sixty-five (65). Nonetheless, Employees over age sixty-five (65) are entitled to select primary coverage under Medicare. To do so, they must decline all coverage under this Plan.

The Employee or spouse must apply for Medicare coverage at their local Social Security office before submitting claims for Medicare benefits. Contact the local Social Security office with any questions about enrollment or eligibility.

If coverage under the Plan lapses because the Employee or spouse elects to decline coverage after reaching age sixty-five (65), they may become covered again only by filling out a request for reinstatement with the Plan Administrator. For dependents, the Employee must successfully re-enroll as well. All other Plan provisions will apply, e.g., open enrollment).

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

(1) A covered Employee/Retiree's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married and shall only include a common law marriage if recognized in the state where the covered Employee lives. The person is no longer considered an eligible Spouse if a Legal Separation or Divorce occurs.

The Plan Administrator may require documentation proving a legal marital relationship. Proof of marriage is established by one of the following:

(a) a copy or abstract of the public record of marriage, or a copy of the church record of marriage, containing sufficient data to identify the parties, the date and place of marriage;

(b) an affidavit of the clergyman or magistrate who officiated; or

(c) an original certificate of marriage, if the Plan Administrator is satisfied it is genuine and free from alteration.

(2) A covered Employee's Child(ren).

An Employee's "Child" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children may also be included as long as a natural parent remains married to the Employee. Any child of an Employee or spouse who enrolled in this Plan as required in a divorce decree or qualified medical child support order (QMCSO) will be eligible as long as they otherwise meet the criteria for a Dependent Child. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents. The child will retain eligibility the same as any other Dependent child (up to the same age limits).

For Coordination of Benefits purposes, the following must be provided to the Claims Supervisor: Custody, guardianship and adoption must be established by valid court order or decree entered after the petition for same has been filed. Custodial parent is the parent awarded physical custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced. (Coverage for expenses incurred after the date of placement shall include the necessary care and treatment of medical conditions existing prior to the date of placement.) Coverage will not continue beyond 31 days of placement unless written application and any required Employee contribution has been paid before that 31st day. The child's coverage will continue subject to any required contributions until the earlier of: (a) the day the child is removed from the Employee's physical custody prior to legal adoption; or (b) the day the coverage would otherwise end in accordance with the Plan provisions.

Any child of an Employee who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan as of the date of the request on the QMCSO. The Employee may elect coverage if not already covered under this Plan. (Refer to the Special Enrollment section.)

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the child must be a qualifying dependent of the Employee. The Plan Administrator may require documentation proving dependency. Proof that a child is your dependent is established by one (1) of the following types of evidence:

(a) For a natural child born to married parents, a copy of the public record of birth showing the Employee was named as parent of the child. For a natural child born to unmarried parents, a copy of the public record of birth showing the Employee was named as parent of the child, as well as any other documentation that the Plan Sponsor may require, including but not limited to DNA testing;

(b) For an adopted child or a child Legally Placed for Adoption, except in jurisdictions where petition must be made to the court for release of adoption documents or information, or where release of such documents or information is prohibited, evidence of relationship will include a copy of the decree of adoption or as copy of the adoptive placement agreement and such other evidence as may be necessary. In jurisdictions where petition must be made to the court for release of adoption documents or information, or where release of such documents or information is

prohibited, a copy of the child's revised birth certificate will be accepted to establish the fact of adoption;

(c) For a step-child, evidence of relationship of a step-child will consist of proof of birth as required for a natural child plus proof of marriage of the Employee to the natural parent of the child;

(d) For Legal Guardianship, a copy of the public record showing the Employee and/or spouse was named as Legal Guardian of the child.

In the event there is a change in status of any Employee's Dependent covered under the Plan following the initial eligibility determination, the Employee must inform the Plan Administrator of the change in status and provide documentation to the Plan Administrator that substantiates such a change in status. In the event of death or divorce, a copy of the death certificate or divorce decree will be required. In the event of adoption or placement for adoption, or acquisition of a step-child, documentation described above for each such situation will be required.

(3) A covered Dependent child, who prior to reaching the limiting age, is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. A Dependent child who becomes Totally Disabled after reaching the limiting age is not eligible to be enrolled on this Plan. A new Employee will not be able to enroll a Dependent child who is over the limiting age and is Totally Disabled. A terminated Employee who is rehired is considered a new Employee for the purposes of this provision. The Plan Administrator may require, at reasonable intervals continuing proof of the Total Disability and dependency.

These persons are excluded as Dependents: other individuals living in the covered Employee'sor Retiree's home, but who are not eligible as defined; the Legally Separated or divorced former Spouse of the Employeeor Retiree; or Foster Children. (Refer to Continuation of Coverage Rights under COBRA section.)

If a Dependent Child of an Employee is under the age of 26 and is also a Full-Time Employee, the Dependent Child may choose to be covered either as an Employee or as a Dependent of the parent (mother, father, step-parent, guardian, etc.) who is an Employee, but not both.

No person, whether Employee or Dependent, can be enrolled in this Plan with both primary and secondary (or subsequent) coverage.

In the case of Employees married to one another without Dependents, the Employees will be covered as separate Employees.

In the case of Employees married to one another with Dependents, one of the Employees must be covered as a Dependent of the other Employee along with the Dependent Children.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums depending upon the coverages elected and which Covered Persons elect those coverages.

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

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

FUNDING

Cost of the Plan. Camdenton R-III School District pays the entire cost of Employee coverage under this Plan. The Employee pays the entire cost of Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and Employee, if any, and reserves the right to change the level of Employee contributions.

Notwithstanding any other provision of the Plan, the Employer's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraphs. Payment of said claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payment.

In the event that the Employer terminates this Plan, then as of the termination date, the Employer and Employees shall have no further obligation to make additional contributions to the Plan.

ELECTION TO DECLINE COVERAGE

This is an advisory statement for those individuals who decline coverage explaining the impact of that decision and the "special events" circumstances that would offer him/her "Special Enrollment Periods" in the future.

If you are declining enrollment for yourself or your dependent(s), which includes your spouse, because of other health insurance coverage (including, but not limited to, Medicare, Medicaid, COBRA, group health plans and some individual policies), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition to the above, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or Legal Guardianship, you may be able to enroll yourself or your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption or Legal Guardianship. If you apply for coverage other than at the above mentioned situations, you will be subject to the Late Enrollment provisions of the Plan.

IF YOU DECLINE COVERAGE UNDER THIS HEALTH PLAN AND DO NOT DIVULGE TO THE PLAN THAT THIS REASON IS DUE TO OTHER HEALTH INSURANCE COVERAGE, AND SUBSEQUENTLY HAVE A HEALTH COVERAGE CHANGE (SEE SPECIAL ENROLLMENT DEFINITIONS), SPECIAL ENROLLMENT PERIODS THAT MIGHT OTHERWISE HAVE BEEN AVAILABLE TO YOU DUE TO THAT HEALTH COVERAGE CHANGE WOULD NOT APPLY. AS A RESULT, YOU AND/OR YOUR DEPENDENT(S) WILL BE SUBJECT TO THE LATE ENROLLEE/ENROLLMENT PROVISIONS OF THE PLAN.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children.

If the Active Employee has Dependent coverage, and the premium for the coverage is unchanged by adding the newborn, the newborn will be automatically enrolled in the Plan from the moment of birth. An enrollment form should be filed with the Plan Administrator as soon as possible to ensure that accurate information on the newborn is available for adjudication of claims.

If the Active Employee is the mother of the newborn and she does not have Dependent coverage and the premium for the coverage is changed by adding the newborn, the newborn will automatically be covered from the moment of birth through the 31st day following birth. To continue coverage beyond the first 31 days, an enrollment form must be filed with the Plan Administrator before the end of the 31-day period and any premiums due must be paid. If the enrollment form is picked up within the 31-day period, the Employee has 10 additional days to return the form to the Plan Administrator.

If the Active Employee is the father of the newborn and he does not have Dependent coverage and the premium for the coverage is changed by adding the newborn, the newborn will only be covered from the moment of birth if the enrollment form is filed with the Plan Administrator and any premiums due are paid within 31 days of the child's birth. If the enrollment form is picked up within the 31-day period, the Employee has 10 additional days to return the form to the Plan Administrator.

Such coverage for a newborn includes: routine nursery care or the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or complications resulting from prematurity. (Refer to Hospital Services and Physician Services in the Schedule of Benefits).

Charges for covered Well Newborn Nursery Care will be applied toward the Plan of the newborn child.

Charges for covered Well Newborn Physician Care will be applied toward the Plan of the newborn child.

TIMELY AND LATE ENROLLMENT

Note: All enrollments and disenrollments must follow Cafeteria Plan guidelines.

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

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

(2) **Late Enrollment (Open Enrollment)** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Every May and June, the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan. Benefit choices for Late Enrollees made during the open enrollment period will become effective July 1st. Plan Participants will receive detailed information regarding open enrollment from their Employer.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator. (Refer to General Plan Information section for contact information.)

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to any of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of Legal Separation, divorce, death, termination of employment or reduction in the number of hours of employment) or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received, unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received, unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons.

(2) For purposes of these rules, a loss of eligibility occurs if:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g., part-time employees).

(d) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(e) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(f) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) **Dependent beneficiaries.** If the Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and:

(a) A person(s) becomes a Dependent of the Employee through marriage, then the new Dependent(s) (Spouse and step-children) and if not otherwise enrolled, the Employee may be enrolled under this Plan as a Covered Person; or

(b) A person becomes a Dependent of the Employee through birth, Legal Guardianship, Qualified Medical Child Support Order (QMCSO), adoption or placement for adoption, then the new Dependents may be enrolled under this Plan as a covered Dependent of the covered Employee. The Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

Eligible Dependents other than those described in (a) or (b) who were not enrolled when first eligible are not eligible to enroll during this Special Enrollment event. They may enroll as Late Enrollees, if allowed by the Plan.

If the Employee is not enrolled in the Plan, he or she may enroll as a Special Enrollee as a result of the Special Enrollment events listed in (a) and (b) above. The newly eligible Dependents may not enroll if the Employee does not elect coverage.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption or Legal Guardianship or the commencement of the school term. To be eligible for this Special Enrollment Period, the Employee must request enrollment of the Plan Administrator during this period. Otherwise, the person is considered a Late Enrollee and will be subject to the Late Enrollment provisions under this Plan. The exception may be the enrollment of newborns. Refer to the Enrollment Requirements of Newborn Children in this Enrollment section.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective no later than the following unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons:

(a) in the case of marriage, no later than the first day of the first month beginning after the date the completed request for enrollment is received (e.g., marriage occurred on January 10. If enrollment form is received January 10-31, the effective date will be no later than February 1. If enrollment form is received February 1-9, the effective date will be no later than March 1.);

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption or Legal Guardianship, the date of the adoption or placement for adoption or Legal Guardianship.

(4) Effective April 1, 2009, under the Children's Health Insurance Program Reauthorization Act of 2009 (“CHIP”): Eligible employees and dependents incur a Special Enrollment event with the opportunity to enroll in the Plan under either of the following conditions: a) when the Employee's or dependent's Medicaid or CHIP coverage terminates as a result of loss of eligibility under those programs; or b) upon obtaining eligibility for a state premium assistance subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request coverage under this Plan within 60 days of the date of termination or the date the Employee or dependent is determined eligible for the premium assistance. The Employee must be enrolled in the Plan in order for his/her dependent(s) to be enrolled. Proper documentation of loss of other coverage and the subsidy being applied must be provided along with the enrollment form if the application is to be accepted.

EFFECTIVE DATE

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

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Effective Date of Retiree Coverage. Coverage for eligible Retirees shall become effective on the retirement date if the request for coverage is received by the Plan Administrator within 31 days following the date Active Employee coverage ends. If the request for coverage is received by the Plan Administrator within the first year following the retirement date, retiree coverage will become effective the

first of the month following the date the request is received. If the request for coverage is received by the Plan Administrator after the first year following the retirement date, the Plan has no obligation under state law to make health care coverage available to the individual.

Active Employee Requirement.

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

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

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a notice that will show the coverage period under this Plan.

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

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

(1) The date the Plan is terminated.

(2) The date the covered Employee’s Eligible Class is eliminated.

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

(4) The last day of the calendar month in which the Employee elects to terminate coverage. (Voluntary termination may or may not be allowed in certain situations according to State and Federal law.)

(5) If an Employee/Retiree commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee/Retiree and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(6) The end of the period for which the Employer and/or the Employee/Retiree made any required contribution for the coverage if the full premium for the next period is not paid when due. If an Employee/Retiree no longer satisfies the eligibility requirements under the Plan and fails to elect COBRA within the appropriate time period, coverage will be retroactively terminated to the date as stated in the applicable item above. If the Employer or Plan is notified during the COBRA election period, the difference in premium can be paid in order to continue coverage.

When Retiree Coverage Terminates. The date the Retiree elects to terminate coverage. Once Retiree coverage is terminated, it cannot be reinstated.

If a Retiree terminates coverage due to eligibility for Medicare coverage due to age or coverage terminates due to the Retiree's death, coverage of the Spouse and Dependent Child will continue as follows:

(1) Covered (Surviving) Spouse will remain eligible under this Plan until he/she reaches Medicare eligibility due to age.

(2) Covered Dependent Child who is Totally Disabled will remain eligible under this Plan until he/she reaches Medicare eligibility due to age or is deemed no longer to be Totally Disabled.

Continuation During Periods of Employer-Certified Leave of Absence. A person may remain eligible for a limited time if Active, full-time work ceases due to leave of absence. The Employer will notify the Employee of any applicable increase in premium contributions. This continuance will end as defined in the employee handbook. Regardless of these established leave policies, the Employer meets the requirements of the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor. This continuance will end as follows:

For FMLA and other Board-approved leave of absence: The Board will continue to pay the Employee's premium (same rate as when active) during the FMLA leave. If the Employee does not return to work at the end of the leave, COBRA may be elected. For non-FMLA leave, COBRA may be elected beginning with the first day of non-active employment. (See the COBRA Continuation Options.)

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

If coverage terminates under this Plan during the FMLA leave, at the request of the Employee, coverage will be reinstated if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. If a terminated Employee experiences a period without any Hours of Service and resumes Hours of Service and:

(1) if the Employee is rehired following a Break in Service (as defined in the Plan's Eligibility Appendix), the Employee will be treated as a New Employee and be required to satisfy all eligibility and enrollment requirements under the Plan as stated in the "Eligibility Requirements for Employee Coverage" section.

(2) if the Employee is rehired without experiencing a Break in Service, the Employee will be treated as a Continuous Employee and is eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with no Hours of Service. Such coverage will be effective the first day of the month following the date Hours of Service resumes.

(3) if the Employee was continuously covered as a COBRA participant of this Plan, a new employment waiting period does not have to be satisfied and coverage will change to Active Employee status as of the first of the month following the date Hours of Service resumes.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

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

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

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

(4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The date the Employee requests that a Dependent's coverage be terminated (Voluntary termination may or may not be allowed in certain situations according to State and Federal law.). This termination is typically not a COBRA qualifying event.

(6) The end of the period for which the required contribution has been paid if the full premium for the next period is not paid when due. If a Dependent no longer satisfies the eligibility requirements under the Plan and fails to elect COBRA within the appropriate time period, coverage will be retroactively terminated to the date as stated in the applicable item above. If the Employer or Plan is notified during the COBRA election period, the difference in premium can be paid in order to continue coverage.

(7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively, the Plan will provide at least 30 days' advance written notice of such action.

The Employee shall be responsible for notifying the Plan Administrator of new Eligible Dependents and of any changes in the eligibility status of a Dependent. (Refer to the COBRA section.) Benefits provided to an ineligible Dependent will be recouped by the Plan in accordance with its rights for reimbursement. Employee contributions paid for a period when the Employee knew or should have known the Dependent was ineligible will not be reimbursed to the Employee.

MEDICAL BENEFITS

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

DEDUCTIBLE

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

This amount will accrue toward the 100% maximum out-of-pocket payment. It does not count toward the coinsurance maximum.

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

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

Refer to the Schedule of Benefits for a list of charges that are included and not included in this limit. Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable as shown in the Schedule of Benefits *00sE for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable as shown in the Schedule of Benefits (except for the charges excluded) for the rest of the Calendar Year.

When a Covered Person elects COBRA, he/she will only receive credit for any individual deductible and coinsurance amounts applied on services incurred prior to the COBRA coverage date. Individual deductible and/or coinsurance amounts applied to claims with dates of service incurred after the COBRA coverage date will not apply toward the prior active family accumulated totals. A Family Unit for Covered Persons who elect COBRA will be the following: Employee plus Spouse; Employee plus child(ren); family; and Spouse plus children. Dependent Children who elect COBRA without a parent will be covered as separate individuals. Covered Persons in a Family Unit on COBRA will accrue their individual totals toward the Family Unit totals.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of Medical and Prescription benefits that will be paid under the Plan for Covered Charges incurred by a Covered Person.

COVERED CHARGES

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

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits.

The Allowed Amount for room charges made by a network Hospital having only private rooms will be the network contracted rate.

If a non-network Hospital having only private rooms is utilized, the Allowed Amount for eligible room charges will be at 80% of the facility's billed private room rate or the Usual and Customary Allowance, whichever is less. If the Hospital/Physician assigns the patient to a private room due to Medical Necessity, the Allowed Amount will be the billed room rate. The admitting Physician must provide documentation of the Medical Necessity to the Claims

Supervisor prior to or along with the Hospital claim for prompt consideration of the billed charges.

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

(2) **Coverage of Pregnancy.** Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

There is no coverage of Pregnancy for a Dependent child.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a *Physician or other health care provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. The *Covered Person* is still responsible for the Precertification process. (Refer to the Cost Management Section.) The 48- or 96-hour Inpatient stay begins at the time the delivery occurs in the Hospital. For deliveries occurring outside of the Hospital, the stay begins at the time the mother and/or newborn are admitted as an Inpatient to a Hospital.

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

(a) the patient is confined as a bed patient in the facility; and

(b) the confinement starts within 14 days of a Hospital confinement of at least 3 days or following a period of Home Health Care that was covered by the Plan; and

(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement;

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility. The care must be likely to result in a significant improvement in the Covered Person's condition; and

(e) the degree of care must be more than can be given in the Covered Person's home, but not so much as to require acute hospitalization.

In lieu of the above criteria, services will be covered if they are precertified/authorized as Medically Necessary through the Utilization Review program.

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

(4) **Physician Care.**

Charges for **multiple surgical procedures**, **Physician's Assistants and Nurse Practitioners** will be a Covered Charge subject to the following provisions, except claims for certain PPO network providers will be based upon the network contracts and reduced by the PPO prior to filing the claim with the Claims Supervisor:

(a) If Bilateral or Multiple Surgical Procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Customary Allowance that is allowed for the primary procedures; 50% of the Usual and Customary Allowance will be allowed for each additional procedure performed through the same incision; and 70% of the Usual and Customary Allowance will be allowed for each additional

procedure performed through a separate incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Customary Allowance for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Customary Allowance for that procedure; and

(c) If an assistant surgeon (another Physician or Certified First Assistant) is required (according to Medicare guidelines), the assistant surgeon's covered charge will not exceed 20% of the surgeon's contract rate, Usual and Customary Allowance, or billed charges, whichever is less. If the acting assistant surgeon is a physician's assistant or nurse practitioner, the covered charge will not exceed 15% of the surgeon's contract rate, the network rate established in the contract, Usual and Customary Allowance or billed charges, whichever is less;

(d) If a physician's assistant or nurse practitioner bills for covered office visits and surgical procedures other than as an assistant surgeon (see above), the covered charge will not exceed 75% of the M.D. or D.O.'s contract rate, Usual and Customary Allowance or billed charges, whichever is less.

(5) Telemedicine/Telehealth/Telemonitoring.

Telehealth is the use of electronic information and communication technologies by a health care provider to deliver health care services to a patient while such individual is located at a different site than where the health care provider is located.

Telehealth can provide remote access to services such as medical consultations and information, health assessments and diagnosis. Telehealth services are provided to a patient by a healthcare professional through interactive telecommunications devices. Similar to telemedicine, telehealth offers a convenient way for patients in need of frequent follow-up or assessment to receive the services they need when they need them without having to worry about the logistics of traveling to the healthcare professional's office.

Telemedicine is the use of interactive telecommunication devices between a patient and a healthcare professional for the purpose of improving or maintaining the health of the patient. Interactive telecommunication devices consist of audio and visual equipment capable of transmitting two-way, real-time (synchronous) communications between a patient and healthcare professional over a distance from multiple locations. Telemedicine can offer a convenient method of delivering healthcare to patients in rural or underserved areas that may otherwise have limited or no access to the healthcare professionals they need.

Telemonitoring, which can encompass telehealth, also includes, for example, the use of electronic remote monitoring devices for purposes such as blood pressure checks, weight checks via a telescale for patients with Congestive Heart Failure (CHF) as well as other remote medical intervention and assessment tools from the convenience of the patient's place of residence.

Standard telephone calls, fax transmissions and email, in the absence of other integrated information and data, do not qualify as a Covered Charge under this benefit.

Coverage may also be subject to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

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

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

(b) **Outpatient Nursing Care**. Charges are covered only when care is Medically Necessary, not Custodial in nature and is in lieu of Inpatient acute care. Outpatient private duty nursing care must be authorized by the Utilization Review Coordinator. Services are subject to the benefits shown in the Schedule of Benefits.

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

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits. Services provided by a home health aide are covered if in conjunction with Home Health Care provided by a nurse or therapist and the services provided support skilled nursing services. The following services are considered Covered Expenses under this benefit:

(a) Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN);

(b) Part-time or intermittent home health aide services which consist primarily of caring for the patient;

(c) Physical therapy, occupational therapy and speech therapy provided by a Home Health Care Agency;

(d) Medical supplies, laboratory services, drugs and medications prescribed by a Physician.

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

Expenses incurred in connection with home health care visits are covered under the Plan provided:

(a) the services are preauthorized as Medically Necessary through the Utilization Review Program,

(b) the services are rendered in accordance with a treatment plan submitted by the attending physician, and

(c) in-patient confinement in a Hospital or Skilled Nursing Facility would be required in absence of Home Health Care.

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

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

Covered Charges for in-patient Hospice Care include room and board and other services and supplies furnished for pain control and other acute and chronic symptom management.

Covered Charges for out-patient Hospice Care include charges for:

(a) part-time or intermittent nursing care by an R.N. or L.P.N. as needed to meet the person's assessed needs;

(b) psychological and dietary counseling;

(c) consultation or case management services by a Physician;

(d) physical therapy;

(e) part-time or intermittent home health aide services; and

(f) medical supplies, drugs, and medicines prescribed by a Physician.

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

(9) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Allergy Treatment.** Evaluation, diagnosis and treatment of allergies (immunotherapy).

(b) Local Medically Necessary professional ground or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to transport a person from the place where he/she is injured or stricken by disease to the nearest Hospital/Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

Ground ambulance is also covered in the following circumstances:

(i) To transport a patient from one Hospital to another nearby Hospital when the first Hospital does not have the required services and/or facilities to treat the patient;

(ii) To transport a patient from Hospital to Skilled Nursing Facility when the patient cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or

(iii) To transport a patient from Skilled Nursing Facility to Hospital for Medically Necessary Inpatient or Outpatient treatment when an ambulance is required to safely and adequately transport the patient.

(iv) To transport a patient from a Non-Participating Provider to a Participating Network Provider.

Ambulette Service or other forms of passenger transportation that are available to the public (e.g., buses, taxis or airplanes) are not covered. (Refer to Plan Exclusions.)

Air Ambulance is a covered expense in the following circumstances:

(i) When a patient requires transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treatment the patient; and

(ii) Ground ambulance transportation is not medically appropriate because of the distance involved or because the patient has an unstable condition requiring medical supervision and rapid transport.

Except in Life-threatening emergencies, coverage of air ambulance transport requires preauthorization.

Transportation by ground or air for patient convenience or for nonclinical (social) reasons is not covered.

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

(d) **Applied Behavior Analysis (ABA)** for Autism Spectrum Disorders (ASD). ABA intervention shall produce socially significant improvements in human behavior through skill acquisition, increase or decrease in behaviors under specific environmental conditions and the reduction of problematic behavior. The services must be Medically Necessary treatment ordered by the treating Physician or psychologist in accordance with a treatment plan. An ASD treatment plan must include all elements necessary for this Plan to pay the claim. The Plan has the right to review the plan once every six months unless the treating Physician or psychologist agrees that more frequently is necessary.

For purposes of this benefit, educational and habilitative therapies are covered when part of the treatment plan.

Payments and reimbursements for ABA therapies can only be made to the ASD service provider or the entity or group for whom the supervising board certified behavior analyst works or is associated. ABA services provided by a line therapist under the supervision of a state-licensed ASD provider must be reimbursed to the provider if the services are included in the treatment plan and are deemed Medically Necessary. ABA services provided by any Part C Early Intervention Program (e.g., First Steps) or any school district to an individual diagnosed with ASD is not covered under this Plan.

The benefit limit stated in the Schedule of Benefits may be exceeded upon prior approval by the Claim Supervisor and/or the Plan Administrator after Medical Necessity has been established. This limit will be reviewed and adjusted every three years beginning January 1, 2012, based upon the increase in the federal Consumer Price Index as calculated by the applicable federal department.

(e) **Blood sugar kits (glucometers)** are a covered expense when Medically Necessary.

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

(g) **Chiropractic Services** by a licensed D.C. All services (manipulations, non-manipulation office visits, evaluations, labs, x-rays, etc.) rendered by a chiropractor will be applied to the Spinal Manipulation/Chiropractic Services maximum stated in the Schedule of Benefits. General anesthesia, IV sedation and maintenance or preventive care visits are not covered. No benefits for Chiropractic Care will be paid under any other section of the Plan.

(h) Initial **contact lenses or glasses** required following eye surgery, except surgeries to correct refractive disorders. In this case, rose-tinting, scratch-resistant coating and the additional charge for progressive lenses are considered cosmetic and not covered. However basic tinting, frames and up to tri-focal lenses are covered. If surgery is performed on one eye and then the second eye within 2 years, only the second lenses will be covered and not a new pair of glasses. If later than that time period, a full pair of glasses will be covered. Refer to the Schedule of Benefits for benefit limitations. Accommodating Intra-Ocular Lenses used to replace the lens of the eye following cataract surgery are not covered under this Plan.

(i) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Sales tax and shipping charges on covered equipment are covered expenses. Shipping charges solely for the patient's convenience will not be covered. DME includes, but is not limited to, crutches, trusses, catheters/ostomy supplies, self-injection supplies for diabetics, wheelchairs, Hospital beds, oxygen/administration equipment, etc.

Rental fees, but not to exceed, in aggregate, the purchase price, for Durable Medical Equipment made and used only for treatment of Injury or Illness.

Replacement of durable medical equipment will be considered a Covered Expense when Medically Necessary and appropriate and when repairs are cost prohibitive. Replacement due to improper use or care (according to the manufacturer's guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. Power-operated vehicles may be replaced no more often than every five years and if repair is cost-prohibitive or is Medically Necessary due to a change in the Covered Person's physical condition.

(j) **Educational training.** One Medically Necessary unit of educational training is allowed per Illness per lifetime, however, subject to approval by the Utilization Review Coordinator a new unit will be allowed when one of the following occurs: a change in diagnosis, prescribed treatment or prescribed supplies (e.g., non-insulin dependent to insulin dependent diabetes; self-injectable to insulin pump). A unit may be multiple visits with different specialists over multiple days.

(k) **Genetic testing** is covered if it aids diagnosing of a Covered Person with functional abnormalities or who is symptomatic of an Illness which may be inheritable and the results of the test will impact the treatment being delivered.

(l) **Hearing exams and hearing aids.** Coverage for newborn hearing screening, necessary newborn rescreening, audiological assessment and follow-up and initial amplification in accordance with Missouri State Law (RSMo 376.1220).

(m) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**. (Refer to the Schedule of Benefits for any limitations.)

Charges for TMJ are subject to the limits as described in the Schedule of Benefits.

(n) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(o) Treatment of **Mental Disorders and Substance Abuse**. Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D. or L.P.C.) or Licensed Clinical Social Worker (L.C.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of these professionals.

Benefits are payable under this provision for Mental Disorders and Substance Abuse upon the diagnosis and recommendation of a Physician. Such effective treatment must meet all of the following tests.

(i) The treatment facility, either Inpatient, Outpatient or at a Residential Treatment center, is appropriate for the diagnosis.

(ii) Treatment is prescribed and supervised by a Physician within the scope of his license.

(iii) Treatment includes a follow-up program, as appropriate, which is Physician directed; and

(iv) Treatment includes patient attendance, as appropriate, at meetings of organizations devoted to the therapeutic treatment of the illness.

Treatment solely for detoxification or maintenance care is not considered effective treatment and is not covered under this provision. “Detoxification” means care is aimed primarily at overcoming the after-effects of a specific drinking or drug episode and “maintenance care” means providing an environment free of alcohol or drugs. Detoxification in conjunction with appropriate therapeutic treatment is covered under this provision.

(p) **Treatment of mouth, teeth and gums.**

(i) **Care of mouth, teeth and gums**. Charges for care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical proceduresor for diagnostic and office visit charges for evaluation of the following services (Note: Tooth extractions will only be covered as listed below. If not listed, extractions are not covered.):

(a) Excision of bony growths of the jaw and hard palate.

(b) Excision or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, hard palate and floor of the mouth.

(c) Incision and drainage of cellulitis.

(d) Incision of sensory sinuses, salivary glands or ducts.

(e) Removal of impacted teeth. No other extractions are covered.

(f) Reduction of dislocations and excision of temporomandibular joints (TMJs).

(g) Osteotomy (jaw surgery) which is Medically Necessary and not cosmetic in nature.

(h) Removal of teeth for the medical management of a hazardous medical condition to include but not limited to the following: anticoagulation, valvular heart disease, hemophilia, preparation for cancer treatment in the neck/head region. Initial office visit and diagnostic services will be covered when connected to the services to remove the teeth. Documentation of the Illness should be submitted with the charges.

This Plan will cover the Usual and Customary allowance for the replacement of any teeth that were required to be removed for this treatment. Benefits will not exceed the amount stated in the Schedule of Benefits. This amount will also be allowed to apply to the cost of dental implants if the person chooses to have dental implants.

(i) Hospital and anesthesia charges for pediatric or adult dental procedures that require the use of anesthesia in an outpatient surgical facility or Hospital setting. Services must be Medically Necessary due to an underlying medical condition requiring this setting. Physician's charges for the dental procedure (unless for removal of impacted teeth as listed above) **are not** eligible under this Medical Plan. Documentation of the Medical Necessity should be submitted with the charges.

(ii) **Injury to or care of mouth, teeth and gums**. Charges for repairs to the mouth, teeth, gums and alveolar processes due to an Injury will be Covered Charges under Medical Benefits only if that care is for the following oral procedures:

(a) Repair (or replacement when necessary):

(i) Due to Injury to the mouth, teeth or gums;

(ii) Of any appliance in the mouth at the time of the Injury; or

(iii) Of previously repaired/replaced teeth due to the Injury.

(b) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Injury as a result of chewing or biting is not considered an accidental Injury.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, dental implants or preparing the mouth for the fitting of or continued use of dentures unless specifically addressed in the benefit. If the Covered Person chooses dental implants as the alternative treatment for the repair/replacement of the teeth, the Plan will allow the coverage up to the amount allowed for a lesser treatment. The Covered Person will be responsible for all charges above that amount.

(q) **Organ transplant** limits. All Organ Transplant services, including evaluation, **must** be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Utilization Review Coordinator (Refer to General Plan Information section for contact information.) when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

(i) DEFINITIONS. For purposes of this section, the following definitions apply.

Approved Transplant: A human organ or bone marrow transplant procedure currently performed at a Designated Transplant Facility.

Approved Transplant Services: Medically Necessary services and supplies which are related to an Approved Transplant procedure; are approved in writing under the Precertification and/or Preauthorization process; and include but are not limited to:

(a) Pre-transplant patient evaluation for the Medical Necessity of the transplant.
(b) Hospital charges.
(c) Physician charges.
(d) Tissue typing and ancillary services.
(e) Organ procurement or acquisition.

Center of Excellence: A Designated Transplant Facility that has a Medicare-approved transplant program and is recognized by the United Network for Organ Sharing (UNOS) and the National Marrow Donor Program (NMDP) (non-profit organizations under contract with the United States Department of Health and Human Services to coordinate organ and bone marrow donation and distribution). These organizations have set standards for physical facilities, laboratory capabilities for organ and tissue matching, the recipient selection process and the availability of specialized services. The criteria used for selection of a Designated Transplant Facility are intended to ensure that approval is given only to facilities with the necessary experience and expertise to perform these complex surgeries successfully.

Medicare-approved medical centers must meet extensive criteria set out by Centers for Medicare & Medicaid Services (CMMS) and a review board comprised of transplant surgeons, specialists, and other clinicians and scientists. A facility must have Medicare-approval status before it can receive payment for transplantation services provided to Covered Persons.

All Designated Transplant Facilities must offer comprehensive services that include experts in many medical specialties, such as radiology, infectious disease and pathology, as well as a range of allied health services that may include physical therapy, rehabilitation and social services.

Clinical Practice Guidelines: Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.

Designated Transplant Facility: A Center of Excellence facility which has an agreement with the Plan Administrator or Claims Supervisor to render Approved Transplant Services to Covered Persons. This agreement will be made through a national organ transplant network and may not be located in the person's geographic area. Contact the Utilization Review Coordinator for a list of facilities.

Non-designated Transplant Facility: A facility which does not have an agreement with the Plan Administrator or Claims Supervisor to render approved Transplant Services to Covered Persons.

Transplant Benefit Period: The period of time from the date the person receives prior authorization and has an initial evaluation for the transplant procedure until the earliest of:

(a) one year from the date the transplant procedure was performed.
(b) the date coverage under the Plan terminates.
(c) the date of the Covered Person's death.

If, during the same admission as the initial transplant a retransplant occurs, the period of time is one year from the date of the initial transplant. If a retransplant will be done during a subsequent admission, a new Transplant Benefit Period starts from the date the person receives authorization for the retransplant.

(ii) DESIGNATED FACILITIES FOR APPROVED TRANSPLANT SERVICES

This provision only applies to transplant procedures listed in the definition of Approved Transplant.

Transplant procedures must have preauthorization. The Covered Person or his/her Physician must call the toll free number provided for this purpose. Retransplantation procedures must also have preauthorization.

If the Physician and the Plan Administrator or Claims Supervisor do not agree that the transplant procedure is Medically Necessary and appropriate, the Covered Person will be informed in writing of the right to a second opinion. A Board Certified Specialist must be utilized for this second opinion.

A person who will be undergoing a transplant procedure will be referred to a Designated Transplant Facility. This referral and authorization for services at a Designated Transplant Facility shall continue to be appropriate through the Transplant Benefit Period.

If the Covered Person is denied the procedure by the Designated Transplant Facility, he/she may be referred to a second such facility for evaluation. If the second facility determines, for any reason, that the person is not an acceptable candidate for the procedure, no benefits will be paid for any services or supplies related to that procedure. This applies regardless of whether the services or supplies are provided at a third Designated Transplant Facility or at a Non-designated Transplant Facility.

(iii) BENEFITS

Benefits for Approved Transplant Services provided during a Transplant Benefit Period will be paid as shown in the Schedule of Benefits. Benefits will be different for services provided at a Designated Transplant Facility than services provided at a Non-designated Transplant Facility. Other transplant procedures will be considered for benefit payment according to the provisions of the Plan.

Benefits will be paid for expenses incurred for Approved Transplant Services done at a Designated Transplant Facility as follows:

The transplant must be performed to replace an organ or tissue.

Donor charges:

(a) Charges for obtaining donor organs or tissue for a covered recipient are considered Covered Charges under this Plan. The donor's expenses will be applied toward the benefits of the covered recipient.

Donor charges include those for:

- evaluating the organ or tissue;
- removing the organ or tissue from the donor.
- transporting the organ within the United States and Canada to the place in the US where the transplant is to take place.

(b) If the organ donor is a Covered Person and the recipient is not, then this Plan will always pay secondary to any other coverage. This Plan will cover donor charges for:

- evaluating the organ or tissue;
- removing the organ or tissue from the donor.
- No transportation charges will be considered.

For procedures done at a Non-designated Transplant Facility, the benefits listed above will be paid as shown in the Schedule of Benefits. The organ transplant limitations will apply.

(iv) EXCLUSIONS

No benefits will be paid for any service:

(a) related to the transplantation of any non-human organ or tissue, except for heart valves.
(b) for a facility or Physician outside the United States of America.
(c) which are eligible to be repaid under any private or public research fund.

(r) The initial purchase (of a single unit per body part), fitting, repair and replacement of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Replacement of orthotics will not be covered unless 1) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or 2) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 3 years). Replacement of the appliance must be preauthorized. (Refer to Cost Management Services.). The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions items Foot and Hand Care and Orthotics for further information.) Preauthorization of services and/or treatment recommended.

(s) **Prescription Drugs** (as defined) and supplies. Refer to the Prescription Drug Benefit section for further details on covered and excluded drugs dispensed at a Pharmacy (including a facility's Pharmacy for dispensing take-home medications for use upon release from that facility). Call the pharmacy benefit manager (PBM) at the number on your ID card for complete information about covered and excluded Prescription Drugs and supplies purchased at the Pharmacy.

Prescription Drugs consumed on the premises of a Physician or facility, e.g., a Hospital, urgent care facility or Physician's office, are covered under the Medical Benefits as stated in the Schedule of Benefits.

The following contraceptive Prescription Drugs and/or supplies through a Pharmacy or Physician's office are covered by the Prescription Drug or Medical Benefits of this Plan: oral, injectable (e.g., Depo Provera), implantable (e.g., Norplant), topical, intravaginal (e.g., ring or diaphragm) or intrautero (e.g., IUD).

Prescription Drug use does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug Utilization Review (DUR) may be retrospective, concurrent or prospective. Retrospective DUR generally involves claim review and may include communication by the PBM with prescribers to coordinate care and verify diagnoses and Medical Necessity. Concurrent DUR generally occurs at the point of service and may include electronic claim edits to protect patients from potential drug interactions, drug-therapy conflicts or overuse or underdose of medications. Prospective DUR may include, among other things, therapy guidelines or Physician or Pharmacy assignment in which one Physician or Pharmacy is selected to serve as the coordinator or Prescription Drug services and benefits for the eligible Covered Person.

(t) **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

(i) **Charges for Routine Well Adult Care**. Routine well adult care is care by a Physician that is not for an Injury or Sickness for Covered Persons age 19 and older.

(ii) Coverage of **Well Newborn Nursery/Physician Care**.

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

Charges for covered routine nursery care will be applied toward the Plan of the newborn child. Charges for a newborn child who is injured or ill will be applied toward the Plan of the newborn.

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

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a *Physician or other health care provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. The *Covered Person* is still responsible for the Precertification process. (Refer to the Cost Management Section.) The 48- or 96-hour Inpatient stay begins at the time the delivery occurs in the Hospital. For deliveries occurring outside of the Hospital, the stay begins at the time the mother and/or newborn are admitted as an Inpatient to a Hospital.

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

Circumcision is considered under this benefit if performed during the initial Hospital confinement. Otherwise, it will be considered an eligible expense under Physician Services (refer to Schedule of Benefits) up to the second birthday of the Dependent Child or within 2 years of legal adoption. Thereafter, it will *not* be considered an eligible charge unless Medically Necessary (refer to Physician Services in the Schedule of Benefits for benefits).

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. Charges for a newborn child who is injured or ill will be applied toward the Plan of the newborn.

(iii) **Charges for Routine Well Child Care.** Routine well child care is routine care by a Physician that is not for an Injury or Sickness up to age 19.

(u) The initial purchase, fitting, repair and replacement of fitted **prosthetic devices** which replace body parts. Replacement of prostheses will not be covered unless (a) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional, or (b) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 5 years). Replacement of the device must be preauthorized. (Refer to Cost Management Services.). Replacement due to improper use or care (according to the manufacturer's guide on proper use) will not be covered. Repairs not covered under the warranty or required

after the warranty expires will be covered, unless cost-prohibitive. The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions for Prosthetic devices for further information.) Preauthorization of services and/or treatment recommended.

Two mastectomy bras are covered every six months; one prosthetic every Calendar Year. Compression stockings are covered with a prescription or Physician's orders. The prescription must require measurement of the patient for proper fitting. Limit two (2) pair per Calendar Year.

(v) **Reconstructive Surgery.** Correction of abnormal congenital conditions, repair of damage from an accident or Injury, repair following Medically Necessary surgery for an Illness and reconstructive mammoplasties will be considered Covered Charges.

The Women's Health and Cancer Rights Act of 1998 (WHCRA) states that since the Plan provides coverage for services related to mastectomies, the Plan must provide coverage for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of initial and replacement prostheses (two mastectomy bras are covered every six months; one prosthesis every Calendar Year) and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(w) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. (Refer to the Schedule of Benefits for benefit maximum.) General anesthesia or IV sedation for the sole purpose of performing a manipulation is not covered. Also refer to Chiropractic Care in this section.

(x) **Sterilization** procedures (once per Lifetime).

(y) **Surgical** dressings, splints, casts, supplies and other implantable devices.

(z) **Therapies.**

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

(ii) **Occupational therapy** by a licensed occupational therapist. Preauthorization of therapy is recommended. Therapy must be ordered by a Physician, result from an Injury or Sickness, improve a body function and treat conditions which are subject to significant improvement through short- term therapy. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan. Certain non-restorative therapies may be provided to Covered Persons who qualify for Part C of the Individuals with Disabilities Education Act (RSMo 376.1218). Documentation of the approval by the Part C early intervention system must be submitted to the Claims Supervisor in order for these services to be considered a Covered Expense.

(iii) **Physical Therapy** by a licensed physical therapist or licensed physical therapy assistant. Preauthorization of therapy is recommended. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration, to improve a body function and to treat conditions which are subject to significant improvement through short-term therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. Accepted level of rehabilitation is when the Covered Person can perform basic Activities of Daily Living. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan. Certain non-restorative therapies may be provided to Covered Persons who qualify for Part C of the Individuals with Disabilities Education Act (RSMo 376.1218). Documentation of the approval by the Part C early intervention system must be submitted to the Claims Supervisor in order for these services to be considered a Covered Expense.

(iv) **Pulmonary rehabilitation** as deemed Medically Necessary, Reasonable and Necessary, and Restorative. These services must be rendered: (a) under the supervision of a Physician; (b) for chronic pulmonary disability with reduction of exercise tolerance which restricts the abilities of the Covered Person to perform daily activities and/or work; and (c) in a Medical Care Facility as defined by this Plan. Pulmonary Function Test must show FEV1 of less than 60% predicted. Maintenance programs are not covered.

(v) **Speech therapy** by a licensed speech therapist. Preauthorization of therapy is recommended. Therapy must be ordered by a Physician and follow either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex; or (b) an Injury or Sickness that results in loss of previously acquired speech or normal swallowing mechanics. Maintenance programs are not covered. Certain non-restorative therapies may be provided to Covered Persons who qualify for Part C of the Individuals with Disabilities Education Act (RSMo 376.1218). Documentation of the approval by the Part C early intervention system must be submitted to the Claims Supervisor in order for these services to be considered a Covered Expense.

(vi) **Vision therapy.** Charges incurred in connection with vision therapy for rehabilitative therapy after brain injury, including stroke, that are Medically Necessary, Reasonable and Necessary, and Restorative. Maintenance programs are not covered.

(aa) **Weight Management/Control**. **Weight-loss programs:** Charges for weight-loss programs will be covered if the program is necessary to treat a medical condition by decreasing the patient's weight. This program must be designed to treat health problems associated with high-risk Morbid Obesity/Severe Clinical Obesity and be administered and supervised by a Hospital or Physician's clinic. These health conditions may include hypertension, diabetes, cardiovascular disease and sleep apnea. The Covered Person must have demonstrated unsuccessful results in a weight-loss program. This weight-loss program must include diet, exercise and behavioral components. Documentation of the Covered Person's participation in qualifying programs must be submitted to the Utilization Review Coordinator for approval. Coverage is limited to Medically Necessary charges for treatment of Morbid Obesity/Severe Clinical Obesity. The weight management must be expected to produce a significant improvement of the Covered Person's condition within a six (6) month period. For the purposes of this provision, "significant improvement" means a reduction of weight by 10% the first 6 months, with a continued 10% reduction every 6 months from the adjusted baseline weight or a minimum of 1 to 2 pounds per week. The need to continue the care and regimen established must be documented in writing by the Physician for each six (6) month period. Benefits will terminate when the Covered Person's body mass index (BMI) has decreased below 30.

Bariatric surgery: Only procedures meeting the criteria established by the Utilization Review Coordinator will be considered a Covered Charge under this Plan. Charges must be preauthorized by the Utilization Review Coordinator. The Covered Person

must meet Medically Necessary criteria established by the Utilization Review Coordinator. The surgeon must be designated as a Center of Excellence by the American Society of Metabolic & Bariatric Surgery. The Covered Person must have failed previous attempts to reduce weight under a Physician-monitored weight-loss program as described above for a minimum of one year in the two-year period immediately preceding the date the Physician requests benefit authorization. The Covered Person's BMI must be 40 or greater in conjunction with at least 1 of the following co-morbidities: hypertension uncontrolled by medical treatment, sleep apnea, coronary artery disease and diabetes mellitus. Physician documentation is required which indicates the Covered Person has been Morbidly Obese (as defined by the plan) for a minimum of 5 years immediately preceding surgery.

Panniculectomy surgery: Surgical removal of redundant skin folds is generally considered a cosmetic procedure. However, in order to be eligible for this surgery post weight-loss, the Covered Person must meet Medically Necessary criteria utilized by the Utilization Review Coordinator and must participate in the follow-up program, as appropriate, which may include an aftercare support group and Physician visits.

(bb) Charges associated with the initial purchase of a **wig** following care and treatment related to alopecia areata or scalp infection or as a result of treatment of a medical condition (e.g., chemotherapy for cancer). Charges for wigs are subject to the limits as described in the Schedule of Benefits.

(cc) **X-rays,** electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

COST MANAGEMENT SERVICES

PREADMISSION CERTIFICATION (Inpatient hospitalizations)

AUTHORIZATION IS NOT A GUARANTEE THAT ALL CHARGES ARE COVERED.

Preadmission Certification (also referred to as Precertification) means the review of all Hospital admissions prior to the admission date. This program is designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital stay is proposed. For example, based on the information provided by the Physician, the Precertification Nurse will make an initial assessment of the condition to determine, among other things: if a second surgical opinion is required or recommended; if the admission is to a network facility; if concurrent review by Utilization Review Coordinator is to be initiated; and if Medical Case Management is applicable.

Precertification Procedures

The Covered Person or the Physician must call the Utilization Review Coordinator (Refer to the General Plan Information section for contact information) for precertification as follows in order to avoid assessment of the precertification penalty:

Scheduled Inpatient hospitalization- Precertify at the earliest time ***prior*** to the admission of a scheduled Hospital stay. When the Covered Person or Physician notifies the Utilization Review (UR) Coordinator (or the entity as listed on the ID card) of a scheduled hospitalization, the UR Coordinator will then determine the length of stay based upon diagnosis, appropriateness of services and the Physician's plan of treatment. The UR Coordinator also assures that reasonable alternatives to Inpatient care are considered, including Outpatient treatment and preadmission testing. Request for second surgical opinion may also be made at that time. For every approved admission, a target length of stay will be assigned by the UR Coordinator, based upon length of stay norms for the geographical region. A preadmission certification letter will be sent to notify the Covered Person, Hospital and attending Physician of the assigned length of stay.

Unscheduled, non-emergent Inpatient hospitalization- Precertify within 48 hours after a weekday admission or within 72 hours after an admission on a weekend or legal holiday. Unscheduled admission means an admission for treatment of an Injury or Illness that requires immediate Inpatient treatment which is Medically Necessary and cannot be reasonably provided on an Outpatient basis.

Emergency Inpatient hospitalization- Precertify within 48 hours after a weekday admission or within 72 hours after an admission on a weekend or legal holiday. Emergency admission means an admission for a Life-threatening medical condition or a condition for which the lack of immediate treatment would cause permanent disability.

Precertification Penalties

Failure to follow the precertification procedure as described above will reduce reimbursement received from the Plan.

If precertification is not obtained as explained in this section, a penalty may be applied. (Refer to the first page of the Schedule of Benefits for details.) Any reduced reimbursement due to failure to follow the precertification procedures will not accrue toward the 100% maximum out-of-pocket as indicated in the Schedule of Benefits.

Exception: A Plan may not, under federal law, require that a Physician or other health care provider obtain precertification from the Plan for prescribing a maternity length of stay of up to 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. However, to use certain providers or facilities, or to reduce the out-of-pocket costs, the Covered Person is still required to obtain precertification for the Hospital stay. If the stay is not precertified, the individual is responsible for the amount indicated in Precertification Penalties above. A Covered Person will not be denied the Hospital stay granted under State or Federal law. For more information on precertification, contact the Plan Administrator or Claims Supervisor.

EXTENDED HOSPITAL STAYS

Once a Hospital stay begins, whether it is a non-emergency or emergency, if the stay is expected to exceed the number of days precertified, the Covered Person or the Physician must contact the Utilization Review Coordinator to request an extension of the length of stay.

EFFECTS OF PREADMISSION CERTIFICATION ON BENEFITS

Authorization is not a guarantee that all charges are covered.

If any part of a Hospital stay is not precertified, the penalty amount shown in the Precertification Penalties section and the Schedule of Benefits may be applied. No part of the penalty will be applied towards the deductible amount shown in the Schedule of Benefits or the maximum out-of-pocket expense limitation.

A Hospital stay is not precertified if:

(1) Precertification is not obtained prior to admission;

(2) The type of treatment, admitting Physician or the Hospital differs from the precertified treatment, Physician or Hospital.

CONCURRENT REVIEW

The purpose of concurrent review is to continually evaluate the Covered Person's progress toward the treatment goal and the patient's ability to function in a non-acute environment and to facilitate timely discharge as appropriate.

PREAUTHORIZATION AND UTILIZATION REVIEW

Preauthorization means the review of services prior to their being rendered to determine if the services are eligible under the Plan. If preauthorization is not obtained as described in this section, benefit reimbursement may be delayed while awaiting further information from the Physician or Covered Person. The Utilization Review Coordinator will consider the following, among other things, in making this decision: medical services, treatments and/or supplies are covered under this Plan; meet standards of care; are Medically Necessary; are ordered by a Physician; and are not Experimental/Investigational or otherwise excluded by this Plan.

Services Subject to Preauthorization and Utilization Review:

Authorization is not a guarantee that all charges are covered.

The Covered Person or the Physician should call the Utilization Review Coordinator for preauthorization of the following services and any other services identified with an "*" on the Medical Schedule of Benefit (refer to the ID card or the last page of this book for the phone number):

Home Health Care
Durable Medical Equipment (greater than $200 purchase value)
Physical, speech and occupational therapy
Cardiac rehabilitation therapy
Obesity Treatment
Private Duty Nursing
Orthotics/Prosthetics (including cochlear implants)
IV Infusion (Outpatient or Physician's office, except for chemotherapy)
Stereotactic radiosurgery. (This service must be preauthorized or it will not be considered a Covered Charge under this Plan. The Utilization Review Coordinator will review the cases for Medical Necessity and applicable exclusions. A second opinion may be required.)
Non-Network Provider services when In-Network Providers are available

MEDICAL CASE MANAGEMENT

The purpose of Medical Case Management is to identify potentially high-dollar claims as a result of serious Illnesses, accidents or other circumstances and to coordinate the highest quality care in the most appropriate, cost-effective setting. The interest of the Covered Person is always primary in this program. The Covered Person receives the type of care required and the available benefits are used more effectively. Large Case Management is more than a cost containment provision. It requires in-depth involvement between the Case Manager, the provider and the Covered Person. The Covered Person, family and the attending Physician must be in agreement for any form of alternative medical care.

The Medical Case Management firm may recommend coverage for services or equipment that is not normally provided to the Covered Person under the Plan. In these instances, exceptions may be made by the Plan Administrator to cover these services or equipment that are recommended. The alternative benefits shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for

the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Services provided by Medical Case Management are:

Continued Hospital Stay Review. The Covered Person may be hospitalized longer than Medically Necessary. Substantial savings can be achieved by reviewing the Covered Person's condition and treatment based on established medical criteria. Inappropriate treatment may be identified and discontinued.

Discharge Planning. Careful advance planning can ease the Covered Person's transfer from an acute-care facility to a less costly and more suitable facility such as a nursing home, rehabilitation center or the Covered Person's own home. It ensures that the benefits or early discharge are not outweighed by the need for a return to the Hospital at a later date for corrective and more costly treatment.

Home Health Care Coordination. With the right home environment and some professional coordination, many services traditionally performed on an Inpatient basis may be handled in the Covered Person's home. Home health care involves coordination of required medical treatment and evaluation of the appropriate required level of care by the Medical Case Management firm. Patient/family counseling would be considered a covered expense in connection with these services, where applicable.

The following types of claim situations may have the potential for Medical Case Management:

(1) Severe trauma (head Injuries, extensive burns, spinal cord Injuries, multiple fractures, etc.);

(2) Coma (any cause);

(3) Neonatal (prematurity, birth Injuries, congenital deformities, profound retardation, etc.);

(4) Organ transplants; or

(5) Any claim where it appears that there will be extensive Inpatient and/or Outpatient charges, particularly for a long duration.

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

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

SECOND AND/OR THIRD OPINION PROGRAM

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

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or is not Life-threatening in nature. Refer to the Schedule of Benefits. If the second opinion is requested by the Utilization Review Coordinator, they will inform you of the benefit payable for the consultation.

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

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

DEFINED TERMS

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

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-tim basis or has been determined to be full-time based on Hours of Service during the Initial Measurement Period or Standard Measurement Period, as applicable. For this purpose, an Employee shall be deemed to be actively employed on the date his or her coverage would otherwise commence if the Employee is absent from work due to a medical condition (including both physical and mental Illnesses).

Activities of Daily Living (ADLs) are the things we normally do for self-care, work, homemaking and leisure. Health professionals routinely refer to the ability or inability to perform ADLs as a measurement of the functional status of a person. This measurement is useful for assessing the elderly, the mentally ill, those with chronic diseases, and others to evaluate the type of health care services needed.

Basic ADLs are the basic activities of daily living and consist of these self-care tasks: bathing/showering; dressing/undressing; eating; transferring from bed to chair, and back; toileting and functional mobility.

Instrumental ADLs (IADLs) are things such as doing light housework; preparing meals; taking medications; shopping for groceries or clothes; using the telephone; managing money; and using technology. *IADLs are not necessary for fundamental functioning, but they let an individual live independently in a community.*

Occupational therapists also evaluate IADLs when completing patient assessments. These include 11 areas of IADLs that are generally optional in nature and can be delegated to others: care of others (including selecting and supervising caregivers); care of pets; child rearing; use of communication devices; community mobility; financial management; health management and maintenance; home establishment and management; meal preparation and cleanup; Safety procedures and emergency responses; and shopping.

Ambulette Service is usually a van equipped with a wheelchair lift and other safety equipment. It is used in non-emergency transportation for wheelchair bound, physically challenged, or elderly patients. They are often used to transport dialysis, radiation, and chemotherapy patients to and from treatment or to transfer patients to and from Hospital, home or nursing facilities. They do not meet the definition of a professional ambulance.

Applied Behavior Analysis (ABA) is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.

Practice of ABA is the application of the principle, methods and procedures of the experimental analysis of behavior and applied behavior analysis (including principles of operant and respondent learning) to assess and improve socially important human behaviors. It included, but is not limited to, applications of those principles, methods, and procedures to:

(1) the design, implementation, evaluation, and modification of treatment programs to change behavior of individuals;

(2) the design, implementation, evaluation, and modification of treatment programs to change behavior of groups; and

(3) Consultation to individuals and organizations.

ABA does not include physical therapy, occupational therapy, speech therapy or cognitive therapies or psychological testing, personality assessment, intellectual assessment, neuropsychological assessment, psychotherapy, sex therapy, psychoanalysis, hypnotherapy, family therapy and long-term counseling as treatment modalities.

Autism Spectrum Disorder (ASD) is a neurobiological disorder, an Illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Bilateral Surgical Procedure shall mean any surgical procedure performed on any body part or paired organ whose right and left halves are mirror images of each other or in which a median longitudinal section divides the organ into equivalent right and left halves or on any pair of limbs. Surgery on both halves or both limbs is performed during the same operative session and may involve one (1) or two (2) surgical incisions.

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

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

Brand Name means a trade name medication.

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

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

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements. Cosmetic Surgery is typically surgery that changes:

The texture or appearance of the skin; or
The relative size or position of any body part

when such surgery is performed primarily for psychological purposes or is not needed to correct or improve a bodily function.

Cost Containment Penalties are structured by the Plan Administrator to encourage the Covered Person's compliance with the policies and procedures. These policies and procedures are designed to maximize benefits and lower costs for both the member and the plan. Penalty amounts do not accrue towards the individual or family maximum out-of-pocket amounts. The following are examples of penalties that can be assessed: benefit reduction for not properly precertifying an Inpatient stay; additional deductible for emergency room or Inpatient stays; charges over the Usual and Customary Allowance or network contract allowance for out-of-network services; higher patient deductible and/or coinsurance for out-of-network services; day/visit/dollar limits for certain services; other provisions as stated in the Plan.

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

Covered Person is an Active Employee, Retired Employee, Surviving Spouse of a Retired Employee, or COBRA Continuant, or the eligible Dependent of an Active Employee, Retired Employee, Surviving Spouse of a Retired Employee, or COBRA Continuant who is covered under this Plan.

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

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

Dependents refer to the Eligibility section for details.

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

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of

health and medicine, could reasonably expect that the absence of immediate medical attention will result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

Examples of these conditions are heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions. The Utilization Review Coordinator or Claims Supervisor will assess emergency treatment/admissions to a non-participating provider to determine if it meets the exception criteria. The exception criteria will be assessed on a case-by-case basis, taking into consideration such things as the individual's medical history, current illness/injury and the circumstances (consciousness, EMT/ambulance services, etc.) surrounding the current illness/injury in relation to the accessibility/location of other participating providers.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship and meets the eligibility requirements outlined in "Eligibility Requirements for Employee Coverage" section. The following persons are specifically excluded from the Plan: persons employed as leased employees or independent contractors; persons who are classified by the Employer as temporary workers; and persons covered by a collective bargaining agreement unless the Employer and collective bargaining unit have agreed to participation under the Plan. For purposes of the foregoing, the Employer's employment classification of an individual shall be binding and controlling for all purposes and shall apply regardless of any contrary classification of such person by any other person or entity, including without limitation, the Internal Revenue Service, the Department of Labor, or a court of competent jurisdiction.

Employer is Camdenton R-III School District.

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

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

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

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

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

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. However, routine patient care costs for a phase III clinical trial for prevention, early detection and treatment of cancer will be covered according to Missouri Revised Statutes when the trial is approved or funded by one of the following entities:

(a) One of the National Institutes of Health (NIH),

(b) An NIH cooperative group or center,

(c) The FDA in the form of an investigational new drug application,

(d) The federal Department of Veterans' Affairs or Defense,

(e) An institutional review board in that state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46), or

(f) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

However, routine patient care costs for a phase II clinical trial for prevention, early detection and treatment of cancer will be covered according to Missouri Revised Statutes if:

(a) The trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and

(b) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

"Cooperative group" is a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating with the group, including the NCI Clinical Cooperative Group and the NDI Community Clinical Oncology program; or

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

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

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

For purposes of defining terms used in the Plan Exclusions section:

"Routine Patient Care Costs" shall include items and services typically provided under the Plan for a Covered Person not enrolled in a clinical trial. However, such items and services do not include:

(a) The investigation item, device or service itself;

(b) Items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or

(c) A service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

"Qualified Individual" is a Covered Person who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and either:

(a) The referring health care professional is a Participating Provider and has concluded that the Covered Person's participation in the clinical trial would be appropriate; or

(b) The Covered Person provides medical and scientific information establishing that the Covered Person's participation in the clinical trial would be appropriate.

"Approved Clinical Trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements.

"Life-Threatening Condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

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

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

Gene Manipulation Therapy is an experimental treatment that involves introducing genetic material (DNA or RNA) into a person's cells to fight disease. Gene therapy is being studied in clinical trials (research studies with people) for many different types of cancer and for other diseases. It is not currently available outside a clinical trial.

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

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

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

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

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

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

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

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

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

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an Inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Healthcare Facilities Accreditation Program (If the Hospital is not accredited by one of the previous entities but has received accreditation through an entity recognized by CMS as an alternative to JCAHO, then this Plan will also recognize the facility as accredited.); it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises. If the Plan has a network that credentials their providers for participation in the network, the facility will be considered eligible regardless of the accreditation or Medicare status required in this definition.

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

Incidental means requiring unplanned treatment, care or services for a non-emergent Illness while outside the network area. For example, requiring Physician services for acute sinusitis while traveling outside the network area.

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

Inpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person who is admitted as a registered bed patient in a Hospital.

Institution of Learning means any accredited high school, accredited college or university, including other recognized educational institutions such as nursing schools, trade school, etc., with full-time curricula, regardless of the length of the term.

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period. (see below).

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child under the age of 18. (Refer to the Eligibility section of this document for eligibility requirements.)

Legally Separated (Legal Separation) means, for purposes of this Plan, a husband and wife have successfully petitioned a court to recognize their separation .

Life Threatening is defined as any serious illness or injury that necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure. Examples: burns, loss of organs, loss of limbs, blindness, heart attack, stroke and excessive uncontrolled bleeding through open wounds.

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

Maintenance programs is a term used to qualify occupational, physical, speech and other rehabilitative therapy programs. These are the repetitive services required to maintain function and generally do not involve complex and sophisticated occupational/physical/speech therapy procedures; and consequently, the judgment and skill of a qualified therapist are not required for safety or effectiveness.

However, in certain instances, the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition if the maintenance program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service and would be a covered expense under the Plan.

Medical Care shall mean professional services rendered by a Physician or Other Professional Provider for the treatment of an Illness of Injury.

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

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

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

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

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

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

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

Morbid Obesity/Severe Clinical Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by 100 or more pounds over normal weight (by insurance underwriting standards) or the body mass index (BMI) is 35 or greater for a person of the same height, age and mobility as the Covered Person.

Multiple Surgical Procedures (shall mean surgical procedures which are performed during the same operative session and which are not incidental or secondary to one (1) primary procedure for which the operative session is undertaken. An "incidental procedure" is a procedure which is not Medically Necessary at the time it is performed. A "secondary procedure" is a procedure which is not part of the primary procedure for which the operative session is undertaken.

Never Events are occurrences that should never happen; *e.g.*, surgery on the wrong body part or death due to contaminated drugs or devices. The criteria for inclusion on the Never Events list include: i) adverse consequence of care results in unintended injury or illness; ii) indicative of a problem in a health facility's safety systems; and iii) important for public credibility or public accountability. Refer to www.cms.hhs.gov for the full listing of Never Events.

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

Nonresidential Treatment Facility is a facility that can provide medical and other services for the treatment of Substance Abuse to individuals who do not require Inpatient status and are free from acute physical and mental complications. The facility must maintain an organized program of treatment that may be limited to less than 12 hours per day and not be available 7 days a week. The facility must be certified by the Department of Mental Health for treatment of Mental Disorder or Substance Abuse.

Other Facility Provider shall mean any of the following: Ambulatory Care Facility, Substance Abuse Treatment Facility, free-standing dialysis facility, Outpatient psychiatric facility, psychiatric day treatment facility, psychiatric Hospital, Hospice, Extended Care Facility, or rehabilitation Hospital, which is licensed as such in the jurisdiction in which it is located.

Other Professional Provider or **Professional Provider** shall mean the following persons or practitioners, including Physicians, acting within the scope of such provider's license which is certified and licensed in the jurisdiction in which the services are provided:

Audiologist	Licensed Practical Nurse
Anesthetist	Vocational Nurse
Certified Athletic Trainers	Physical Therapist
Chiropractor	Registered Nurse
Emergency Medical Technician	Respiratory Therapist
Independent Laboratory Technician	Speech – Language Pathologist
Pharmacist	Clinical Social Worker
Any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his/her license.	

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

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

Partial Hospitalization is an Outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse condition when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licenses to provide partial hospitalization services, if required, by the stat in which the facility is providing these services. Treatment lasts less than 24 hours, but more than for hours, a day and no charge is made for room and board.

Participating or **Network Physician** shall mean a duly licensed Physician under contract with any of the Plan's contracted Networks.

Participating or **Network Provider** shall mean any Hospital, Physician, pharmacy, Other Professional Provider, Other Facility Provider or other entity under contract with the Plan's contracted Networks.

Participating (or Network) **Provider Organization (PPO)** is most commonly a network of providers who have agreed contractually to provide covered services at reduced rates to eligible members. The Covered Person retains the freedom to choose his/her own provider subject to a potential impact on his/her benefits.

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

Pharmacy Benefit Manager means a third party administrator of prescription drug programs who is primarily responsible for processing prescription drug claims. They also are responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. (Refer to the medical plan ID card for contact information.)

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) and Doctor of Podiatry (D.P.M.).

Plan means Camdenton R-III School District Employee Health Care Plan, which is a benefits plan for certain Employees of Camdenton R-III School District and is described in this document.

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

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

Pre-Admission Testing is pre-operative or pre-procedural diagnostic screening required to determine the Covered Person's health status prior to a scheduled medical or surgical procedure on an Inpatient or Outpatient basis.

Predetermination of Benefits can be requested in writing by the provider or the Covered Person for services that normally do not require precertification or preauthorization of benefits.

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

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

Preventive Care ("Well Adult" and "Well Child" care) is care by a Physician that is not for an Injury or Sickness. Preventive care includes services as defined under the Affordable Care Act. Preventive services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Examinations, screenings, tests, items or services are not covered under the Preventive Care benefit when such services are diagnostic, investigational or experimental, as determined by the Plan. Services for diagnostic reasons may be covered under other applicable plan benefits.

The Plan will use reasonable medical management techniques to control costs of the Preventive Care benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Care services, which must be satisfied in order to obtain payment under the Preventive Care benefit. Covered Charges under Medical Benefits for adults and children are payable as described in the Schedule of Benefits.

Reasonable means not excessive or extreme as determined by the Plan Administrator. See also Usual & Customary Allowance. If it is determined that a charge is not Reasonable, but services are still eligible, the allowance will be based upon an estimated 150% of the Medicare allowable, regardless of previously negotiated or contracted rates.

Reasonable and Necessary is a term used to qualify occupational, physical, speech and other rehabilitative therapy programs. To be considered Reasonable and Necessary, the following conditions must be met:

(1) The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.

(2) The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist or under his/her supervision. Services which do not require the performance or supervision of a therapist are not considered reasonable or necessary services, even if they are performed or supervised by a therapist.

(3) The development, implementation, management, and evaluation of a patient care plan constitute skilled therapy services when, because of the patient's condition, those activities require the skills of a therapist to meet the patient's needs, promote recovery, and ensure medical safety. Where the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program because of an identified danger to the patient, those reasonable and necessary management and evaluation services may be covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

(4) While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, the key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.

(5) There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.

(6) The amount, frequency, and duration of the services must be reasonable.

Residential Treatment Facility meets the following criteria:

(1) Operates legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

(2) Is certified by the Department of Mental Health for treatment of Mental Disorder or Substance Abuse.

(3) Is primarily engaged in providing diagnostic and therapeutic services for treatment of Mental Disorders and Substance Abuse on an Inpatient basis; maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients.

(4) Has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff.

(5) Operates on a 24-hour basis, 7 days a week under an organized program.

Restorative Therapy is a term used in conjunction with occupational, physical, speech or other rehabilitative therapy which must, among other things, be Reasonable and Necessary to the treatment of the individual's Illness or Injury. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of the therapy services required to achieve such potential, the therapy would not be considered Reasonable and Necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a Reasonable (and generally predictable) period of time. However, if at any point in the treatment of an illness/injury it is determined that the expectations will not materialize, the services will no longer be considered Reasonable and Necessary and they would, therefore, be excluded from coverage.

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

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

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

(1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare, the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities.

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

Specialty Drugs treat multi-faceted chronic diseases. They typically require unique clinical, administration, distribution and handling requirements. They are more expensive than traditional prescriptions and there are limited generics and biosimilars available. Biosimilars are a potential future opportunity that will provide therapeutic options for already approved specialty brand drugs at potentially lower costs. A list of these drugs is available by contacting the Claims Supervisor or Pharmacy Benefit Manager as stated on your health plan ID card. Only available through network specialty pharmacy or retail location.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

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

Surviving Spouse means the person recognized as the deceased covered Retired Employee's husband or wife (or the husband or wife of a deceased Active Employee who was eligible for retirement at the time of his/her death) under the laws of the state in which the Retired Employee lived and who had been continuously covered since retirement as an eligible dependent of the Retired Employee prior to the death.

Temporomandibular Joint (TMJ) Syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. (Refer to Schedule of Benefits and Medical Benefits for what services are covered by this Plan.)

Total Disability (Totally Disabled) means: In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer in conjunction with the determination by the treating Physician.

In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Usual and Customary Allowance is determined by the Plan Administrator using the following information:

(1) Third Party data;

(2) Contracted allowables;

(3) Medicare data;

(4) Historical data of Claims Supervisor;

(5) Geographic region of provider;

(6) Cross-section of providers in geographic areas other than where the service is provided if the service is performed less frequently or is a newer service;

(7) The nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience; and/or

(8) Any other available data to make the determination.

(9) When the Usual and Customary Allowance cannot be determined with any of the above, the Plan Administrator or its designee has the discretionary authority to decide the reasonable allowance for the care, treatment or service.

(10) Even though the Usual and Customary Allowance or network/contracted rate can be determined, the Plan Administrator or its designee has the discretionary authority in determining if the established allowance is Reasonable.

For the purposes of this section, "Reasonable" means not excessive or extreme as determined by the Plan Administrator.

The Plan will consider the actual charge billed if it is less than the Usual and Customary Allowance.

Utilization Review Coordinator is the person who evaluates the appropriateness, medical need and efficiency of health care services, procedures and facilities according to established criteria or guidelines (industry, Claims Supervisor or appropriate third party) and under the provisions of this Plan. Typically, the review includes new activities or decisions based upon the analysis of a case. The Coordinator performs proactive procedures (such as discharge planning, concurrent planning, precertification), clinical case appeals, proactive processes (such as concurrent clinical reviews and peer reviews), and reviews appeals introduced by the provider, payer or Covered Person. A separate entity may provide the precertification services. (Refer to General Plan Information section and the health care plan ID card for contact information.).

Waiting Period is the time beginning on the first day of employment as a Non-variable Employee and ends at midnight on the 45th day (classified) or last day of the month (certified) (as long as remaining eligible). Similarly, for a Variable Hour, Part-time, Seasonal or Ongoing Employee with a change in employment status from non-Full-time to Full-time during the Measurement Period or Stability Period, it is the time beginning on the first day of employment as a Full-time Employee and ends at midnight on the 45th day (classified) or last day of the month (certified) (as long as remaining eligible). If earlier, coverage will be effective the 1st day of the Stability Period, if the Employee averaged 30 Hours of Service or more per week (130 Hours of Service or more in a Month) during the Measurement Period.

PLAN EXCLUSIONS

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

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

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy, a therapeutic abortion is deemed Medically Necessary by an M.D. or D.O. for medical conditions determined to be non-compatible for the life of the fetus or the Pregnancy is the result of rape or incest.

(2) **Acupuncture or acupressure.** Services, supplies, care or treatment for acupuncture or acupressure.

(3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness that occurred while the Covered Person was illegally using alcohol (whether operating a motorized vehicle or another illegal situation). Expenses will be covered for Injured Covered Persons other than this Covered Person. The on-site and/or responding officer or treating facility's notation and/or determination of inebriation (such as through a field sobriety test, observations and Blood Alcohol Content level test) will be sufficient for this exclusion. The exclusion applies regardless of whether the use of alcohol was the direct cause of the Injury. The Covered Person's expenses for Substance Abuse treatment will be covered as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(4) **Ambulette Service**. Ambulette Services or other forms of passenger transportation that are available to the public (e.g., buses, taxis or airplanes).

(5) **Charges** for failure to keep scheduled appointments, completion of claim forms, preparation of medical reports, late payment charges or mileage costs.

(6) **Complications of non-covered conditions or treatments.** Care, services or treatment required as a result of a condition not covered under the Plan (e.g., is excluded) or complications from a treatment not covered under the Plan. Complications from a non-covered abortion are covered.

(7) **Correctional agency or court-ordered care.** Care provided while a Covered Person is in the custody or care of a correctional agency; or when a Covered Person receives care under the authority of a court order for services rendered as a condition of parole or probation or in lieu of other correctional action.

(8) **Cosmetic reasons.** Care and treatment provided for or in connection with cosmetic procedures. Refer to the Medical Benefits Reconstructive Surgery section for information about covered expenses.

(9) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(10) **Dental Expenses.** Care, services or treatment provided for expenses incurred for dental work, unless such care is specifically covered in the Schedule of Benefits or Medical Benefits section of this Plan.

(11) **Dental Implants.** Dental implants, including any appliances and/or crowns and the surgical insertion or removal of implants, unless such care is specifically covered in the Schedule of Benefits or Medical Benefits section of this Plan.

(12) **Educational or vocational testing.** Services for educational or vocational testing or training; non-medical self-care or self-help training; and remedial reading and special education. (Refer to Medical Benefits for coverage of Education related to newly diagnosed conditions.)

(13) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Customary Allowance.

(14) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac or pulmonary rehabilitation, occupational or physical therapy covered by this Plan; charges for enrollment in a health, athletic or similar club; or charges for athletic trainers (this does not include athletic trainers who are certified and licensed as defined under Other Professional Provider in this Plan.).

(15) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for a Qualified Individual who is a participant in an Approved Clinical Trial with respect to the treatment of cancer or another Life-Threatening Disease or Condition. The Plan shall not deny, limit or impose additional conditions on Routine Patient Care Costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another Life-Threatening Disease or Condition, and either: (1) the referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate. (Refer to Defined Terms “Experimental and/or Investigational” for definitions of capitalized terms.)

(16) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan. Accommodating Intra-Ocular Lenses used to replace the lens of the eye following cataract surgery are not covered under this Plan.

(17) **Foot and Hand care.** Treatment of flat feet, corns, calluses and trimming of or treatment of fungal infections of the nails (unless needed in treatment of a metabolic or peripheral-vascular disease and authorized by the Utilization Review Coordinator). Surgical treatment of toenails is eligible if Medically Necessary. Charges for the purchase of orthopedic shoes or arch supports are not covered.

(18) **Foreign travel.** Care, treatment or supplies outside of the U.S. if travel is for the sole purpose of obtaining medical services. This exclusion also applies to Prescription Drugs obtained from outside the U.S. even if travel was not required. Exception: Care, treatment or supplies related to an Emergency Medical Condition or Medically Necessary treatment of an Illness while traveling outside the U.S.

(19) **Gene Manipulation Therapy.** Care, treatment or services for gene manipulation therapy.

(20) **Genetic testing.** Genetic testing is not covered unless it aids diagnosing of a Covered Person with functional abnormalities or who is symptomatic of an Illness which may be inheritable and the results of the test will impact the treatment being delivered.

(21) **Government coverage.** To the extent permitted by law, medical care, services and supplies which are furnished by a Hospital or facility operated by or at the direction of the United States government or any authorized agency thereof, or furnished at the expense of such government or agency, or by a Physician employed by such a Hospital or facility, unless (1) the treatment is of an emergency nature, and (2) the Covered Individual is not entitled to such treatment without charge by reason of status as a veteran or otherwise. This will also apply to services excluded under “**Correctional agency or court-ordered care**” listed above. This does not apply to Medicaid or when otherwise prohibited by law.

(22) **Hair loss.** Care and treatment for hair loss. Care and treatment includes wigs, hair transplants or any Prescription Drug that promises hair growth, whether or not prescribed by a Physician. However, care and treatment, except hair transplants, related to alopecia areata or scalp infection or as a result of treatment of a medical condition (e.g., chemotherapy for cancer) will have Prescription Drug coverage (with a prior authorization on file) and coverage for a wig. (Refer to the Schedule of Benefits for benefit information).

(23) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding or bungee jumping.

(24) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids (including external or implanted hearing aids) or exams for their fitting, except as exams may be covered under the well adult or well child benefits of this Plan. (Also, refer to "Hearing exams and hearing aids" under Medical Benefits.)

(25) **Home modifications.** Expenses for modification of home or living quarters due to medical disabilities.

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

(27) **Hypnosis.** Charges for hypnosis.

(28) **Illegal acts** (as defined by the state statutes where the incident occurred)**.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly by engaging in a Felony, an illegal occupation, a riot or public disturbance. For purposes of this exclusion, the term "Felony" shall mean any act or series of acts that may be punishable by more than a year of imprisonment. It is not necessary that criminal charges be filed. If charges should be filed, it is not necessary that a conviction result or that a sentence of imprisonment for a term in excess of one year be imposed in order for this exclusion to apply. The Plan will review information such as the police report, eye-witness accounts and/or provider medical records to determine if a criminal Felony has occurred. Proof beyond a reasonable doubt is not required. If a crime can be categorized as both a misdemeanor and a Felony, the Plan will use its discretion in determining if this exclusion will apply. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition. Refer to the Alcohol exclusion for the separate criteria for Injuries involving alcohol.

(29) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(30) **Infertility.** Care, supplies, services and treatment for infertility, including but not limited to diagnostic services, artificial insemination, other artificial methods of conception, in vitro fertilization, sexual dysfunction or a surrogate mother (even in the absence of an infertility diagnosis). If the treatment of the medical condition is Medically Necessary for an indication other than the promotion of fertility, then the services will be covered.

(31) **Lost, stolen or misused appliances/Durable Medical Equipment (DME).** Charges incurred to replace lost or stolen appliances/DME or to replace or repair appliances/DME due, in whole or in part, to improper use or care (according to the manufacturer's guide on proper use).

(32) **Maintenance.** Care and treatment for Maintenance.

(33) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(34) **Military-related disability or coverage.** Care in connection with a military-related Illness or Injury to which the Covered Person is legally entitled and for which facilities are reasonably available, to the extent permitted by law; or coverage while engaged in service with the armed forces of any international organization, nation or state.

(35) **Never Events.** Services, supplies, care or treatment as a result of a Never Events.

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

(37) **Non-compliance.** Charges in connection with treatments or medications where the Covered Person is non-compliant with prescribed treatment. If it is determined by the Claims Supervisor that a Covered Person is repeatedly non-compliant with prescribed treatment and the non-compliance has and will continue to result in additional treatment, the Claims Supervisor may, at its discretion, deny coverage of any additional treatment. The Covered Person will be notified of the effective date and condition, treatments and/or medications that have been determined to be ineligible. The Claims Supervisor will review medical records for compliance by the Covered Person to determine eligibility of additional treatment.

(38) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Emergency Medical Condition admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission. This preadmission (presurgical) day will not be covered if it is not approved through the precertification process for the surgery.

(39) **Non-Prescription Drug/Vitamins/Supplements.** Charges for non-Prescription Drugs, vitamins and nutritional supplements unless necessary for the treatment of an Illness and is approved by the Utilization Review Coordinator. (Refer to General Plan Information for contact information.)

(40) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

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

(42) **Not specified as covered.** Medical services, treatments and supplies which are not specified as covered under this Plan. Medical services, treatments and supplies that meet standards of care, are Medically Necessary, are ordered by a Physician, are not Experimental/ Investigational and not otherwise excluded by this Plan will be covered.

(43) **Obesity.** Care and treatment of obesity, weight loss or dietary control. Medically Necessary charge for health problems associated with high-risk Morbid Obesity/Severe Clinical Obesity will be covered. Refer to Weight Management in the Medical Benefits section for details.

(44) **Occupational.** Care and treatment of an Injury or Sickness that is occupational (that is, arises from work for wage or profit including self-employment) for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law. If the Covered Person is entitled to these benefits but did not receive them due to a failure to follow that plan's guidelines, this Plan will not consider those eligible charges. The Plan will not pay for any medical benefits related to a condition for which the Covered Person received a settlement for future medical benefits from a workers' compensation carrier.

(45) **Orthotics.** Replacement of orthotics will not be covered unless 1) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or 2) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 3 years). Replacement of the appliance must be preauthorized. (Refer to Cost Management Services.). The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions items Foot and Hand Care and Orthotics for further information.)

(46) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, water purifiers, non-prescription room humidifiers (this exclusion is not applicable for CPAP/BIPAP humidifiers), electric heating units, orthopedic or hypoallergenic pillows and mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies, non-hospital adjustable beds, hot tubs, whirlpools and exercise equipment. Compression stockings are covered with a prescription / Physician's orders. The prescription must require measurement of the patient for proper fitting. Limit two (2) pair per year.

(47) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(48) **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.

(49) **Prosthetic devices.** Certain prosthetic devices are not covered under this Plan: electrical convenience aids, either anal or urethral; implants for cosmetic or psychological reasons, penile prostheses for non-organic impotence; dental appliance; remote control devices; devices employing robotics; all mechanical organs; and investigational or obsolete devices and supplies. Replacement of prostheses will not be covered unless (a) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or (b) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 5 years). Replacement of the device must be preauthorized. (Refer to Cost Management Services.). Replacement due to improper use or care (according to the manufacturer's guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions for Prosthetic devices for further information.)

(50) **Psychoanalysis or counseling with relatives** (except if the counseling is with a covered parent on behalf of a covered minor child)**,** unless stated otherwise in the Medical Benefits section.

(51) **Psychological reasons.** Surgery performed for psychological or emotional reasons.

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

(53) **Routine care.** Routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected will only be covered if the benefit is listed in the Schedule of Benefits and explained in the Medical Benefits section or required by applicable law.

(54) **Safety devices.** Charges for safety devices such as helmets (except cranial molding helmets), shower chairs, restraints, telephone alert systems, safety eyeglasses and safety enclosure bed frames/canopies (e.g., Vail enclosures, Posey bed enclosures/canopy systems) which are used to prevent a patient from leaving their bed. These devices are not primarily medical in nature and are therefore considered not Medically Necessary.

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

(56) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

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

(58) **Sexual dysfunction.** Care, services or treatment for sexual dysfunction unrelated to organic disease.

(59) **Smoking cessation.** Care and treatment for smoking cessation programs, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma. (Refer to Prescription Drug Benefits for coverage of smoking cessation medications.)

(60) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(61) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

(62) **War.** Any loss that is due to a declared or undeclared act of war. This also applies for intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime.

PRESCRIPTION DRUG BENEFITS
(Dispensed at a Pharmacy)

Pharmacy Drug Charge

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

Copayments

The copayment is applied to each covered pharmacy drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply or a 90-day supply for maintenance drugs.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the Covered Person should follow the guidelines for filing the claim. The amount payable will be as shown in the Schedule of Benefits.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This does include oral contraceptives purchased at the Pharmacy, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection, such as Insulin, Imitrex, Lovenox, Betaseron, Copaxone, Avonex, Epogen, Neupogen or any other medication available to be filled as a self-injectable through the pharmacy. If the Plan covers oral contraceptives, Depo Provera will be considered a covered expense when purchased through the Pharmacy. This list is subject to change. For the latest information on approved drugs and to obtain approval for the purchase of the drug through the pharmacy, please contact the Pharmacy Benefit Manager as listed on the health care plan ID card.

(5) Administration of a prescription at a Pharmacy.

(6) All drugs required to be covered under the Affordable Care Act when purchased at a Participating Pharmacy.

(7) Any drugs specifically allowed under the prescription benefits as established with the Pharmacy Benefit Manager that may be excluded under Medical Plan.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

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

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

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

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal, unless prior authorized with the Utilization Review Coordinator/Claims Supervisor for treatment of an Illness or Injury.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person. A prior authorization is required for coverage of drugs related to a covered clinical trial for which the Covered Person is responsible for the cost of the drugs.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless prior authorized with the Pharmacy Benefit Manager or Utilization Review Coordinator/Claims Supervisor. (Refer to medical plan ID card for contact information.)

(9) **Immunization.** Immunization agents or biological sera.

(10) **Infertility.** A charge for infertility medication.

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

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

(13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions unless specifically allowed under the prescription benefits as established with the Pharmacy Benefit Manager.

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

(15) **Non-legend drugs.** Any drug for which no prescription is required by federal or state law, unless a specific medication or class of medications is covered under this Plan.. These are generally referred to as “over-the-counter” items. Contact the PBM for details (Refer to ID card for phone number).

(16) **No prescription.** Any drug for which no prescription is required by federal or state law. These are generally referred to as “over-the-counter” items. This does not apply to injectable insulin. Contact the Pharmacy Benefit Manager for details. (Refer to medical plan ID card for contact information.) Certain non-prescription medications are eligible for coverage under these benefits; however, a prescription for a Physician is required.

(17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT A CLAIM

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

Charges for medical services are billed by the provider at their normal rates. This is the price an individual would be charged in absence of any contractual arrangements with the provider. When contractual arrangements exist, the claim is re-priced to the discounted rate. This repricing function may either be performed by the Claims Supervisor or a PPO Network. The billed amount less any ineligible amount (including Usual and Customary Allowance), contracted discount or negotiated discount results in the Allowed Amount under this Plan. (Refer to the Schedule of Benefits for further information.)

A "Claim" is defined as any request for a Plan benefit, made by a Covered Person or by an Authorized Representative of a Covered Person that is filed with the Plan in accordance with the procedures described below. There are different types of Claims that may be filed under this Plan (as defined in the Claims and Appeals Timelines section below). For purposes of the appeals procedures as outlined, a Claim also includes any appeal of the Plan's decision to retroactively rescind your coverage due to fraud or intentional misrepresentation. For purposes of this section, a Claim does NOT include any request for eligibility to participate or to change an election under the Plan. If you have a question about eligibility or enrollment, contact the Plan Administrator.

How do I file a claim?

If you visit a network provider, the provider will file the Claim on your behalf. Even though the network provider files on your behalf, you should check with the provider to ensure that the provider did, in fact, file the Claim on your behalf.

If you visit an out of network provider, you or your Authorized Representative must file the Claim with the Plan at the address identified on your ID Card. You must file the Claim in accordance with the procedures described below.

(1) Obtain a Claim form from the Benefits Office or www.med-pay.com.

(2) Complete the primary insured portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) If a claim or bill from the provider is not available with all the information requested, have the Physician complete the provider's portion of the form.

(4) Attach bills or invoices from the provider for the services rendered for which you are requesting benefits under the Plan.

(5) Send the above to the **address on the ID card**.

Regardless of whether a network provider, you or your Authorized Representative files the Claim, it is not possible to make a determination that benefits are payable unless the Claim constitutes a "Clean Claim". A **"Clean Claim"** means a claim void of any material errors, omissions of pertinent information, coordination of benefits issues, and any liability issues, as determined by the Plan Administrator. Where not otherwise specified, this Plan follows National Correct Coding Initiative (NCCI) for coding modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in making determinations. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

For the purposes of this section, an "Authorized Representative" is the individual who has been designated by a claimant to receive information (depending on the type of claim) from the Plan Administrator or Claims Supervisor, as applicable, with respect to any claim for benefits that entails notification of either the Plan Administrator's or Claims Supervisor's action on the claim, as required in this section. An Authorized Representative shall be named by the Covered Person or beneficiary by filing a written designation to that effect with the Claims Supervisor or Plan Administrator, as applicable, except that, in a situation involving Urgent Care, (a) the designation may be made orally, and (b) a health care professional with knowledge of the claimant's medical condition shall be recognized as the claimant's Authorized Representative.

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Supervisor within 12 months of the date charges for the service were incurred. The following additional filing limitations apply:

(1) Claims for Benefits for services or treatments for which a Claim has not previously been filed but that relate to charges for services or treatments for which a Claim has been file are still considered a new claim and must be filed in the time limit above.

(2) Corrected information submitted on an initial claim determination is considered an appeal and not a newly filed claim. The filing limit will follow the appeal guidelines explained further in this section.

(3) **I**f the person is not capable of submitting the claim due to Illness including mental or physical incapacity that made it unreasonably difficult to file the claim within the specified timeframe. The Claims Supervisor will determine if it was or was not reasonably possible for the claim to be submitted within the time limit above.

(4) If there are complications in the filing of claims due to the person having primary insurance with another plan and this plan is the secondary plan, the filing period will continue to be limited to 12 months from the date of service. The Claims Supervisor will determine if it was or was not reasonably possible for the claim to be submitted within the time limit above.

(5) The Plan Administrator will determine the length of time for claims to be filed following the plan's termination date. The Employee will be notified of the filing limit so appropriate follow-up may be performed with providers regarding outstanding claims. The time period typically allowed for the filing of claims is at least 90 days from the Plan's termination date.

If you do not receive timely notice of the determination of your Claim (as described below), please contact the Claim Supervisor directly at the phone number listed on your ID card to verify receipt of the claim. You may also contact the provider to make sure the claim was filed correctly.

NOTE: Benefits are based on the Plan's provisions at the time the services or treatments were provided

NOTICE OF DETERMINATIONS AND APPEALS

Once the Claims Supervisor receives your timely and properly filed Claim, the Claims Supervisor will review your Claim to determine whether Benefits are payable in accordance with the terms of the Plan. The following describes the step by step process once the Claims Supervisor receives your Claim and your and the Plan's rights and obligations under the Plan with respect to appeals of any denials of your Claim. In addition, you may also be eligible to request an external review of any denied Claims and Appeals. See the "External Review" section below for more details.

Step 1: Notice is received from Claims Supervisor.

You will typically receive a notice from the Claims Supervisor indicating the extent to which Benefits are payable under the Plan with respect to your Claim. If your Claim is denied in whole or part, the Claims Supervisor will provide a written notice of its determination to you or your Authorized Representative within the time frames set forth in the Claims and Appeals Timeline Chart in this section. If the Claim is an Urgent Care Claim, the Claims Supervisor may initially notify you of its determination orally. The Claims Supervisor may take an extension of time to make the determination for reasons beyond the Claims Supervisor's control (e.g. your Claim is not a Clean Claim). If an extension is needed, the Claims Supervisor will notify you in writing (oral notice may be provided if the Claim is an Urgent Care Claim) within the time frames identified in the chart below. If the reason for the extension is that you need to provide additional information in order for the Claims Supervisor to make a determination, you will be afforded the opportunity to provide the missing information prior to the date set forth in the extension notice, which will be no less than 45 days from the date you receive the extension request. The Claims Supervisor's time period for making a determination is suspended until the date that your provide the information or the end of the information gathering period, whichever is earlier.

The notice will contain the following information:

(1) The reason(s) for the denial and the Plan provisions on which the denial is based.

(2) A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information.

(3) A statement indicating whether an internal rule, guideline or protocol was relied upon in

making the denial and a statement that a copy of that rule, guideline or protocol will be made available upon request free of charge

(4) If the denial is based on a medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request, and

(5) If the claim was an Urgent Care Claim, a description of the expedited appeals process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you no later than three days after the oral notification.

(6) Information sufficient to identify the claim (including the date of service, the health care provider, and the claim amount (if applicable).

(7) An explanation of how to request diagnosis and treatment codes (and their corresponding meanings).

(8) The contact information for the office of health insurance consumer assistance or ombudsman to assist you with your claims, appeals and external review.

Step 2: If you disagree with the decision and you desire additional consideration, you must file a 1st level Appeal with the Claims Supervisor.

If you do not agree with the decision of the Claims Supervisor, or the Pharmacy Benefit Manager (PBM) in the case of prescriptions drugs filled through a Pharmacy, and you desire additional consideration, you must submit a written appeal to the Claims Supervisor (or PBM as applicable) within 180 days of receiving the denial from the Claims Supervisor (or PBM as applicable). If the Claim is an Urgent Care Claim, you may submit your request orally by contacting the Utilization Review Coordinator (or PBM as applicable) as indicated on your ID card or in the General Plan Information section of this document.

You should submit all of the information identified in the denial letter as necessary to perfect your claim. In addition, you should include any additional information that you believe will support your Claim.

Step 3: Notice of denial on the 1st Level Appeal.

If your 1st Level Appeal is denied in whole or part, the Claims Supervisor (or PBM as applicable) will notify you in writing of its determination within the period described in the Claims and Appeals Timeline Chart in this section. The notice of determination will include the same information as the denial notice referenced in Step #1 above.

Step 4: If you disagree with the decision and you desire additional consideration, you must file a 2nd level Appeal with the Plan Administrator.

If you do not agree with the Claims Supervisor's (or PBM's as applicable) 1st Level Appeal Determination, and you desire additional consideration, you must submit a written appeal to the Plan Administrator within 90 days of receipt of the Claims Supervisor's (or PBM's as applicable) 1st Appeal denial letter. If the claim involves urgent care, your appeal may be made orally by contacting the Plan Administrator (Refer to the General Plan Information section of this document.)

You should submit all of the information identified in the Claims Supervisor's (or PBM's as applicable) denial letter (referenced in Step #1) as necessary to perfect your claim. In addition, you should include any additional information that you believe will support your Claim.

Step 5: Notice of determination following the 2nd Level Appeal.

The Plan Administrator (or Independent Review organization in the case of Pharmacy claims) will make its determination within the time frames set forth in the chart below. The notice will contain the same information as outlined in Step 1.

Other important information regarding your appeals:

(1) Each level of appeal will be independent from the previous level (e.g., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal).

(2) On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.

(3) If a claim involves medical judgment, then the claims reviewer will consult with an independent health care professional during the Appeal that has expertise in the specific area involving medical judgment.

(4) You may review the claim file and present evidence and testimony at each step of the appeals process.

(5) You may request, free of charge, any new or additional evidence considered, relied upon, or generated by the plan in connection with your claim.

(6) If at any level of appeal a decision is made based on a new or additional rationale, you will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.

(7) If you wish to submit relevant documentation to be considered in reviewing your claim for appeal, it must be submitted with your claim and/or appeal.

(8) You cannot file suit in federal court until you have exhausted these appeals procedures. Except as otherwise required by applicable law you must exhaust the external review process before filing suit.

(9) Please note that you must raise all issues that you wish to appeal during the Plan's internal appeal process and during the external review. If you pursue legal action to appeal your claim, you are barred from raising any issue in your lawsuit that you did not raise during the administrative claims review process.

(10) All notices from the Claims Supervisor (or PBM as applicable) or the Plan Administrator are deemed to be received by you within three (3) business days of the postmark date unless you provide objectively credible evidence to the contrary.

External Reviews

If your 2nd Level Appeal was denied by the Plan Administrator in whole or part, and the Claim involved Medical Judgment, you may request an external review from an independent review organization (IRO) in accordance with the procedures described below.

You may also seek an external review by an Independent Review Organization for a denial of an Urgent Care Claim based on Medical Judgment provided that the time frames to complete an appeal of an Urgent Care Appeal will seriously jeopardize your life or health or would seriously jeopardize your ability to regain maximum function.

How to Request an External Review

You must file your written request for an external review with the Claims Supervisor within 4 months of the date you received the applicable denial (see above for appeals that enable you to request an external review).

Within 5 business days of receiving your request for external review, the Plan Administrator will complete a preliminary review of the request to determine whether you were covered under the Plan at the time the expense was incurred and whether you have exhausted the internal appeal process where required. Within 1 business day of making the determination, you will be notified if the external review request is approved or denied and if denied, you will be provided with (i) the reasons why the claim is initially ineligible for external review, or (ii) the information or materials needed for a complete request. In the event your request is denied due to lack of information or materials, you must perfect your claim by the later of the end of the 4-month period following the date you received the 2nd level appeal determination or 48 hours following notification that your request for external review was denied.

If initially eligible for an external review, the Plan Administrator will assign the request to an Independent Review Organization (IRO). The IRO will make a determination and provide you and the Plan with notice of its determination within 45 days of receiving the review request.

If, due to your medical condition, the timeframe for completion of the standard external review process would seriously jeopardize your life or health or your ability to regain maximum function, you may request an expedited external review. Under an expedited external review, the preliminary review will be completed immediately. If determined to be initially eligible, the Claims Supervisor will assign the request to an IRO and the IRO will complete the review as expeditiously as your medical condition requires, but in no event more than 72 hours after receiving the request.

Claims and Appeals Timelines

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials. The definitions of the types of health claims are:

Pre-Service Claim. A claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you precertify hospital admissions.

Concurrent Care Claim. A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments. Concurrent Care Claim also includes a retroactive rescission of coverage due to fraud or intentional misrepresentation.

Post-Service Claim. A claim for care that has already been received.

Urgent Care Claim: A Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:

- Seriously jeopardize the life of the claimant (in the view of a prudent layperson acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant's medical condition) or
- Subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant's condition).

Claims and Appeals Timeline Chart
Group Health Benefit Plans

Type of Claim	Initial Claims		
	Claimant must be notified of determination as soon as possible but no later than…	**Extension period allowed for circumstances beyond Claims Supervisor's control…**	**If additional information is needed, claimant must provide information within…**
Pre-Service	15 days after Claims Supervisor's receipt of Claim (Including approval of Benefits)	One extension of 15 days.	At least 45 days of date of extension notice
Pre-Service involving Urgent Care	72 hours after Claims Supervisor's receipt of Claim (including approvals)	Must provide notice within 24 hours of receiving Claim if additional information is needed	At least 48 hours. Claims Supervisor must notify claimant of determination within 48 hours of receipt of claimant's information.
Concurrent: To end or reduce treatment prematurely	Claims Supervisor will notify claimant of the decision to reduce or terminate benefits sufficiently in advance of the end date in order to allow the claimant to appeal	N/a	N/A
Concurrent: To deny your request to extend treatment	Treat as any other pre or post service claim.	One extension of 15 days	At least 45 days after date of extension notice
Concurrent involving Urgent Care	24 hours, if claimant's request is made at least 24 hours before the date treatment is scheduled to end. Otherwise, request is treated as "Pre-Service Urgent Care" claim (including approvals of benefits)	None	N/A
Post-Service	30 days after Claims Supervisor's receipt of Claim	One extension of 15 days	At least 45 days after date of extension notice

Type of Claim	1st Level Appeal		2nd Level Appeal	
	Claimant must file appeal within…	**Claimant will be notified of determination as soon as possible but no later than…**	**Claimant must file appeal within…**	**Claimant will be notified of determination as soon as possible but no later than…**
Pre-Service	180 days upon receipt of Claims Supervisor's notice of determination	15 days after Claim Supervisor's receipt of appeal	90 days following Claimant's receipt of determination notice	15 days after Plan Administrator's receipt of appeal
Pre-Service involving Urgent Care	180 days upon receipt of Claims Supervisor's notice of determination	72 hours after Claims Supervisor's receipt of appeal	Not available	Not available
Concurrent: To end or reduce treatment prematurely	180 days upon receipt of Claims Supervisor's notice of determination	15 days after Claim Supervisor's receipt of the appeal	90 days following Claimant's receipt of determination notice	15 days after Plan Administrator's receipt of appeal
Concurrent: To deny your request to extend treatment	180 days upon receipt of Claims Supervisor's notice of determination	Treat as any other pre or post service claim	90 days following Claimant's receipt of determination notice	Treat as any other pre or post service claim
Concurrent involving Urgent Care	180 days upon receipt of Claims Supervisor's notice of determination	72 hours after Claims Supervisor's receipt of appeal	Not available	Not available
Post-Service	180 days upon receipt of Claims Supervisor's notice of determination	30 days of Claims Supervisor's receipt of appeal	90 days following Claimant's receipt of determination notice	30 days after Plan Administrator's receipt of appeal

COORDINATION OF BENEFITS

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

The plan that pays first according to the COB rules (Refer to Benefit Plan Payment Order that follows) will pay as if there were no other plans involved. As a subsequent plan, this Plan will consider the allowable amount to be the lesser of:

(1) what this Plan would have allowed as the primary plan; or

(2) the lesser amount allowed by any preceding plan(s).

This Plan will apply benefits (deductible, coinsurance, copay, etc.) according the Schedule of Benefits. As the subsequent plan, the amount payable by this Plan will be reduced by the payment made by the primary plan. The Total payment by this Plan may be reduced so as not to exceed 100% of this total allowable amount when added to any preceding plan's reimbursement and any responsibility of the Covered Person. Should the reimbursement(s) by any preceding plan(s) exceed this total allowable, no payment will be made by this Plan.

If the primary or any other preceding plan denies a claim (in part of in full) for any of the following:

(1) The Covered Person or provider's failure to respond to a request for more information;

(2) Lack of Medical Necessity;

(3) Failure to follow plan guidelines (e.g., prior authorization, precertification, timely filing of claims, proper appealing of claims); or

(4) Other denial that can be appealed,

this Plan will not consider the charges as eligible. The appeals procedures under the prior plan(s) must be properly followed and exhausted. The results must be provided to this Plan before charges will be reviewed for consideration. This process must be completed according to the appeal procedures of this Plan.

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

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

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

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

Allowable Charge. To be considered a Covered Charge under this Plan, treatment, services and/or supplies must meet all of the following criteria: **(1)** Medically Necessary; **(2)** Ordered by an appropriate Physician; **(3)** Not excluded under the Plan; and **(4)** Meets the standards of care for the diagnosis..

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance which insures the Covered Person, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. (For purposes of this section, "available" means that the insured has personal injury coverage under his/her personal automobile insurance, and applies whether the coverage is provided directly or indirectly (e.g., under a spouse's or parent's auto policy). This Plan is secondary even if no claim is filed with the auto carrier. Accident claims filed with this Plan will not be considered pending receipt of the auto policy information. If the information is not provided within the requested period, the claim(s) will be denied. (Refer to the Claims Procedure section.)

This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier (only available in some states).

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

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

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

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

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

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

(d) When a child is covered as a Dependent and the parents are married(whether or not living together) or are living together (whether or not they have ever been married), these rules will apply:

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

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

(e) When a child's parents are divorced or Legally Separated, these rules will apply:

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

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

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

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

(v) If there is no court decree allocating responsibility for child’s health care expenses or health coverage or for parents who were never married to each other and not living together, the rules apply as follows as long as paternity has been established:

The Plan of the Custodial Parent;

The Plan of the spouse of the Custodial Parent;
The Plan of the non-custodial parent; and then
The Plan of the spouse of the non-custodial parent.

If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health insurance coverage, that Plan is primary. This rule applies to Claim Determination Periods or Plan Years commencing after the Plan is given notice of the court decree.

If a court decree states that both parents are responsible for the Dependent Child's health care expense or health insurance coverage, the provisions of subparagraph (d) of this section shall determine the order of benefits.

For the purposes of this section:

Custodial Parent means the parent awarded custody by a court decree; or in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year excluding any temporary visitation.
Claim Determination Period means a Calendar Year. Claim Determination Period does not include any part of the Calendar Year during which a claimant has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

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

(g) This Plan will follow the adopted NAIC rules for how to coordinate benefits when a Dependent Child is covered under their own or their spouse's insurance plan and either or both of his/her parents.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon the benefit determination by Medicare under Parts A, B and D or this Plan, if the benefit would be less. The Covered Person must exhaust all option Medicare benefits such as reserved inpatient days before this Plan will be considered the primary payer. This Plan will always follow the standard Medicare Secondary Payer rules as may be revised from time to time.

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

(5) The Plan will pay primary to Tricare to the extent required by federal law.

(6) The Plan will pay primary to Medicaid coverage. Your eligibility for coverage under this Plan will not be affected by the fact that you receive medical assistance or are eligible for coverage under Medicaid.

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

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

While the Covered Person may receive payment of such claims pursuant to the terms of the Plan, the Covered Person shall be required to refund to the Plan all medical or dental expenses paid if the Covered Person Recovers from any other party.

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

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

Payment Prior to Determination of Responsibility of a Third Party
The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Person for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party.

However, subject to the terms and conditions of this Section, the Plan may advance payment after receipt of a properly executed reimbursement agreement and consent to lien, and pay claims in accordance with the Plan of Benefits, until it is determined whether or not a third party is required to pay for those services or supplies.

By accepting an advance of benefits paid by the Plan the Covered Person jointly and severally agrees that:

- **(1)** the Plan has a priority lien against the proceeds of any such settlement, judgment, arbitration, or recovery to assure that reimbursement is promptly made; and
- **(2)** the Plan will be subrogated to every Covered Person's right of recovery from that third party or that third party's insurer to the extent of the Plan's advances any benefit payments; and
- **(3)** the Covered Person(s) will, jointly and severally, reimburse the Plan out of any and all amounts paid or payable to any or all of them by any third party or that third party's insurer to the extent of the entire amount advanced for related claims to the accident or injury by the Plan.

The Plan's reimbursement and/or subrogation rights will include all claims, demands, actions and rights of recovery of all Covered Persons against any third party or insurer, including any Workers' Compensation insurer or governmental agency, and will apply to the extent of any and all advance payments made or to be made by the Plan. This means that the Covered Person recognizes the Plan's rights to 100%, first dollar priority over any and all Recoveries and/or funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, whether by judgment, settlement, arbitration award or otherwise and shall not be limited by any other characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. This priority is over any claims, including medical, non-medical or dental charges, attorney fees, or other costs and expenses associated with the enforcement of the Plan's rights under this Right of Recovery/Subrogation benefit.

The Plan shall be Subrogated, and shall be entitled to Reimbursement, for any payment by a Third Party to a Covered Person for future medical expenses paid pursuant to a judgment, settlement or contract on the following bases:

(1) If any amount is awarded by means of a verdict after a full and complete trial and the judgment or verdict form itemizes by separate finding or special amount awarded for future medical expenses, such amount shall be binding on the Plan and the Covered Person as the amount of future medical expenses to which the Plan is subrogated and entitled to reimbursement.

(2) If there exists any contract or policy of insurance by which future medical expenses are paid (other than a policy or contract of health care, hospitalization or disability insurance issued to and in the name of such Covered Person), the Plan shall be subrogated to and entitled to reimbursement and deemed secondary or excess insurance to such contract or policy and amounts paid thereby.

(3) If any amount is paid to a Covered Person by means of a settlement or general judgment or verdict which does not itemize components of damage, the Plan Administrator and the Covered Person shall agree on the amount which is attributable to future medical and dental expenses. In the event that the Plan Administrator and the Covered Person cannot agree on the amount attributable to future medical expenses, the Plan Administrator, in its sole and absolute discretion, shall determine the amount attributable to future medical expenses

If any amount awarded under subsection (1), the total amount of future medical expenses to which the Plan is Subrogated and entitled to reimbursement shall be reduced by and, in determining the amount to which the Plan is Subrogated and entitled to reimbursement under subsection (3), consideration may be given to:

(a) the amount of proportionate or comparative fault assessed against the Covered Person which reduces the amount of total future medical expenses which are paid by the other;

(b) the amount not collectible.

In addition, in determining the amount of future medical expenses paid under subsection (3) above, consideration shall be given to the percentage of total future medical expenses paid by the one who is jointly liable with another, the other remaining liable, any discount for present value of future expenses and any discount for possibilities of incurring the claimed future medical expenses.

When any amount is paid or payable pursuant to Subsections (1), (2) or (3) above, the Covered Person shall pay all medical expenses incurred in the future for treatment of the injuries sustained for which the payments under (1), (2) or (3) were made or agreed to be made, and the Plan shall have no responsibility or liability to pay any such future medical expenses, nor shall the amount of any such payment be considered to represent a Covered Expense incurred under this Plan for purposes of satisfying any of the provisions of this Plan with respect to the Deductible or co-payment requirements, until the amount under subsection (1), (2) or (3) is fully used.

The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its right to recover any amount it advanced in accordance with the Plan of Benefits, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Persons.

However, in doing so, the Plan will not represent, or provide legal representation for, any covered individual with respect to that Covered Person's damages to the extent those damages exceed any advance on account of the Plan of Benefits.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Person against any third party or that third party's insurer on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Person's injury or illness that resulted in the advance by the Plan.

Reimbursement and/or Subrogation Agreement
The Covered Person (or his/her representative in the case of minor child(ren) or an incapacitated Covered Person), recognizes that compliance with this section of the Plan is a condition of participating in and having payments made under this Plan, and that as such the Covered Person agrees to the provisions of this section.

The Plan's standard administrative procedure will be to ascertain the nature of any injury to determine whether a third party could be held liable. Claims will not be paid until this determination is made. If it is determined that the claim may be the result of a third party's negligence, the Plan will not process any claims without a properly signed Reimbursement Agreement and Consent to Lien.

Every Covered Person on whose behalf an advance may be payable must execute and deliver any and all agreements, instruments and papers requested by or on behalf of the Plan (including but not limited to the reimbursement agreement and consent to lien), and must do whatever is necessary to protect the Plan in obtaining reimbursement and/or subrogation rights. As a condition precedent to the advance payment of related claims by the Plan, all Covered Persons will, upon written request, execute a Reimbursement Agreement or Consent to Lien in a form provided by or on behalf of the Plan.

If any Covered Person does not execute any such Reimbursement Agreement or Consent to Lien for any reason, it will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan reimbursement and/or subrogation rights if the Plan, at its discretion, makes an advance and inadvertently pays benefits in the absence of a reimbursement and/or subrogation agreement.

Cooperation with the Plan by All Covered Persons
By accepting an advance for related claim payment, every Covered Person agrees to do nothing that will waive, compromise, diminish, release or otherwise prejudice the Plan's Reimbursement and/or Subrogation rights.

By accepting an advance payment for related claims to an injury, every Covered Person agrees to notify and consult with the Plan Administrator or its designee before:

(1) starting any legal action or administrative proceeding against a third party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Person's injury that resulted in the Plan advance payment of claims; or

(2) entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the Covered Person's injury that resulted in the Plan's advance for claims related to such injury.

By accepting an advance in claim payments, every Covered Person agrees to keep the Plan Administrator and Claims Supervisor informed of all material developments with respect to all such claims, actions or proceedings.

All Recovered Proceeds Are to Be Applied to Reimbursement of the Plan The Covered Person agrees to automatically assign his/her rights against any Third Party or insurer when this provision applies. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered' Person's Third Party Claims.

By accepting an advance payment of claims for an injury, every Covered Person agrees to reimburse Plan for all such advances by applying **any and all** amounts paid or payable to them by any third party or that third party's insurer by way of settlement or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized in the settlement or judgment as being paid on account of the medical expenses for which any advance has been made by the Plan. In such event the Plan must be fully reimbursed within 31 days, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees.

If the Covered Person fails to take action against a responsible Third Party to recover damages within one (1) year or within thirty (30) days of a request by the Plan, the Plan shall be deemed to have acquired, by assignment or Subrogation, a portion of the Covered Person's claim equal to its prior payments. The Plan may thereafter commence proceedings directly against any responsible Third Party. The Plan shall not be deemed to waive its rights to commence action against a Third Party if it fails to act after the expiration of one (1) year, nor shall the Plan's failure to act be deemed a waiver or discharge of the Lien described in this section.

The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

Also, The Plan's right to Subrogation and reimbursement still applies if the Recovery received by the Covered Person is less than the claimed damage, and as a result, the claimant is not made whole.

If any Covered Person fails to reimburse the Plan as required by this section, the Plan may deny payment of claims and treat prior paid claims (related to the accident/injury) as overpayments recoverable by offset against any and all future claims for benefits that may become payable on behalf of all Covered Persons within the injured Covered Person's immediate family to the amount not reimbursed.

Once the claim is settled, the Plan will not pay future benefits for claims related to that Injury or accident unless it is determined by the Plan Administrator or Claims Supervisor that the original settlement was reasonable and the subsequent claims were not recognized in the settlement.

The Plan shall have no obligation whatsoever to pay medical or dental benefits incurred by a Covered Person if a Covered Person refuses to cooperate with the Plan's Reimbursement and/or Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Reimbursement and Subrogation rights.

No Fault Insurance Coverage
If you are required to have No-Fault insurance coverage, the automobile No-Fault Insurance carrier will initially be liable for lost wages, medical, surgical, hospital, and related charges and expenses up to the greater of:

the maximum amount of basic reparation benefit required by applicable law: or
the maximum amount of the applicable No-Fault Insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided health coverage. Before related claims will be paid through this Plan, the Covered Person or his dependent will be required to sign a Reimbursement Agreement.

If the Participant or his dependent fails to secure No-Fault Insurance as required by state law, the Participant or dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself and/or his dependents arising out of the accident.

Refund of Overpayment of Benefits - Right of Recovery
If the Plan pays benefits for expenses incurred on account of you or your Eligible Dependent, you or any other person or organization that was paid must make a refund to the Plan if:

(1) all or some of the expenses were not paid, or did not legally have to be paid by you or your Eligible Dependents.

(2) all or some of the payment made by the Plan exceeds the benefits under the Plan.

(3) all or some of the expenses were recovered from or paid by a source other than this Plan including another Plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions. The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If you or any person or organization that was paid does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

RIGHT OF RECOVERY

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

If the Covered Person's total Recovery from all sources does not adequately reimburse him for his expenses and injuries, the Plan Administrator, in its sole and absolute discretion, may accept a lesser

amount in full satisfaction of its rights. The Plan Administrator shall have sole authority to determine whether a Covered Person has been adequately reimbursed and whether to accept a lesser amount.

Waiver of Subrogation Rights. The Plan Administrator, in its sole and absolute discretion, may agree to waive the Plan's Subrogation rights. Such waiver shall not automatically occur in any matter. Waivers of the Subrogation and reimbursement interest of the Plan may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. Waivers of Subrogation and reimbursement interests will generally not be granted if the past medical expenses are greater than $500 or if the total judgment or settlement exceeds $5,000.

Conflict Within the Plan. If any portion of this Section on Subrogation and reimbursement is deemed to conflict with any other provision of the Plan on coordination of benefits of primary-secondary insurance coverage, the other portion of the Plan shall control and the provisions of this section shall supplement such other provisions to the extent that they are not inconsistent.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on any and all approved settlements.

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

Defined terms:

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

"Lien" is a right created by law to obtain Reimbursement from monies paid by a Third Party in compensation for a loss. This means the Plan retains the right to repayment for the value of all benefits provided by the Plan that are associated with the Injury or Illness for which the Third Party is or may be responsible, plus the costs to perfect the Lien. To prevent a double Recovery on the payment of medical expenses, a Lien is created in favor of this Plan in providing payment of medical expenses for the injured Covered Person.

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

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

"Reimbursement" means that the Plan has a right to be paid a Recovery received by the participant or to the extent not contrary to law, to offset all or any part of the Plan's Recovery against any amount the Plan or the Employer owes to the Covered Person or owes as benefits for the Covered Person.

"Subrogation" means the right of the Plan to be substituted in place of any Covered Person with respect to that Covered Person's lawful claim, demand, or right of action against a third party who may have wrongfully caused the Covered Person's injury or illness that resulted in a payment of benefits by the Plan.

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA. (Refer to General Plan Information section for contact information.)

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

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

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

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

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

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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

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

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

(1) The death of a covered Employee.

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

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

(4) A covered Employee's enrollment in any part of the Medicare program.

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

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

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

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

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

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

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

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

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

(1) the end of employment or reduction of hours of employment,

(2) death of the employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

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

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm designated by the Plan Administrator.

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

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

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

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

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have

been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

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

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

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

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

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

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

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

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

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

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

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

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

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

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

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

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

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

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

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

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

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

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Camdenton R-III School District Employee Health Care Plan is the benefit plan of Camdenton R-III School District, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by Camdenton R-III School District to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Camdenton R-III School District shall appoint a new Plan Administrator as soon as reasonably possible.

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

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Supervisor to pay claims.

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

(8) To maintain the Plan in accordance with all applicable State and Federal laws. If this Plan has not been amended according to a required change, the administration of the Plan will comply with the change until such time that the Plan is amended.

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

CLAIMS SUPERVISOR IS NOT A FIDUCIARY. A Claims Supervisor is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

DELAY OF DUTIES OF PLAN ADMINISTRATOR OR CLAIMS SUPERVISOR DUE TO FORCE MAJEURE. Force Majeure is a circumstance not within a person’s control, including but not limited to: fire, flood, war, civil disturbance/riot, court order, strike, partial or complete destruction of facilities, etc. No suit or action in law or equity may be taken against them on account of any of these events. The Plan Administrator and Claims Supervisor will have no liability or obligation if their respective services are delayed or not provided; or if medical care is delayed, not provided, or covered as non-network care due to Force Majeure. The Plan Administrator and Claims Supervisor will, however, make a good-faith effort to provide services during and subsequent to any of these events.

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

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

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past,

present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

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

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

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

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

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

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

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

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

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

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

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

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

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

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

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

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

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

The following members of Camdenton R-III School District's workforce are designated as authorized to receive Protected Health Information from Camdenton R-III School District Employee Health Care Plan ("the Plan") in order to perform their duties with respect to the Plan: Plan Administrator, Central Office staff (when required for job function) and Camdenton R-III School Board Members.

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

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

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

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived solely from the funds of the Employer.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and Employee, if any, and reserves the right to change the level of Employee contributions.

For Dependent Coverage: Funding is derived solely from contributions made by the covered Employees.

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

Benefits are paid directly from the Plan through the Claims Supervisor.

Assignment and Non-Alienation of Benefits: Amounts payable at any time may be used to make direct payments to health care providers. Except as applicable law may otherwise require, no benefit, right or interest of any member hereunder shall at any time be used or be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

Assignment means, for purposes of this Plan, that the Plan may pay any benefits due under this Plan directly to the Provider. The rights of a participant and the benefits to which he is entitled or for which he applies under the Plan are not assignable, except for assignment of payments directly to a provider, or in accordance with the subrogation provisions of the Plan. The Plan has full discretionary authority to accept or reject an assignment. The provisions of this Plan shall supersede any and all other assignment or alienation provisions, under whatever terms that may be used, that a member may make with a provider of health care services. Moreover, this Plan has priority lien against any and all proceeds that may be due the plan.

THE TRUST AGREEMENT

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

(1) A copy of the Trust agreement.

(2) A complete list of employers and employee organizations sponsoring the Plan.

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

The Plan Administrator will have final determination of benefits if there are typographical or grammatical errors that appear in this document. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

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

PHYSICAL EXAM

The Plan has the right and opportunity to examine any Covered Person with respect to a claim for benefits that is pending under the Plan when and as often as it may reasonably require. The Provider will be of the Plan's choosing and at the Plan's expense. A Covered Person is required by the Plan to submit to such examination as a condition of coverage. This may be required to assist the Plan Administrator/Claims Supervisor in determination of non-covered services (e.g., malpractice claim, suspected felony, or other non-covered service).

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

MATERIAL MODIFICATIONS

Material Modifications to the Plan will be provided to all Covered Persons according to applicable Federal law and/or Missouri State law.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Supervisor. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Employer may insure claims for specific and/or aggregate "Stop-Loss" claim reimbursement through a re-insurance contract.

PLAN NAME: Camdenton R-III School District Employee Health Care Plan

PLAN NUMBER: 501

GROUP NUMBER: 070103CSD

TAX ID NUMBER: 44-6004944

PLAN EFFECTIVE DATE: July 1, 2000. Herein revised July 1, 2016.

PLAN YEAR ENDS: June 30th

EMPLOYER INFORMATION

Camdenton R-III School District
119 Service Road/PO Box 1409
Camdenton, Missouri 65020
(573) 346-5651

PLAN ADMINISTRATOR

Superintendent
Camdenton R-III School District
119 Service Road/PO Box 1409
Camdenton, Missouri 65020
(573) 346-5651

CLAIMS SUPERVISOR and COBRA ADMINISTRATOR

Med-Pay, Inc.
PO Box 10909
Springfield, Missouri 65808
(417) 886-6886 or (800) 777-9087

UTILIZATION REVIEW COORDINATOR

MPI Care
PO Box 10909
Springfield, Missouri 65808
(417) 886-6886 or (800) 777-9087(Refer to health care plan ID card for precertification contact.)

TRUSTEE(S)

Superintendent
119 Service Road/PO Box 1409
Camdenton, Missouri 65020

BY THIS AGREEMENT, Camdenton R-III School District Employee Health Care Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Camdenton R-III School District on or as of the day and year first below written.

By _____
Plan Administrator
Camdenton R-III School District

Date July 1, 2016

Witness _____

Date July 1, 2016