Barton County Community College

Medical, Dental, and Prescription Plan Document /
Summary Plan Description

Employee Health Care Plan

911377- PPO Healthcare Plan

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

INTRODUCTION AND PURPOSE

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund, or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for Hospital and medical charges. The Plan Document is maintained by Barton County Community College and may be inspected at any time during normal working hours by any Plan Participant.

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

The Covered Person has two Options from which to choose in receiving benefits under this Plan.

(1) PPO Network Option ("Network").

(2) Non-Network Option ("Out-of-Network").

The Covered Person receives greater benefits from using a PPO Network provider rather than a Non-Network provider; however, the choice of provider lies with the patient and benefits will be paid as shown.
PPO Network Option: Network providers are made up of Hospitals, Physicians and other providers which have agreed to a reduced fee schedule. The percentage payable under the Plan is a percentage of this reduced fee schedule and not upon Reasonable and Usual and Customary Charges. Each Covered Person can request a list of PPO Network providers as part of the enrollment process or at anytime from the Plan Administrator.

Out-of-Network Option: Out-of-Network providers are not bound by any reduced fee agreements with the Plan. They can charge their normal fees. The Plan will reimburse their services based upon the Out-of-Network Deductible, percentage and the Reasonable and Usual and Customary Charge. Therefore, the Covered Person is responsible for charges in excess of this Reasonable and Usual and Customary Charge. These excess charges are the responsibility of the Covered Person and will not apply to the Plan Co-Insurance limits.

NETWORK PROVIDER INFORMATION CAN BE OBTAINED FREE OF CHARGE FROM THE PLAN ADMINISTRATOR OR BY CALLING ProviDrsCare NETWORK AT 800-801-9772 OR THROUGH THEIR WEBSITE AT www.providrscare.net.

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. All eligible individuals who apply and are accepted as a member of the Plan agree to abide by all terms and conditions as set forth in this document.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right through a procedure described in the Plan Administration section to terminate, suspend, discontinue, or amend the Plan at any time upon advance notice to all Participants.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Co-Payments, exclusions, limitations, definitions, eligibility, and the like. 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 summary fashion in this document. Additional information is available from the Plan Administrator at no extra cost.

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.

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

GENERAL PLAN INFORMATION

Name of Plan:	**Barton County Community College**
Plan Sponsor:	**Barton County Community College** **245 NE 30 Rd** **Great Bend, KS 67530** **Phone: 620-792-9222**
Plan Administrator: **(Named Fiduciary)**	**Barton County Community College** **245 NE 30 Rd** **Great Bend, KS 67530** **Phone: 620-792-9222**
Plan Sponsor ID No. (EIN):	**Barton County Community College- 48-0720175**
Source of Funding:	**Self-Funded**
Applicable Law:	**ERISA**
Plan Year:	**November 1st, 2024**
Plan Number:	**501**
Plan Type:	**Medical** **Dental** **Prescription Drug**
Claims Administrator:	**Freedom Claims Management, Inc.** **P.O. Box 1365** **Great Bend, Kansas 67530** **Phone: (866) 792-9151 or (620) 792-9151** **www.freedomclaimsinc.com**
Participating Employer:	**Barton County Community College** **245 NE 30 Rd** **Great Bend, KS 67530** **Phone: 620-792-9222**

The Plan shall take effect for each Participating Employee on the Effective Date unless a different date is set forth above opposite such Participating Employer's name.

LEGAL ENTITY; SERVICE OF PROCESS. The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

NOT A CONTRACT. This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any Employees.

APPLICABLE LAW. This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

DISCRETIONARY AUTHORITY. The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participant's rights; and to determine all questions of fact and law arising under the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

TABLE OF CONTENTS

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

ELIGIBILITY, FUNDING, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of the Plan benefits or requirements.

Eligible Classes of Employees:
Full-Time Employees as defined below that have not elected the Barton County Community College Level II Preventive Health Benefits Plan.

Eligibility Requirements For Employee Coverage.

A person is eligible for Employee coverage the first day of the month following the date he or she:

(1) Is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 40 (forty) hours per week on an annual basis and is on the regular payroll of the Employer for that work.
(2) Is in a class eligible for coverage.
(3) Completes the employment Waiting Period of:
First of the month following 30 (thirty) days of Full-Time employment.

A person is **excluded** from coverage under this plan if they fall into one off the following employment classes:

(1) Part-time/variable hour workers, meaning those persons regularly scheduled to work less than 30 hours per week.
(2) Employees covered under a collective bargaining agreement.
(3) Seasonal Employees, meaning employees who are employed on a seasonal basis into a position for which the period of customary annual employment is six (6) months or less.
(4) Leased workers, as that term in used in Code § 414(n) of the Internal Revenue Code.

Eligible Classes of Dependents.

Dependent is any one of the following persons:

(1) Spouse. The term "Spouse" shall mean the participant's Spouse (if not legally separated from the covered Employee). The term Spouse excludes non-married, same sex marriage, or common law Spouses, unless such relationship is provided for in state or case law for the state of residence. Common law marriage must be documented as requested by the Plan Administrator to include proof of an ongoing common law marriage relationship. The Plan Administrator may require documentation proving a legal marital relationship.

(2) Child(ren). Children from birth to the limiting age of twenty-six (26) years. The term "Children" shall include:

- Children under the age of twenty-six (26) who are either the birth Children of the Insured or the Insured's Spouse or legally adopted by or placed for adoption with the Insured;
- Children under the age of twenty-six (26) in which the Insured is required to provide health care coverage pursuant to the Qualified Medical Child Support order (QMCSO).
- Children under the age of twenty-six (26) in which the Insured is the court-appointed legal guardian.

The term "Children" shall include natural Children, adopted Children or Children placed with the covered Employee in anticipation of adoption or a Child who has been placed under the legal guardianship of the Participant. Step-children who reside in the Employee's household may also be included.

If a Dependent is acquired other than at the time of his birth, due to a court order or decree, that Dependent will be considered an eligible Dependent from the date of such court order or decree, provided that this new Dependent is properly enrolled as a Dependent of the covered Employee within 63 (sixty-three) days of the court order or decree.

As required by the federal Omnibus Budget Reconciliation Act of 1993, any Child of a Plan Participant who is an alternate recipient under a QMCSO shall be considered as having a right to Dependent coverage under this Plan with no Pre-Existing Conditions provisions applied. A participant of the Plan may obtain, without charge, a copy of the procedures governing QMSCO determinations from the Plan Administrator.
The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

Coverage may be continued if a covered Dependent Child is incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two (2) years following the Dependent's reaching the limiting age, subsequent proof of the Child's disability and dependency.

After such two (2)-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

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

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

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

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.

Eligible Classes of Retirees:

Retiree as defined below.

“Retiree(s)” means an individual who, in the event Plan Sponsor has elected to provide coverage to Retirees under this Plan, satisfies the conditions required to be considered a Retiree, as specified below.

The term “retirement” means that the Participant has terminated employment and is receiving a retirement or disability benefit for service with the Employer.

To the extent Plan Sponsor has elected to provide coverage to Retirees under the Plan, a Retiree shall be an individual who satisfies each of the following conditions:

- **(1)** Term of Service. The Plan Participant has at least ten (10) years of service with the Employer at the time of his/her retirement from the Employer.
- **(2)** Waiver of COBRA. The Plan Participant waives his/her right to elect COBRA continuation coverage pursuant to Section COBRA Continuation Options of the Plan Document.
- **(3)** Timely Election to Continue Coverage. The Plan Participant affirmatively elects, using the procedures prescribed by the Plan Administrator, to continue coverage under the Plan no later than sixty-three (63) days after his/her retirement from employment with the Employer.

Eligibility Requirements For Retiree Coverage.

If Plan Sponsor has elected to cover Retirees under the Plan, the eligibility conditions for a Retiree are as set forth Eligible Classes of Retirees. Individuals receiving COBRA continuation coverage shall not be eligible for Retiree coverage under this Plan. An individual whose coverage as a Retiree under this Plan is subsequently terminated for any reason shall thereafter not be eligible again for coverage as a Retiree under this Plan.

Effective Date of Coverage for Retirees.

If Plan Sponsor has elected to cover Retirees under the Plan, an individual who meets the Plan's eligibility conditions for Retirees and who timely submits to the Plan Administrator a properly completed application for Retiree coverage shall begin coverage as a Retiree on the first day of the month coincident with or next following the date on which the individual terminated employment with the Employer at a time that he/she satisfied the Plan's conditions for Retiree coverage. The deadline for submitting an application for Retiree coverage shall be the same deadline that is applicable to all other new enrollees (other than Special Enrollees) in the Plan, as elected by Plan Sponsor in the Plan Document. An individual who fails to submit a timely application for Retiree coverage shall thereafter be prohibited from enrolling in the Plan as a Retiree.

Eligible Classes of Dependents of Retirees.

As defined in the Eligible Classes of Employees Dependents.

The Dependents of a Retiree who is eligible to, and does, continue his/her coverage under the Plan shall be eligible to continue their participation in the Plan if, and only if, they were covered under the Plan at the time of the Retiree's termination of employment with Plan Sponsor.

FUNDING

Cost of the Plan. The Plan Administrator may require a contribution from the Plan Participant in order to maintain Employee participation and the participation of any Dependents in the Plan. Eligible Plan Participants will be advised of any required contributions at the time they apply for enrollment in the Plan. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required contribution amount. Participants in the Plan that do not require contribution at the time they enrolled will be notified by the Plan Administrator prior to the date a contribution requirement is made effective. Coverage for persons under COBRA is solely the responsibility of the Covered Person(s). Employees on unpaid Leave of Absence or other leave are responsible for paying their portion of the premiums to the Plan on a timely basis, or as determined by Barton County Community College.

Cost of the Plan for Retiree. The Plan Participant must pay the entire cost of coverage for this Retiree continuation coverage. Although exact premiums will be determined by the Plan Sponsor, the Plan Sponsor may also require that the Plan Participant pay an administrative fee of up to 25% of the cost of the coverage.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage also, including coverage for Newborn children.

Enrollment Requirements for Newborn children. It is important to remember that a Newborn Dependent is NOT automatically enrolled in the Plan. Newborn Children of a Covered Employee will be covered from the moment of birth, including the necessary care or treatment of medically diagnosed Congenital Birth Defects, birth abnormalities or prematurity, provided the Child is Enrolled as a Dependent of the Covered Employee within sixty-three (63) days of the Child's date of birth. This provision shall not apply nor in any way affect the normal maternity provisions applicable to the mother. If the Child is not enrolled within sixty-three (63) days of birth, the enrollment will be considered a Late Enrollment.

SPECIAL ENROLLMENT

If an eligible Employee or Dependent declined coverage hereunder at the time of initial eligibility (and stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage hereunder within sixty-three (63) days of the loss, such individual shall be a Special Enrollee provided such person:

(1) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(2) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including, as a result of:

- legal separation
- divorce
- death
- termination of employment
- reduction in the number of hours of employment or Employer contributions toward such coverage were terminated.

Individuals who lose other coverage due to nonpayment of premium or for cause (i.e., filing fraudulent claims) shall not be Special Enrollees hereunder. An eligible Employee or Dependent who seeks to enroll in the Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the eligible Employee or Dependent enrolls within sixty-three (63) days of the acquisition of the new Dependent.

Coverage for a Special Enrollee (other than a Newborn, newly adopted Child or newly acquired Dependent through marriage) shall begin as of the first day of the calendar month following the enrollment request. Coverage for a newly adopted, Newborn, or acquired Dependent through marriage Special Enrollee shall begin as of the date of the adoption, placement for adoption, birth, or date of marriage.

Special Enrollment and Children's Health Insurance Program (CHIP)

If an eligible Employee or Dependent declined coverage hereunder at the time of initial eligibility (and stated in writing at that time that coverage was declined because they were unable to afford the premiums) and later approved for premium assistance under the Medicaid or CHIP, as long as you and your Dependents are eligible, but not enrolled, and make application for coverage hereunder within sixty (60) days of being determined eligible for premium assistance this will be considered a Special Enrollment. For more information, please contact the Plan Administrator or www.insurekidsnow.gov.

TIMELY AND LATE ENROLLMENTS

An enrollment is either "timely" or "late":

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than sixty-three (63) days after the person becomes eligible for the coverage.

If two Employees (husband and wife) are covered under the Plan and one of the Employees 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** - An enrollment is "late" if it is not made on a "timely basis" or considered a Special Enrollment and coverage shall not become effective until the end of the next Open Enrollment Period. The Open Enrollment Period will be an annual Open Enrollment Period during the month of August, at which time an Employee may change to single or elect family coverage under the plan as a Late Enrollee to be effective on September 1st. The forty-five (45)-day Waiting Period will be waived. Employees or Dependents who do not sign up during the first enrollment or Open Enrollment Period, who have no coverage or voluntarily lose other coverage (such as not paying premiums) in another plan, will be denied coverage in this Plan.

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 Actively at Work Requirement
(3) Completes the employment Waiting Period of:
First of the month following thirty (30) days of Full-Time Employment.

ACTIVELY AT WORK REQUIREMENT

Active Employees - An Employee must be Actively at Work for a benefit, or a benefit increase to take effect. An Employee will be considered Actively at Work if the Employee is performing the regular duties of employment on that day either at the Employer's place of business or at some location to which the Employee is required to travel for the Employer's business.

An Employee is considered to be Actively at Work on each day of a regular paid vacation or personal paid time off, and on each regular non-workday on which the Employee is unable to perform the essential functions of his or her job, if the Employee was Actively at Work on the last preceding regular workday.
If an Employee is absent from work due to the inability to perform the essential functions of his or her job on the date this Plan would otherwise have been effective, the effective date will be deferred until the date on which the Employee returns as an Active Employee.

Effective Date of Dependent Coverage. Subject to the Deferral Rule, a Dependent's coverage will take effect on the day that the Eligibility Requirement is met, the Employee is covered under the Plan and all Enrollment Requirements are met. For marriage, birth, or adoption (or placement for adoption), provided the Employee enrolls within sixty-three (63) days, coverage will become effective the date of marriage or the date of birth or adoption (or placement for adoption).

Effect of the Working Aged Provision. Persons affected by the Working Aged Provision are:

(1) Employees age sixty-five (65) and older
(2) Employee's Dependent Spouses age sixty-five (65) and older

If the Employee rejects coverage under the Plan for health benefits, all Dependents will not be eligible for any health benefits under the Plan. If the Dependent Spouse rejects coverage under the Plan for health benefits, the Spouse will not be eligible for any health benefits under the Plan.

If the covered Employee or Covered Dependent changes his or her mind and later rescinds the rejection, he or she would not be eligible for health benefits under the Plan.

Eligibility for benefits for the Employee and his or her Spouse as described above is in effect from the first day of the month in which each of them, respectively, attains age 65 provided the Employee remains in an employment relationship as determined by the Employer.

Deferral Rule. If a Dependent, other than a Newborn child, is a patient in a Hospital or other Medical Care Facility or confined at home on the date coverage would otherwise become effective, coverage will be deferred until the day following the date the Dependent is discharged from the facility or home confinement, is in good health and able to perform all of the normal activities of a person of the same age and sex.

TERMINATION OF COVERAGE

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.
(2) The date in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of employment of the covered Employee. (See the COBRA Continuation Option.)
(3) The date the Employee ceases to be in a classification shown in the Schedule of Benefits or eligibility section.
(4) The end of the period for which any required contribution has been paid if the charge for the next period is not paid when due.
(5) The date the Employee enters full-time military service of any country.

Continuation During Periods of Disability, Sabbatical, or approved Leave of Absence. A person may remain eligible for a limited time if active, Full-Time work ceases due to Disability or approved Leave of Absence. 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. Premium payments are required by the Employee during this period of time unless approved by the Plan Administrator.

- For periods of Disability or approved Leave of Absence: This continuance will end at the end of the three (3) calendar month period that next follows the month in which the person last worked as an Active Employee (This to include the Family Medical Leave Act (FMLA)).
- For sabbatical leave only: This continuance will end at the end of the 12-month period after the approved sabbatical leave commences or at the end of the leave in the event the Employee does not return to Full-Time work.

Continuation During Family and Medical Leave. All provisions of the Plan are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the Company, group health benefits may be maintained during certain Leaves of Absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements and obligations of the Employer and Employee concerning conditions of leave, the notification and reporting requirements are specified in the FMLA. Any Plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. An Employee with questions concerning any rights and/or obligations should contact the Plan Administrator to obtain further information free of charge.

Military Leave Act. Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan, during the Employee's absence from employment by reason of military service, no Pre-Existing Condition exclusion or Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon re-employment of the Employee unless such Pre-Existing Condition exclusion or Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military Leave of Absence.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all of the Plan's eligibility and Waiting Period requirements.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of:

(1) The date the Plan is terminated.
(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)
(3) The date Dependent coverage is terminated under the Plan.
(4) On the first day that he or she ceases to be a Dependent as defined by the Plan (See the COBRA Continuation Option).
(5) The date the Plan is changed to end coverage for a class to which the Dependent belongs.
(6) The date the Employee fails to make any required contribution for Dependent coverage within thirty (30) days of the premium due date

When Retiree Coverage Terminates. Retiree coverage will terminate on the earliest of these events:

(1) The Participant attains age sixty-five (65);
(2) The Participant becomes covered, or becomes eligible to be covered, under another employer's group health plan;
Note: The reference to "another employer's group health plan" only refers to an employer of the Participant himself/herself.
(3) The Participant fails to make a required premium payment on a timely basis; or
(4) The Employer terminates the Plan.

When Retiree Dependent Coverage Terminates. The coverage of the Spouse and/or Dependent(s) shall terminate upon the earliest occurrence of the following events:

(1) The Participant's coverage under the Plan terminates;
(2) The Spouse/Dependent attains age sixty-five (65);
(3) The Participant fails to make a required premium payment on a timely basis;
(4) The Spouse/Dependent becomes covered, or becomes eligible to be covered, under another employer's group health plan; or
(5) The Employer terminates the Plan.

Construction and Application. This section shall be construed and applied in a manner consistent with the requirements of Kansas Statutes Annotated 12-5040.

SCHEDULE OF BENEFITS

Eligibility Verification. Call 620-792-9151 or 866-792-9151 to verify eligibility for benefits **before** the charge is Incurred.

NETWORK PROVIDER INFORMATION: Can be obtained from the Plan Administrator or by calling ProviDrsCare Network at 800-801-9772 or through their website at www.providrscare.net. PPO Network providers are subject to change without notification.

OUT-OF-AREA NETWORK: Is available for Covered Persons seeking healthcare services outside of the PPO service area (outside the state of Kansas). When a Covered Person receives services outside the PPO service area by an out of area Network provider, The Covered Charges are considered at the PPO Network level of benefits. Out-of-area Network information can be obtained by calling 800-226-5116 or through their website at www.myfirsthealth.com. The out of area Network providers are subject to change without notification.

Claims Audit. In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

TeleMedicine:
Telemedicine provided by TelaDoc at www.MyDrConsult.com or 1-800-DOC-CONSULT (362-2667).

LIVING CONNECTED PROGRAM
The Plan will provide 100% reimbursement for diabetes testing supplies when obtained through the LivingConnected Program managed by MedWatch & CCS Medical. Members will not have any Co-Payments, Deductible, or Co-Insurance through this exclusive program. Participation in the LivingConnected Program is voluntary. Diabetic testing supplies obtained outside of this program will continue to be eligible expenses under this Plan; however, they do not qualify for the program's 100% no cost-sharing benefit. This means you may experience higher out-of-pocket costs if you purchase supplies from another vendor, provider, pharmacy or supplier.
Persons who utilize an insulin pump where the pump and glucose meter communicate wirelessly, and the glucose meter manages the amount of insulin dispensed by the pump will not qualify and should continue to utilize their current insulin pump and supplies.
Program participants receive the following exclusive benefits:

- Access to an innovative new mobile health solution that incorporates and easy to use cellular-enabled glucose meter along with patient tools, care team portals, and advanced self-management support and coaching.
- Instant feedback and support provided to the member via 2-way messaging and alerts sent directly to the wireless glucose meter
- Live call center monitoring and intervention
- Coaching from a Registered Nurse when your readings are out of range
- 24/7/365 toll-free access to live Nursing Support
- Coverage for the following diabetic testing supplies at no cost to you:
  - Cellular-enabled wireless glucose meter

- Glucose meter starter kit
- Control solution
- Lancing device(s)
- Lancets
- Automatic refills based on your testing frequency mailed directly to your home.

To learn more contact CCS Medical Customer Support team at 1-800-274-1853 to speak to a dedicated team specialist and for more information about how you can join this exclusive program and receive services and supplies to help manage a diabetic condition.

CancerCARE Program provides benefit coverage for evidence-based cancer care services. Upon diagnosis of cancer of any type, Covered Individuals must call the CancerCARE Program at **877-640-9610** for registration in the program. Failure to register with the CancerCARE Program will prevent the Covered Individual from receiving enhanced CancerCARE benefits. Please refer to the description of services for the CancerCARE Program listed in the Covered Services section of the Plan Document.

MEDICAL BENEFITS

Important notes about Deductible and Co-Insurance out-of-pocket:

- Network and Non-Network Deductible and Co-Insurance accumulate together.
- Prescription Drug and expenses do not apply to the Medical Deductible or Co-Insurance out-of-pocket.
- After satisfaction of the Deductible, the Plan will pay the designated percentage of Covered Charges until the out-of-pocket amounts are reached, then the Plan will pay 100% of the Covered Charges for the remainder of the Plan Year unless stated otherwise.

Deductible payable by Plan Participants, per Plan Year- Network Providers

Per Covered Person $1,200
Per Family Unit.....$2,400

Deductible payable by Plan Participants, per Plan Year- Non-Network Providers:

Per Covered Person $1,200
Per Family Unit.....$2,400

Percentage payable by the Plan, per Plan Year:

Network Providers:

Hospital care and Services.....80%

Physician care and Services.....80%

Outpatient Care and Services.....80%

Non-Network Providers-.....60%
*Out-of-area/Medical Emergencies 80%

*Out-of-area means locations other than the PPO identified on your ID card and their service area.

*Medical Emergencies are defined as treatment or services provided for emergency or life-threatening situations. However, the patient must be discharged or moved to an In-Network facility as soon as it becomes medically feasible.

Maximum Co-Insurance out-of-pocket payments, per Plan Year

The Plan will pay the percentage of Covered Charges designated above until the following amounts of out-of-pocket payments are reached, at that time the Plan will pay 100% of the remainder of Covered Charges for the rest of the individual's Plan Year unless stated otherwise.

Network Providers-

per Covered Person.....$2,000
per Family Unit.....$4,000

Non-Network Providers-
per Covered Person.....$4,000
per Family Unit.....$8,000

Many times, you submit claims for covered services that are not in the same order that you received the covered services. Regardless of the order claims were Incurred, the Deductible and Co-Insurance will be applied to Covered Services in the sequence that claims are submitted and ready for payment.

The charges for the following do not apply to the 100% benefit limit and are never paid at 100%.
(1) cost containment penalties
(2) amounts over the Allowed Amount

Maximum Benefit Amounts
Lifetime, while covered…….....Unlimited
There are other maximums on individual benefits. These follow under Benefit Limits.

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

(1) If a Covered Person has no choice of PPO Network providers in the specialty that the Covered Person is seeking within the PPO service area. Additionally, benefits will be upgraded to the PPO Network level in limited situations when the Claims Administrator determines the PPO provider availability is insufficient and a person would be required to travel more than fifty (50) miles to seek services.
(2) If a Covered Person receives services from a Municipal Health Department.
(3) If a Covered Person has a Medical Emergency or is out of the PPO service area and has a Medical Emergency requiring immediate care.
(4) If a Network Physician or Medical care Facility refers x-ray and laboratory services to a Non-Network provider.
(5) If a Non-Network assistant surgeon performs services in a Network facility.
(6) If a Covered Person receives Physician or anesthesia services by a Non-Network provider at a Network facility.
(7) If a Covered Person has no choice for purchasing Medical/Surgical Supplies and Durable Medical Equipment through a Network provider.

If you receive services from a Non-Network provider, the provider may bill you for amounts in excess of the Allowed Amount. Payment of the balanced billed amount is the responsibility of the Covered Person.

Medical and Dental Benefits are independent. If medical coverage is desired, you must elect medical coverage on the enrollment form that is provided to you by the Plan Administrator. If you do not elect medical coverage, you are not a Covered Person for Medical Benefits.

<u>Benefit Limits</u>
Emergency Room-
Deductible-.....applies
Co-Insurance .....applies

Physician Office Visit (Network or Non-Network)**-**
Primary Care Physician.....Deductible/Co-Insurance
Specialist Physician.....Deductible/Co-Insurance
Walk-in Retail Health Clinic/Convenience Care .....Deductible/Co-Insurance
Urgent Care Office Visit or Facility Charge .....Deductible/Co-Insurance
Mental Health Outpatient Office Visit .....Deductible/Co-Insurance

Preventive Care Benefit (In Network ONLY)-
Maximum Payable per individual Plan Year.....100% No Annual Limit
See "Covered Charges/Preventive Care Services" in this Benefit Description for a complete list of preventive Covered Charges, on page 20.

Women's Preventive Care Services in accordance with the Affordable Care Act (ACA) - Full description of benefits can be obtained through the Plan Administrator.

Preventive Care Benefit (Out of Network)-

Subject to normal Out of Network Benefits

Elective Sterilization*-

Deductible .....applies
Co-Insurance .....applies

*When performed by a Network provider, sterilization procedure for women are covered at 100% without cost-sharing.

Hospital Daily Room and Board*-

Payment rate.....the average semi-private room rate
Deductible .....applies
Co-Insurance .....applies

Intensive Care Unit-

Daily Limit.....Hospital's ICU Charge
Deductible .....applies
Co-Insurance .....applies

Skilled Nursing Facility-

Deductible .....applies
Co-Insurance .....applies
Maximum number of days payable.....60 days per Plan Year

Ambulatory Surgical Center/Outpatient Hospital Surgery Facility-

Deductible .....applies
Co-Insurance .....applies

Private Duty Nursing-

Deductible .....applies
Co-Insurance .....applies

Home Health Care-

Deductible .....applies
Co-insurance .....applies

Rehabilitative Facility-

Deductible .....applies
Co-Insurance .....applies

Outpatient Physical, Speech, Occupational, Cardiac, Pulmonary, and Respiratory Therapy, or Neurological testing-

Deductible .....applies
Co-Insurance .....applies

Hospice Care-

Deductible .....applies
Co-Insurance .....applies

Durable Medical Equipment-

Deductible .....applies
Co-Insurance .....applies

Mental Health Disorder Inpatient Treatment –
Deductible .....applies
Co-Insurance .....applies

Mental Health Disorder Outpatient Treatment –
Deductible .....applies
Co-Insurance .....applies

Substance/Chemical Inpatient Treatment –
Deductible .....applies
Co-Insurance .....applies

Substance/Chemical Outpatient Treatment –
Deductible .....applies
Co-Insurance .....applies

Orthotic/Prosthetic Devices-
Deductible .....applies
Co-Insurance .....applies

Surgery/Anesthesia (Inpatient or Outpatient)-
Deductible .....applies
Co-Insurance .....applies

Ambulance-
Deductible .....applies
Co-Insurance .....applies

Spinal Manipulation/Chiropractic Services-
Deductible .....applies
Co-Insurance .....applies
Plan Year Maximum .....30 Visits

Allergy Injections and Testing, Serum, and Antigens
Deductible .....applies
Co-Insurance .....applies

Injectables in an Outpatient Setting-
Deductible .....applies
Co-Insurance .....applies

Medical Surgical Supplies-
Deductible .....applies
Co-Insurance .....applies

Infertility Benefits-
Based on type of service and place of service. Includes care, supplies, and services for the diagnosis of the medical condition causing Infertility and charges for surgical correction of physiological abnormalities of Infertility. Assisted Reproductive Technology is excluded.

Pregnancy-
Based on type of service and place of service. Pregnancy benefits include prenatal, delivery, and post-partum care. Prenatal obstetrical visits and certain laboratory services are covered at 100%, no cost-sharing, when performed by a Network provider. Such services as x-ray, sonograms, and delivery expenses are subject to the applicable Deductible

and Co-Insurance. See also "Covered Charges/ Preventive Care Services" for additional information regarding Preventive Care Pregnancy benefits.

Newborn Nursery Care*-
Deductible .....applies
Co-Insurance .....applies
**Care while the Newborn is confined after birth. Charged to the plan of the Newborn.*

Outpatient Diagnostic Testing-
Deductible .....applies
Co-Insurance .....applies

Dialysis*-
Deductible .....applies
Co-Insurance .....applies
*Subject to Dialysis Program- see page 32.

Organ Transplant Coverage Limits-
Pre-Certification is required! Certification MUST be obtained at least 5 days in advance or within 48 hours in the case of an emergency. There is no coverage related to a transplant surgery for which pre-certification was not obtained. Must be received in a Designated Transplant Facility.
Deductible .....applies
Co-Insurance .....applies

Routine Vision- Covered at 100%. One time per Plan Year.
Deductible .....Does not apply
Co-Insurance .....Does not apply

Routine Hearing Exam- Covered at 100%. One time per Plan Year.
Deductible .....Does not apply
Co-Insurance .....Does not apply

Hearing Aids*-
Deductible .....applies
Co-Insurance .....applies
**One hearing aid per ear every three (3) Plan Years limited to $1,500 per aid. Four (4) additional ear molds per Plan Year up to two (2) years of age. See Covered Services- Audiology Services for a complete description of this benefit.*

All Other Covered Services-
Deductible .....applies
Co-Insurance .....applies

General Preventive Health Services	
Abdominal Aortic Aneurysm Screening	Limited to ultrasonography in men who have ever smoked ages 65 to 75 years, one time only.
Alcohol Misuse Screening and Counseling	Screening for and counseling to reduce alcohol misuse. Brief behavioral counseling interventions available for persons who engage in risky or hazardous drinking. Does NOT include care, treatment, or services for alcohol or substance abuse.
Aspirin Use	Limited to the following ages: • Female: 11 through 78 years • Men: 45 through 78 years *Requires Physician's written order. Available through Prescription Drug Card.*
Blood Pressure Screening	Available for all persons as an integral part of an annual exam.
Colorectal Cancer Screening	Limited to adults ages 50 to 75 years. If family history of colorectal cancer is present, age limitation does not apply. Limited to: • Fecal occult blood testing • Sigmoidoscopy, or • Colonoscopy. *Colorectal cancer screening performed in connection with a diagnosis or treatment of a medical condition is not considered a Preventive Care service.*
Depression Screening	Available for all persons.
Diabetes (Type 2) Screening	Limited to asymptomatic persons ages 18 and older with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
Healthy Diet Counseling	Counseling for a healthy diet when a person has hyperlipidemia or other known risk factors for cardiovascular and diet related chronic disease. Intensive counseling may be delivered by a Physician or Specialist working within the scope of his or her license such as a licensed nutritionist or dietician.
Falls Prevention	Limited to: • Exercise or physical therapy that is provided by a licensed health care provider, and • Vitamin D supplementation in community-dwelling adults ages 65 and older who are at increased risk for fall. *Vitamin D supplementation requires Physician's written order. Available through Prescription Drug Card.*
Hepatitis B Screening	Available to: • Persons at increased risk • Pregnant women
Hepatitis C Screening	Available for persons with high risk for infection and a one-time screening for persons born between 1945 and 1965.
HIV Screening	Available to: • Persons ages 15 to 65 • Younger adolescents and older adults who are at increased risk • Pregnant women including those who present in labor who are untested and whose HIV status is unknown
Immunization Vaccines	Standard vaccinations are covered as recommended by the Center for Disease Control. Vaccinations for overseas travel are excluded.

Lung Cancer Screening	Limited to once per Plan Year with low-dose computed tomography in adults ages 55 to 80 years.
Obesity Screening and Counseling	Intensive, multicomponent behavioral counseling intervention is available for persons with a body mass index of 30/kg/m^2 or higher.
Preventive Exam/Routine Physical	Limited to once per Plan Year.
Preventive Laboratory Services	Limited to once per Plan Year.
Prostate Cancer Screening	Limited to once per Plan Year.
Sexually Transmitted Infection (STI) Counseling	High-intensity behavioral counseling to prevent sexually transmitted infections is available for all sexually active persons.
Skin Cancer Behavioral Counseling	Counseling to minimize exposure to ultraviolet radiation to reduce risk for skin cancer limited to ages 10 to 24 years.
Syphilis Screening	Available for all sexually active persons.
Tobacco Use Screening and Interventions	Tobacco use screening is completed when the clinician obtains the patient's lifestyle history. Tobacco cessation interventions are available for persons who use tobacco products. Interventions are: • Smoking cessation products, such as Chantix, limited to 2 cessation attempts per Plan Year, • Education, • Brief counseling to prevent the initiation of tobacco use in school-age Children, or • Augmented, pregnancy-tailored counseling for regnant women who smoke. *Smoking cessation products require Physician's written order. Available through Prescription Drug Card.*

Preventive Health Services for Women

See also "General Preventive Health Services" for additional preventive health services covered by this Plan.

Anemia Screening	Available for asymptomatic pregnant women.
Bacteriuria Screening	Screening for asymptomatic bacteriuria with urine culture for pregnant women.
BRCA Risk Assessment and Genetic Counseling/Testing (BRCA 1 and BRCA 2)	Available for women who have family members with breast, ovarian, tubal, or peritoneal cancer. Women with a positive result may receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast Cancer Mammography Screening	Limited to once per Benefit Year. *A mammogram performed in connection with a diagnosis or treatment of a medical condition is not considered a Preventive Care Service.*
Breast Cancer Preventive Medications	Women at increased risk for breast cancer may receive counseling from their Physician about risk-reducing medications. Preventive Care Services includes coverage for the risk-reducing medication in women who are at increased risk for breast cancer and low risk of adverse medication effects such as tamoxifen and raloxifene.

Breastfeeding Comprehensive Support and Counseling	Coverage is limited to comprehensive lactation (breastfeeding) support and counseling, by a trained provider during Pregnancy and/or in the postpartum period, and costs for breastfeeding equipment. • Breast pumps for post-partum women are limited as follows: o One manual or electric breast pump purchase per delivery is covered. o Benefit available after participant is delivered of the baby. o Breast pumps come with certain supplies, such as tubing, shields, and bottles. All supplies are excluded (i.e. creams, nursing bras, bottles, replacement tubing for breast pump). o Breast pumps must be purchased from a participating DME vendor. o Hospital grade breast pumps are excluded and not covered.
Cervical Cancer Screening	Limited to women once per Plan Year.
Chlamydia Infection Screening	Available for women.
FDA-Approved Contraception Methods, Sterilization Procedures, and Contraceptive Counseling	Available for women as follows: Education and counseling related to contraceptives and sterilization. Surgical sterilization (hysterectomies are excluded). Contraceptive methods (devices and associated procedures), such as device removal, and pharmaceutical contraceptives for women with reproductive capacity. • OTC Contraceptives: female condoms, sponges, spermicides, emergency contraception • Cervical Caps • Diaphragms • Injections • Implantable Rods • IUDs • Oral contraceptives (generic only unless a generic is not available or compelling reason exists for the patient's use of a brand name product) • Trans-dermal contraceptives • Vaginal rings *Many contraceptive products are available through the Prescription Drug Card and require Physician's written order.*
Folic Acid Supplementation	Folic Acid supplementation is available for women of childbearing age. *Requires Physician's written order. Available through Prescription Drug Card.*
Gestational Diabetes Screening	Limited to pregnant women who are asymptomatic for diabetes.
Gonorrhea Screening	Available for all sexually active women.
Human Papillomavirus (HPV) DNA Test	Limited to ages 30 years and older once every 3 Plan Years.

Intimate Partner Violence Screening and Intervention	Available for women of childbearing age who do not have signs or symptoms of abuse including domestic violence. Includes intervention services for women who screen positive.

Osteoporosis Screening	Available for women beginning at age 60 or younger if there is an increased risk.
Rh Incompatibility Screening	Available for women. If screening is positive, RH incompatibility treatment is a Preventive Care service.
Well Woman Visit	Annual Preventive Care visit to obtain recommended preventive services that are age and developmentally appropriate including preconception counseling and prenatal obstetrical office visits. Several visits may be needed to obtain all necessary recommended preventive services. *Services such as delivery, x-rays, ultrasounds, facility charges, and medications associated with Pregnancy are NOT part of this Preventive Care service.*
Preventive Pediatric Health Services (Birth to age 21 years)	
See also "General Preventive Health Services" for additional preventive health services covered by this Plan.	
Physical Examination	Age-appropriate physical examination for preventive pediatric health. Each exam may include a medical history and body measurements: length/height/weight, head circumference, weight for length, body mass index, and blood pressure. Some of the assessments and screenings listed below may also be integral parts of the exam.
Developmental/Behavioral Assessments	
Alcohol and Drug Use Assessments	Available to Children to 21 years.
Autism Screening	Available to Children to 21 years.
Behavioral/Psychosocial Assessments	Available for Children to 21 years
Depression Screening	Available to Children to 21 years.
Developmental Screening	Available to Children to 21 years.
Developmental Surveillance	Available to Children to 21 years.
Procedures	
Newborn Blood Screening	Limited to Newborns using the Recommended Uniform Newborn Screening Panel as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children and state Newborn screening laws/regulations.
Cervical Dysplasia Screening	Available for sexually active females.
Critical Congenital Heart Defect Screening	Limited to newborns using pulse oximetry.
Hematocrit or Hemoglobin Screening	Available to children to 21 years.
Hemoglobinopathies or Sickle Cell Screening	Limited to Newborns.
Hypothyroidism Screening	Limited to Newborns.
Phenylketonuria (PKU) Screening	Limited to Newborns.
Lead Screening	Limited to: Birth up to 21 years of age.
Tuberculin Test	Available to Children to 21 years.
Other Services	
Chemoprevention of Dental Caries	Limited to: • Application of fluoride varnish to the primary teeth of all infants and Children starting at the age of primary tooth eruption, and • Oral fluoride supplementation for Children ages 6 months through four (4) years of age. *Oral fluoride requires Physician's written order. Available through Prescription Drug Card,*

Gonorrhea Prophylactic Medication	Limited to Newborns.
Hearing Loss Screening	Limited to Newborns.
Iron Supplements	Available for Children ages 6 months to age 12 months. *Requires Physician's written order. Available through Prescription Drug Card.*
Oral Health Risk Assessment	Available for Children birth through age 10.
Sensory Screening – Vision	Available for all Children. Generally, part of a well-Child visit.
Sensory Screening – Hearing (beyond newborn screening)	Available for all Children. Generally, part of a well-Child visit.
Visual Acuity Screening	Limited to visual acuity screening for Children between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors.
Vision Exam Paid 100% by the Plan regardless of network or non-network status	Limited to one (1) vision exam including refraction per Plan Year.
Dental Exam Paid 100% by the Plan regardless of network or non-network status	Limited to one (1) dental exam including cleaning and polishing per Plan Year. Does not include dental x-rays. Ages birth up to 19 years. See Dental Benefits for Covered Persons who have elected Dental Coverage.

Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

(a) If the mammogram is performed in connection with the diagnosis or treatment of a medical condition and the provider properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the Plan dealing with diagnostic x-rays.

(b) If the Covered Person is at high risk of developing breast cancer or has a family history of breast cancer and the provider properly files the claim with this information, the claim will be processed as a preventive procedure according to the benefit provisions of the Plan's Preventive care services.

In all other cases the claim will be subject to the provisions described for Preventive Care services.

Colorectal Cancer Screenings

Benefits for colorectal cancer screenings vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

(a) If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition and the provider properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the Plan dealing with surgical procedures. If a polyp is removed during the course of a preventive colonoscopy, the colonoscopy procedure, removal of the polyp, and the charges for pathological examination of the specimen are considered under the Plan's Preventive Care services.

(b) If the Covered Person has a family history of colon cancer and the provider properly files the claim with this information, the claim will be processed as a preventive procedure according to the benefit provisions of the Plan's Preventive Care services.

In all other cases the claim will be subject to the provisions described for Preventive Care services.

The Plan intends to comply with the Affordable Care Act. Preventive Care services may be added without notification. Contact the Claims Administrator if you have questions about these benefits.

COVERED SERVICES

Plan 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. To be covered, the expenses must be Incurred due to an accidental Injury, Sickness or covered Pregnancy and the service or treatment must be Medically Necessary. All benefits are subject to the limitations and exclusions of the Plan. If additional information is needed to prove Medical Necessity of a condition or if an insured is not following a Physician's orders for the treatment of a medical condition, the Plan reserves the right to request a 2nd opinion which in turn could result in denial of the claim.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Benefit Year a Covered Person must meet the Deductible shown in the Schedule of Benefits. Typically, there is one Deductible amount per Plan Year. The Claims Administrator may allocate the Deductible amount to any eligible charges and apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident. These persons need not meet separate Deductibles for treatment of Injuries incurred in this accident; instead, only one Deductible for the Plan Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

COPAYMENT

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. Copayments do not accrue toward the Deductible or Coinsurance maximum out-of-pocket amount.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been Incurred by members of a Family Unit toward their Plan Year Deductibles and Co-Insurance maximums, the Deductibles and Co-Insurance maximums of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the Deductible. Payment will be made at the rate shown under the percentage payable 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

Each Plan Year, Covered Charges are payable at the percentages shown in the Schedule of Benefits until the out-of-pocket maximum limit is met. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Plan Year. When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Plan Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges Incurred by a Covered Person for Essential Health Benefits during the Plan Year.

ACQUIRED COMPANY

Employees of an acquired company who are Eligible Individuals under this Plan and who were also covered under the prior employer-sponsored group medical plan on the date of acquisition will be eligible for the benefits under this Plan on the date of acquisition. Any Waiting Period previously satisfied under the prior health plan will be applied toward satisfaction of the Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Individuals will be eligible on the date of the acquisition.

ORDER OF CLAIMS DETERMINATION
Many times, claims for covered services are not submitted in the same order the covered services are provided. Regardless of the order claims are Incurred, the Deductible and percentage payable will be applied to covered services in the sequence that claims are submitted and ready for payment.

CHANGES IN COVERAGE
If a change in the coverage of a Covered Person, that would otherwise increase the Plan Benefit Maximum applicable to the Covered Person, becomes effective in accordance with the terms of the Plan, then such increase shall not apply with respect to the Covered Person until the first day on which the Employee is Actively at Work, and the amount of the Plan Benefit Maximum applicable to him or her either remains the full amount of his or her previous coverage as specified in the Schedule of Benefits or elsewhere in the Plan.

If a change in the coverage of a Covered Person that would otherwise decrease the Plan Benefit Maximum applicable to the Covered Person becomes effective in accordance with the terms of the plan, such decrease shall apply immediately with respect to the Covered Person.

COVERED CHARGES

Covered Charges are the Allowed Amounts that are Incurred for the following items of service and supply. These charges are subject to the "Benefit Limits" of this Plan. A charge is Incurred on the date that the service or supply is performed or furnished. Unless specifically stated otherwise, the service or supply must be Medically Necessary, required for treatment of a Sickness, Injury or covered Pregnancy and recommended and approved by the attending Physician.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital, Medical Care Facility, or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits unless a private room is doctor approved or if a semiprivate room is unavailable. After 48 observation hours, a confinement will be considered an Inpatient confinement. Observation in excess of forty-eight (48) hours require pre-certification as an Inpatient stay. Pre-certification penalties may apply if observation exceeds forty-eight (48) hours.

Room charges made by a Hospital having only private rooms will be paid at the private room rate. If a private room is assigned at the Covered Person's request, then the reimbursement is at the semi-private room rate.

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

(2) **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;
(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities is limited to the covered daily charge limit shown in the Schedule of Benefits.

(3) **Physician Care.** The professional services of a Physician for surgical or medical services.

(4) **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 Medical Necessary and not custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Service and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(5) **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 by 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.

A home health care visit will be considered a periodic visit by either a nurse or four (4) hours of home health aide services. Therapies are subject to the Outpatient Rehabilitation Services benefit as shown in the Schedule of Benefits.

(6) **Diabetes Supplies, Equipment and Self-Management Programs** as described:
All Physician prescribed Medically Necessary and appropriate equipment and supplies used in the management and treatment of diabetes; and
Diabetes Outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with gestational, Type I, and Type II diabetes.
For Covered Persons with diabetes who have documented peripheral vascular disease and/or peripheral neuropathy, the Plan will cover one (1) pair of orthopedic shoes and two (2) pair of associated shoe inserts per Covered Person per Plan Year as deemed Medically Necessary and ordered by a Physician.

(7) **Prophylactic Mastectomy or Oophorectomy** (ovary removal surgery). Even though a current cancer diagnosis does not exist, risk-reducing surgery will be considered the same as any other Illness when there is an increased risk of breast or ovarian cancer, when a documented family history exists of breast or ovarian cancer, or when genetic testing demonstrates the existence of the cancer risk.

(8) **Medical/Surgical Supplies.** Covered Charges for Medically Necessary Medical and Surgical Supplies. This includes gradient compression stockings and gradient compression wraps with a Physician's written order. These items may commonly be called anti-embolism, custom, circular knit, flat-knit, silver, or lymphedema compression stockings.
Excluded are:
- **(a)** Gradient compression stockings or wraps used for athletic purposes, and
- **(b)** Support stockings, usually those with less than 18 mmHg, sold over the counter.

(9) **Infertility.** Care, supplies, and services for the diagnosis of the medical condition causing Infertility and charges for surgical correction of physiological abnormalities of Infertility. Assisted Reproductive Technology (ART) whether by chemical or mechanical means is not covered.

Additionally, travel costs, donor eggs or semen and related costs including collection, preparation and storage are not covered.

(10) The initial purchase, fitting and repair of **Orthotic Appliances** such as braces, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. In all cases, repair, or replacement due to abuse or misuse, as determined by the Plan Sponsor, is not covered.

Excluded are:

- **(a)** Benefits are not payable for special or extra-cost convenience features.
- **(b)** Foot only orthotics except as described under "Diabetic Supplies, Equipment, and Self-Management Program."
- **(c)** Over the counter shoe inserts or orthotic devices.

(11) **Podiatry.** The treatment for the following foot conditions:

- **(a)** Bunions, when an open cutting operation is performed;
- **(b)** Toenails, when at least part of the nail root is removed; and
- **(c)** Any Medically Necessary surgical procedure required for a foot condition.

(12) **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 (6) months and placed the person under a Hospice Care Plan.

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

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependent(s)). Bereavement services must be furnished within six (6) months after the patient's death.

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

- **(a)** Anesthetic; oxygen and use of equipment for its administration; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- **(b)** **COVID-19** laboratory and diagnostic testing and immunizations as mandated by Federal Law. This benefit is subject to change as the law is amended.
- **(c)** Diagnostic x-rays.
- **(d)** Laboratory studies and pathological studies.
- **(e)** **Preventive Care Services**. Covered Charges under Medical Benefits are payable for Preventive Care Services as shown in the Schedule of Benefits on page 20. Additionally, the Employer-sponsored immunization clinic and/or preventive lab fair, if any, are Covered Charges under this Plan and reimbursed without cost-sharing regardless of the provider's network or non-network affiliation.
- **(f)** **Audiology Services**. Hearing and balance assessment services furnished by a Physician or audiologist. Technicians or other qualified staff may furnish those parts of a service that do not require professional skills under the direct supervision of a Physician. Audiological diagnostic testing refers to tests of the audiological and vestibular systems including, but not limited to, hearing, balance, auditory processing, tinnitus, and diagnostic programming of auditory Prosthetic Devices. Coverage includes tubing required to properly re-fit a hearing aid due to the person's physiological change and for which a charge is normally made by the provider. See also "Hearing Aids" in the Schedule of Benefits for certain limitations. Batteries are excluded and not covered by the Plan.

Hearing aids are amplifying devices that compensate for impaired hearing. Hearing aids include air conduction devices that provide acoustic energy to the cochlea via stimulation of the tympanic membrane with amplified sound. Cochlear implants, auditory brainstem implants and osseiointerated implants are Prosthetic Devices. See also "Prosthetics."

(g) Clinical Trial. Regardless of the Experimental and Investigational nature of the Approved Clinical Trial itself, coverage will be provided for all routine patient care costs associated with the provision of healthcare services, including drugs, items, devices, treatments, diagnostics, and services that would otherwise be covered if those drugs, items, devices, treatments, diagnostics and services were not provided in connection with an Approved Clinical Trial program for cancer or other diagnoses that are life threatening or severely and chronically disabling that have failed to respond with conventional treatments. Services covered will include those health care services typically provided to patients not participating in a clinical trial.

Excluded are:

- **i.** The costs of the investigational drugs or devices themselves, or the costs of any non-medical services that might be required for the Covered Person to receive the treatment or intervention.
- **ii.** Healthcare services that, except for the fact that they are being provided in a clinical trial are otherwise specifically excluded from coverage under the policy or certificate.
- **iii.** Transportation and/or lodging costs incurred while receiving such treatment.

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

(i) Rental of **Durable Medical (or surgical) Equipment** if deemed Medical Necessary subject to the following:

- **i.** The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury.
- **ii.** These items may be bought rather than rented, with the costs 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. Rental price not to exceed purchase price (oxygen equipment is not limited to the purchase price). Any amount paid to rent the equipment will be applied toward the purchase price.
- **iii.** Benefits will be limited to standard models, as determined by the Plan Administrator; and
- **iv.** The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medically Necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan; and
- **v.** If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repair or replacement due to abuse or misuse, as determined by the Plan Sponsor, is not covered.

Excluded are:

- **i.** Home traction units
- **ii.** Equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility.
- **iii.** Equipment designed to provide the walking capability for individuals with non-functioning legs.

(j) Local Medically Necessary professional **land or air Ambulance Service**. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing

Facility where necessary treatment can be provided, unless the Plan Administrator finds a longer trip was Medically Necessary.

(k) Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

(l) Temporomandibular Joint syndrome (TMJ) Medically Necessary service for care and treatment.

(m) The initial purchase, fitting, and repair of fitted **Prosthetic Devices** which replace body parts as shown in the Schedule of Benefits.

Replacement devices must be Medically Necessary due to growth, other physiological change, change in the Covered Person's condition, or deterioration of the device which renders repair unacceptable. Benefits are not payable for special or extra-cost convenience features. In all cases, repair or replacement due to abuse or misuse, as determined by the Plan sponsor, is not covered. Dental plates, bridges, orthodontic braces, and dental prothesis are excluded under this benefit and are not considered eligible expenses by the Plan.

Coverage is available for two (2) post-mastectomy bras per Covered Person per Plan Year. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prosthesis.

The Plan covers cochlear implants, auditory brainstem implants and osseiointegrated implants. Cochlear implants and auditory brainstem implants means devices that replace the function of cochlear structures or auditory nerve and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays. Osseiointegrated implants mean devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer.

Benefits are also provided for penile prosthesis required for physiological (not psychological) impotence subject to advance approval by the Plan and only in the following situations: trauma, radical pelvic surgery, diabetes, Peyronie's Disease, vascular or neurological disease when the individual situation warrants coverage in the Plan's opinion.

(n) Rehabilitation services, such as, but not limited to, respiratory therapy, neuropsychological testing, cardiac rehabilitation, and pulmonary rehabilitation that are Medically Necessary are covered on both an Inpatient and Outpatient basis. Rehabilitation services are covered only if they are expected to result in significant improvement in the patient's condition. Cardiac rehabilitation is a Covered Services the 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 (twelve) weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(o) Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function.

(p) Speech therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); (ii) an Injury or; (iii) a Sickness.

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

(r) Spinal Manipulation/Chiropractic services by a licensed M.D., D.O. or D.C. Physical medicine modalities including, but not limited to, correction or adjustment by manual, mechanical, electrical, or physical means (including use of light, heat, water or exercise) of

structural imbalance, distortion, subluxation or misplaced tissue of any kind or nature of the human body. Coverage does not include nutritional supplements.

(s) **Surgical sterilization**. Reversal of sterilization is excluded. See "Preventive Services" in this section for additional information regarding women's contraceptive and sterilization benefits.

(t) Initial contact lenses or glasses required following cataract surgery.

(u) **Prescription Drugs** (as defined) will be reimbursed as shown in the Schedule of Benefits. Covered drugs, including insulin, are drugs which can only be obtained with a written prescription from your Doctor. Drugs not approved for use in the United States are not covered. Medications administered in the Physician's office or other Medical Care Facility are Covered Charges under the Medical Benefits subject to the exclusions and limitations of the Plan.

(v) Medical and surgical charges for participant, who is currently receiving treatment that elects breast reconstruction in connection with a mastectomy.

The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a mastectomy. The new Federal law requires group health plans that provide mastectomy coverage to also cover breast reconstruction surgery and prostheses following mastectomy.

As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary mastectomy will also receive coverage for:

i. Reconstruction of the breast on which the mastectomy has been performed;

ii. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

iii. Prostheses and physical complications from all stages of mastectomy, including lymphedemas;

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

(w) A charge for **Telemedicine** services provided by a practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

(x) **Dietary counseling** for a covered medical condition. See also "Diabetes Supplies, Equipment and Self- Management Programs" and "Preventive Care" in this section.

(y) **Contraceptive injections and devices** administered in an office setting including Municipal Health Department and family planning clinic. The office visit for planning purposes, fitting, and implantation or administration of the injection or device is included. See also "Preventive Care Services" and Prescription Drug Card Benefits" for more information about women's contraceptive and sterilization benefits.

(z) **Nutritional Supplements** which are Physician prescribed or other enteral supplementation necessary to sustain life including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) including over-the-counter nutritional supplements is a Covered charge when prescribed by a Physician. Over-the-counter nutritional supplements or infant formulas, other than for treatment of PKU, will not be considered eligible even if prescribed by a Physician. Rental or purchase of equipment is subject to the Durable Medical Equipment benefit shown in the Schedule of Benefits. The supplements are subject to Medical/Surgical Supplies as shown in the Schedule of Benefits.

(aa) Care, services, and treatment of **obesity/Morbid Obesity** the same as any other Illness when Medically Necessary. Excluded are fees for club/gym memberships or membership fees of any king or type; costs associated with enrolling/attendance in an exercise program; appetite suppressants, nutritional supplements, or food products unless specifically stated elsewhere; and

equipment used for exercise including, but not limited to, treadmills, elliptical machines, weight machines, pools, or hot tubs of any type

(bb) Dialysis Treatment on an Outpatient basis. See Dialysis Program below.

Dialysis Program: The Plan has established a specialized procedure for determining the amount of Plan benefits to be provided for Outpatient Dialysis Treatment, regardless of the condition causing the need for such treatment; this procedure is called the "Dialysis Program." The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to a Covered Person and for managing cases and claims involving Outpatient dialysis services and supplies, regardless of the condition causing the need for dialysis. The Dialysis Program shall consist of the following components:

(1) Application. All claims filed by, or on behalf of, a Covered Person for coverage of Outpatient Dialysis Treatment ("Dialysis Claims") shall be subject to the provisions of this section, regardless of the treating healthcare provider's participation in the Preferred Provider Organization ("PPO").

(2) Mandated Cost Review. All Dialysis Claims shall be subject to cost containment review, negotiation and settlement, application of the maximum benefit payable analysis (as set forth below), and/or other related administrative services, which the Plan Administrator may elect to apply in the exercise of the Plan Administrator's discretion. The Plan Administrator reserves the right, in the exercise of its discretion, to engage relevant and qualified third-party entities such as Zelis Claims Integrity, LLC, for the purpose of determining the Usual and Customary and Reasonable and Appropriate Outpatient Dialysis Charge.

(3) Maximum Benefit. The Maximum Benefit Payable for any and all Dialysis Claims after all applicable Deductible and cost-sharing shall be the lessor of (a) the Usual and Customary and Reasonable and Appropriate Outpatient dialysis charge, (b) the maximum Allowed Amount, and (c) such charge as is negotiated between the Plan Administrator or its designee and the provider of Outpatient treatment.

Secondary Coverage. A Covered Person eligible for other health coverage under any health coverage under any other health plan is strongly encouraged to enroll in such coverage. A Covered Person who does not enroll in other coverage for which they are eligible may incur costs not covered by the Plan that would have been covered by the other coverage. The Plan will only pay for costs payable pursuant to the terms of the Plan, which may not include any costs that would have been payable by such other coverage.

MULTIPLE SURGICAL PROCEDURES

When more than one surgical procedure is performed through the same body opening during one (1) operation, you are covered only for the most complex procedure. If separate procedures are performed through separate incisions, you are covered for full benefits for the first or major procedure. For additional procedures, the Plan will pay 50% of the benefits that would have been paid for a completely separate operation.

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.

If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the charge 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 Allowed Amount for that procedure.

If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 25% of the surgeon's Allowed Amount.

CARE FOR MOUTH, TEETH AND GUMS

Injury to or care of care of the mouth, teeth, gums and alveolar process will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

(1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
(2) Emergency repair due to Injury to sound natural teeth. This includes replacement of natural teeth lost due to an Injury. This repair must be made within twelve (12) months from the date of an accident.
(3) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
(4) Excision of benign bony growths of the jaw and hard palate.
(5) External incision and drainage of cellulitis.
(6) Incision of sensory sinuses, salivary glands or ducts.
(7) Removal of impacted teeth.
(8) X-rays in connection with covered oral surgery listed in 1-7 above.
(9) General anesthesia for covered oral surgery.
(10) Facility charges determined to be Medically Necessary for the dental care, and provider to the following persons:
(a) Covered Dependent Children five years of age or under; or
(b) A Covered Person who is severely disabled; or
(c) A Covered Person who has a medical or behavioral condition, which requires Hospitalization or general anesthesia when dental care is provided.

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

TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE

These benefits may not be less than the benefits required under federal mental health and substance abuse parity requirements. All treatment is subject to the benefit payment shown in the Schedule of Benefits.

ORGAN TRANSPLANT COVERAGE LIMITS

Charges otherwise covered under the Plan that are Incurred for the care and treatment due to an organ, bone marrow or tissue transplant are subject to these limits:

(1) The transplant must be performed to replace an organ, bone marrow or tissue of the Covered Person.
(2) The transplant must be a human-to-human organ, bone marrow, or tissue transplant.
(3) All other conventional means of treatment have been unsuccessful in treating the condition.
(4) The condition is covered by the Plan.
(5) The Covered Person is obligated to pay for the transplant; it is not covered by a government agency or transplant program.
(6) The transplant is not considered Experimental and/or Investigational.
(7) The transplant must be performed at a Designated Transplant Facility. Cornea and skin grafts/transplants are excluded from this limit.

The following charges for obtaining donor organs, marrow or tissue are Covered Charges under the Plan:

(1) Evaluating the organ, marrow, or tissue
(2) Removing the organ, marrow, or tissue from the donor

(3) Transportation of the organ, marrow, or tissue from within the United States and Canada to the place where the transplant is to take place.

If the recipient is a Covered Person under this Plan but the donor is not, then this Plan will cover the donor's charges as those of the recipient. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan.

If both the donor and the recipient are Covered Persons under this plan, eligible expenses Incurred by each person will be treated separately for each person.
If the recipient is not a Covered Person under this Plan, then the donor's charges are not covered under this Plan.

The Designated Transplant Facility's contracted rate supersedes any negotiated PPO Network discount. Eligible transplant charges received at a Designated Transplant Facility are subject to Network benefits.

Excluded are lodging expenses including meals; expenses related to the Covered Person's transportation; the purchase price of any bone marrow, organ, tissue, or any similar items, which are sold rather than donated; and transplants which are not medically recognized and are Experimental and/or Investigational in nature.

COVERAGE OF NURSERY CARE

Routine nursery care is room, board and other normal care for which a Hospital makes a charge.

The Reasonable and Usual and Customary Charge made by the Hospital for routine nursery care provided while the mother is Hospital confined after birth will be considered as covered charges under the Plan.
This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the termination of the Pregnancy and the Child is an eligible Dependent and is neither injured nor ill. Newborns not enrolled in the Plan will be covered for the delivery and the earlier of 5 (five) days, or until dismissed from the hospital.

The Newborn's Covered Charges will be applied to the Plan of the Child and the Child's own Deductible and Co-Insurance provisions will apply when the Newborn is added to the Plan.

The benefit is limited to the Reasonable and Usual and Customary Charges made by a Physician for the Newborn child while Hospital confined as a result of the Child's birth.

COVERAGE OF PREGNANCY

Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a Covered Person. See "Preventive Care Services" under this section for additional information regarding coverage for prenatal obstetrical visits and certain laboratory services.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers 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 cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer. **Pre-authorization is not required for the 48/96 hour Hospital stay. However, authorization is needed for a longer stay than as described above.**

CancerCARE Program Coverage

Providers must submit chemotherapy, radiation, and surgical treatment plans related to a cancer diagnosis to CancerCARE for treatment review prior to delivery to Covered Persons. Cancer-related diagnostic and staging tests are excluded from these review requirements.

IMPORTANT: Failure to submit treatment plans prior to delivery of care may result in penalties and/or denial of payment. Contact CancerCARE at (877) 640-9610 for treatment plan submission.

The Plan provides benefit coverage for evidence-based cancer care services provided at local, regional and national cancer programs. In order to obtain the best outcomes for Covered Persons, the Plan employs INTERLINK's CancerCARE Program with specialized care coordination nurses, McKesson Clear Value Plus with Value Pathways powered by NCCN® and NCCN Clinical Practice Guidelines in Oncology®. To be eligible for enhanced Plan benefits, all Covered Persons with a cancer diagnosis must as soon as reasonably possible call the CancerCARE Program at 877-640-9610 and complete registration.

DEFINITIONS:

CancerCARE Allowable: For inpatient and outpatient hospital and professional services, CancerCARE Allowable means the Maximum Allowed Amount for Covered Expenses provided in compliance with the CancerCARE Program, minus non-covered services and supplies, negotiated price concessions, discounts and professional charges beyond Customary and Reasonable Amounts for such services. Once treatment is certified by the Plan for services from a CancerCOE Provider, payment to the provider will be paid at the applicable benefit reimbursement percentage based on the applicable contract allowable.

CancerCARE Program: A comprehensive cancer management program operated by INTERLINK, which employs care coordinator nurses to monitor care and coordinate care at CancerCOE Providers for appropriate Covered Persons.

CancerCARE Benefits	
Preferred Providers Required For Compliant Benefits	
Compliant Benefit	**Non-Compliant Benefit**
• **Standard benefits apply as defined by the Schedule of Benefits;** • **Clinical Trials as defined below;** • **CancerCARE Second Opinion benefits;** • **Travel Benefits as defined below.**	• **Standard benefits apply as defined by the Schedule of Benefits**

National Comprehensive Cancer Network (NCCN®): An alliance of the nation's most prominent hospitals that review outcome information for cancer treatments, publish evidence-based NCCN Guidelines® and update them as needed.

NCCN Guidelines®: NCCN® disease-specific, committee recommended, evidence-based treatment processes for specific cancers with integrated drugs, dosing and biologics recommendations.

Value Pathway: Optimal course of treatment created by the input of patient specific clinical facts into the McKesson Clear Value Plus application which utilizes NCCN Guidelines®. Each Value Pathway has been based on efficacy, toxicity and cost, providing value to the Covered Person and the Plan.

CancerCOE Provider: A cancer center, hospital or other institution, physician or ancillary provider that has been designated by the CancerCARE Program to provide complex cancer care services. CancerCOE providers have been selected to participate in this nationwide network based on their designation as a National Cancer Institute (NCI) Cancer Center or NCCN® member institution and their ability to meet other predefined criteria. Once selected, these providers are evaluated annually to ensure they continue to meet the eligibility criteria for continued participation in the CancerCOE Network.

Compliant Benefit Level: A Covered Person status obtained when the Covered Person 1) has completely registered into the CancerCARE Program; 2) the treatment is deemed concordant to a Value Pathway; and 3) the provider's office has achieved Clear Value Participation. If all the above conditions have been met, and there is no Value Pathway available, treatment must be concordant with NCCN Guidelines®, or the care plan must be deemed consistent with evidence-based medicine by CancerCARE. This status is reported by the CancerCARE Triage Center to the Plan.

Non-Compliant Benefit: If the Covered Person does not 1) register and participate with the CancerCARE Program, 2) achieve a Compliant Benefit Level, or 3) attend a Preferred Provider, the Plan's standard benefits apply as outlined within the Schedule of Benefits.

Clear Value Participation: In order to determine courses of care, testing occurs and the results of those tests (Clinical Facts) are used to determine any applicable Value Pathways. Clear Value Participation requires the provider to: 1) submit Clinical Facts to CancerCARE when care is being planned; 2) consider Value Pathways as treatment options; and 3) confirm with CancerCARE the optimal Value Pathway course of care will be utilized.

Case Management Recommendation: Alternate providers may be identified and recommended by a CancerCARE Program Nurse as a cost effective alternative if there is no reduction in the quality of care. In these instances, alternate providers will be reimbursed at the applicable CancerCARE Benefit Level currently in effect with the existing provider. If pharmacy benefits are utilized to obtain medications otherwise provided in a provider's office, normal copays shall be waived if savings to the Plan are realized.

CancerCOE Referral: CancerCARE provides benefits and support for all cancer diagnoses, but Covered Persons with a diagnosis or condition that is considered rare, aggressive or complex will be evaluated for referral to a CancerCOE Provider. Such diagnoses or conditions are evaluated and determined by the CancerCARE Medical Team in consultation with a Medical Advisory Board and other relevant medical literature. These diagnoses and conditions are reviewed and revised periodically. Please contact CancerCARE for details regarding what cancer diagnoses or conditions are currently considered rare, aggressive or complex.

ADDITIONAL PROVISIONS:

Registration Requirement: Upon diagnosis of cancer of any type, Covered Persons must call the CancerCARE Program at 877-640-9610 for registration into the Program. Failure to register with the CancerCARE Program will prevent the Covered Person from receiving enhanced CancerCARE benefits.

CancerCOE Travel Benefits: The Plan provides a maximum travel and lodging benefit up to $10,000 per Covered Person per lifetime. Travel benefits will only apply for Covered Persons with cancer diagnoses or conditions as described within the CancerCOE Referral provision that have been directed to a CancerCOE Provider by the CancerCARE Program. The CancerCOE location must be at least 50 miles from the Covered Person's home. Travel and lodging assistance shall be coordinated by the CancerCARE Program. While receiving care at a CancerCOE Provider, the Plan will reimburse lodging, meals and incidentals. The Plan covers travel costs (coach air, train or mileage at Internal Revenue Service "IRS" Standard Mileage Rate for travel by car) for the Covered Person plus one companion if the Covered Person is an adult (18 or older), or up to two companions if the Covered Person is less than 18. The benefit is subject to INTERLINK's CancerCARE Program coordination and approval guidelines.

CancerCARE Second Opinion: The Plan provides coverage for a CancerCARE Second Opinion through utilization of the CancerCOE Providers, which may include a review of the diagnosis, review of the treatment plan or both. Second Opinions may require travel to a CancerCOE Provider to qualify for benefits. A Second Opinion may consist solely of having pathology slides reviewed by a specialized lab or may include other services. Genetic Testing is a Covered Expense when coordinated by a CancerCARE Program Nurse.

Clinical Trial Benefits: The Plan provides Clinical Trial coverage for Routine Patient Costs consistent with Medical Expense Benefits section of this Summary Plan Description.
Routine Patient Costs shall be reimbursed at the Compliant Benefit level, provided that the Clinical Trial: (1) is provided at a CancerCOE Provider and (2) is approved and coordinated by a CancerCARE nurse. Otherwise, Clinical Trial Routine Patient Costs shall be reimbursed per standard plan benefits as outlined by the Schedule of Benefits.

Covered Persons are encouraged to contact CancerCARE at 877-640-9610 for further information on clinical trial coverage.
Questions: If there are any questions regarding coverage or a specific provision of the CancerCARE Program, please contact the Plan Administrator or the CancerCARE Program at 877-640-9610.

PLAN EXCLUSIONS

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

(1) 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.

(2) Services, treatments, and supplies which are not specified as covered under this Plan. These services include, but are not limited to, missed appointments, completion of claim forms, professional charges for travel expenses, mileage, traveling time, and independent expenses for telephone calls, faxes, and electronic communications. Excluded also are Physician's fees for any treatment, which is not rendered by a Physician.

(3) Charges excluded by the Plan design as mentioned in this document.

(4) Charges Incurred for which the Plan has no legal obligation to pay.

(5) Care and treatment of an Injury or Sickness which arises out of, or as the result of, any work for wage or profit, will not be covered by this Plan to the extent such person is covered by Worker's Compensation law. If such person enters into a settlement giving up his or her right to recover past or future medical benefits under the Worker's Compensation law, this Plan will not pay past or future medical benefits that are the subject of or related to that settlement. In addition, if you are covered by a Worker's Compensation program that limits benefits if other than specified providers are used, this Plan will not pay the balance of charges from such non-specified providers.

(6) 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.

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

(8) Care, treatment, or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law. Also, this exclusion does not apply to Covered Charges rendered through the United States Veteran's Administration for non-service related Illness or Injury

(9) Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(10) The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowed Amount.

(11) Illegal acts. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or serious of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one (1) year could be imposed. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply (a) if the Injury or Sickness resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

(12) Any loss that is due to a declared or undeclared act of war, insurrection, rebellion, armed invasion, or aggression.

(13) 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, sister, or Spouse's parent, whether the relationship is by blood or exists by law.

(14) Care and treatment provided for Cosmetic Reasons, including Cosmetic Surgery. This exclusion will not apply if the care and treatment is for repair of damage from a covered accident, or is for correction of an abnormal Congenital Birth Defect or congenital condition in a Dependent Child. Reconstructive mammoplasty will be covered after Medically Necessary surgery as explained under Covered Charges section of this document.

(15) Radial Keratotomy or other eye surgery to correct refractive disorders. See "Preventative Care Services" for more information about preventive vision services. Also excluded are lenses for the eyes and for their fitting. This lens exclusion does not apply to: Aphakic patients, soft lenses or sclera shells intended for the use of corneal bandages, and initial contact lenses or eyeglass lenses following cataract surgery.

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

(17) Services for educational or vocational testing, therapy or training services or any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies, except as may be required by applicable law. See "Covered Charges" for diabetic self-management.

(18) 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 service such as, but not limited, to residents or interns.

(19) Personal comfort items or other equipment such as, but not limited to, air conditioners, air purification units, humidifiers, dehumidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, hot tubs, pools, hypo-allergenic pillows, power assist chairs, railings, ramps, waterbeds, non-Prescription Drugs and medicines, and first aid supplies and non-Hospital adjustable beds regardless of a Physician's written order, recommendation or reason the item is to be used.

(20) Care, services or treatment of transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or Psychiatric treatment.

(21) Infertility care, supplies, and services except as stated in Covered Services.

(22) Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(23) Care and treatment for sleep disorders unless deemed Medically Necessary.

(24) Exercise programs for treatment of any condition, except for Physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(25) Care, services or treatment required as a result of complications from a treatment not covered under the Plan. Complications from a non-covered abortion are covered.

(26) Charges for travel or accommodations, whether or not recommended by a Physician, except for:

- **(a)** ambulance charges or as defined as a Covered Expense; or
- **(b)** Travel and/or lodging expenses covered by the COE Travel Benefits under the prescription benefits.

(27) Care or treatment for dental services unless specifically stated in the Covered Charges

(28) External defibrillators which require the assistance of a third party for operation.

(29) Blood Donor's expense.

(30) Charges for autopsies.

(31) Charges for the completion of claim forms or claims filed after any claim filing deadlines.

(32) Charges Incurred outside the United Sates if the Covered Person traveled to such a location for the primary purpose of obtaining medical services, drugs, or supplies.

(33) Professional Provider charges for travel expenses, mileage, traveling time, or telephone calls. This does not include charges filed for Telemedicine office visits.

(34) Charges for or related to massage therapy.

(35) Charges for alternative medicine including, but not limited to, autogenic feedback/biofeedback services and materials, aromatherapy, naturopathy, and homeopathic and holistic treatment or acupuncture/acupressure and hypnosis.

(36) Expenses covered under any individual health insurance policy except hospital indemnity type policies.

(37) Expenses Incurred due to the negligence of a third party, or otherwise, if such expenses are or could be compensable by a liability or medical carrier or would have been compensable if said Covered Person had not released said third party from liability for such expenses.

(38) Expenses Incurred by an adoptive birth mother.

(39) Charges for care, supplies, treatment, and/or services of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

(40) Charges for orthotic shoes and/or inserts, whether or not recommended by a Physician for any diagnosis, except as stated in the Schedule of Benefits. This exclusion also applies to any casting or fitting charges related to orthotic shoes.

(41) Counseling services and treatment related to relational problems, anti-social behavior, academic or phase-of-life problems, religious counseling, marital/relationship counseling, vocational or employment counseling and sex therapy.

(42) Court ordered testing or rehabilitation. Charges for court ordered testing or rehabilitation are not covered. Testing and rehabilitation are not covered if a Covered Person arranges in lieu of conviction, to undergo care or treatment as an alternative to, or in addition to, a fine or imprisonment.

(43) Surgical treatment of scarring secondary to acne or chickenpox to include, but not limited to, dermabrasion, chemical peel, salabrasion, and collagen injections.

(44) Dialysis Program. Charges in excess of the Dialysis Program Maximum Benefit Allowed.

(45) Evaluations and diagnostic tests ordered or requested in connection with determinations of paternity, divorce, Child custody, or Child visitation proceedings.

(46) Milieu therapy. Milieu therapy or any confinement in an institution primarily to change or control one's environment.

(47) Mouth, teeth, and gums. Care and treatment for mouth, teeth, and gum whether considered medical or dental in nature except as specifically stated by the Plan.

(48) Non-compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital, Medical Care Facility, or Skilled Nursing Facility against medical advice.

(49) Radioactive contamination. Radioactive contamination or the hazardous properties of nuclear materials.

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

(51) Smoking cessation. Care and treatment for smoking cessation programs, including smoking deterrent products, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma

(52) Training. Charges for orthoptics, vision training, vision therapy or subnormal vision aids.

(53) Chelation Therapy, except for the acute arsenic, gold, mercury, or lead poisoning.

(54) Sexual Dysfunction. Charges for the treatment of sexual dysfunction.

(55) Sex change operation. Surgery for sexual reassignment or change.

(56) Abortion. Expenses incurred for abortion. This exclusion does not apply when the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest or a fetal chromosomal abnormality exists which was diagnosed prior to the abortion. If complications arise after the performance of any abortion, expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.

(57) Growth Hormones. Human growth hormones. See " Prescription Durg Card Benefits" for injectable drugs.

PRESCRIPTION DRUGS

Prescription Drug Benefit Services provided through Elixir.

Acute Retail Medications - (Up to a 34-day supply):

Generic Drugs	$10 Copayment
Formulary Brand Name Drugs:	20% up to a $60 Copayment
Non-Formulary Brand Name Drugs	20% up to a $120 Copayment
Specialty Drugs*	20% up to a $300 Copayment

*Limited to a 30-day supply. Must be filled at a MedTrak BIC Specialty Pharmacy or through Payer Matrix.

Maintenance Retail Medications and Performance 90 Pharmacy-(Up to a 90-day supply)

Generic Drugs	$10 Copayment
Formulary Brand Name Drugs:	20% up to a $150 Copayment
Non-Formulary Brand Name Drugs	20% up to a $300 Copayment

Walgreen's, CVS, & Target Pharmacies Acute Retail Medications-(Up to a 34-day supply)

Generic Drugs	$20 Copayment
Formulary Brand Name Drugs:	35% up to a $120 Copayment
Non-Formulary Brand Name Drugs	35% up to a $240 Copayment
Specialty Drugs*	Not available

Walgreen's, CVS, & Target Pharmacies Acute Retail Medications-(Up to a 90-day supply)

Generic Drugs	$20 Copayment
Formulary Brand Name Drugs:	35% up to a $300 Copayment
Non-Formulary Brand Name Drugs	35% up to a $600 Copayment

Prescription Drug Maximum Out-Of-Pocket Amount per Plan Year

Per Covered Person	$6,200
Per Family	$12,400

Pharmacy Drug Charge-

Participating Pharmacies have contracted with the Pharmacy Benefit Manager to charge Covered Persons reduced fees for covered Prescription drugs under the Plan. Elixir is the administrator of the Pharmacy Benefit. Refer to the Covered Person's identification card for the telephone number and website address.

If a drug is purchased from a non-participating Pharmacy, the amount payable in excess of the amounts shown in the Schedule of Benefits will be the ingredient cost and dispensing fee.

Co-Payments

The Co-Payment is applied to each covered Pharmacy drug charge and is shown in the Schedule of Benefits. The Co-Payment amount accumulates toward the Prescription Drug maximum out-of-pocket amount. The Co-Payment amount does not accumulate toward the medical Deductible or Co-Insurance maximum out-of-pocket amount.

Non-Network Pharmacies

After obtaining a prescription at a Non-Network pharmacy or failing to show the Covered Person's ID card at a participating pharmacy, submit a claim to the Pharmacy Benefit Manager to obtain reimbursement. If so, obtain a Pharmacy claim form from the Pharmacy Benefit Manager, complete the form, and submit it- along with the prescription receipt- to the Pharmacy Benefit Manager. The Pharmacy Benefit Manager will process the claim and reimburse the Covered Person in accordance to the Plan. Reimbursement is at 50% of the Network Allowed Amount for the drug. You may have higher out-of-pocket expense if you use a Non-Participating Pharmacy.

The Allowed Amount is limited to the Network Allowed Amount. The Covered Person may have higher out-of-pocket costs if a Prescription Drug is purchased from a Non-Network provider. The amount over the Allowed Amount will not be used to satisfy any out-of-pocket maximum amount.

Covered Prescription Drugs

(1) Prescription Legend Drugs – All legend drugs which, under applicable State and/or Federal laws, requires a prescription to be legally dispensed, except for the exclusions as listed. The prescription must be written in the name of the member for whom it is prescribed;
(2) Compound Medications – The compounded prescription must contain at least one legend drug in a therapeutic amount.
(3) Insulin and other diabetic supplies when prescribed by a Physician.
(4) Injectable drugs or any prescription directing administration by injection, except Growth Hormones.
(5) Vaccines. Limitations may apply by Pharmacy.

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:

(a) Refills only up to the number of times specified by a Physician.
(b) Refills up to one year from the date of order by a Physician.

Special Instructions-

(1) Abortifacients- Not covered (Plan B, Next Choice, etc.)
(2) Acne Medications- Covered up to age 26. After age 26, Prior Authorization required.
(3) Antifungals- Covered.
(4) Anorexiants (Weight Loss Drugs)- Not covered.
(5) Male Impotency Medications- Not covered.
(6) Androgens/Testosterone- Prior Authorization required. Injectable testosterone covered only after Prior Authorization for diagnosis of Hypogonadism.
(7) Self-Injectables- Covered
(8) Growth Hormones- Not covered.

Mandatory Generic
If a Generic equivalent is available, then that equivalent is the benefit. If the patient or Physician, for whatever reason, demands the more expensive branded product be dispensed, the patient pays, in addition to the appropriate Co-Pay, the difference in cost between the Generic and Brand Name drugs. The difference in cost will not be used to satisfy any out-of-pocket maximum amount.

Step Therapy Program
Under this program, a "step" approach is utilized for certain high-cost medications. To receive the benefit, the Covered Person may be directed to first try a proven cost-effective medication before using a more costly treatment, if possible. However, treatment decisions are always between the patient and the patient's Physician. Drug categories which may be included in the Step Therapy Program are medications such as alpha-blockers, blood pressure, diabetes, high cholesterol, depression, acid reflux, acne, proton pump inhibitor medications, and more. For a specific list of Step Therapy Program mediations contract Elixir at the number listed on the Covered Person's ID card.
The Step Therapy Program requires the Covered Person to have a prescription history for a "first-step" medication before the Plan will cover a "second-step" medication. A first-step drug is recognized as safe and effective in treating a specific medical condition, as well as being cost-effective. A second-step drug is a less-preferred or sometimes more costly treatment option.
Step 1- Whenever possible, the Physician should prescribe a first-step medication that is appropriate for treatment of the medical condition.

Step 2-If the Physician determines that the first-step drug is not appropriate or is not effective, the Plan will cover a second-step drug when certain conditions are met. The Pharmacy and the Covered Person's Physician will work with Elixir to obtain prior authorization for the second-step medications.

First-Fill-Free
Elixir offers a First-Fill-Free program which allows Individuals to obtain a first fill medication of select Generic Drugs at $0 Copayment. When the Covered Person purchases a medication for the first time, ask the pharmacist if the brand Name Drug is eligible for the First-Fill-Free program. This program allows an individual to try a lower costing, but effective Generic Drug that will save on out-of-pocket costs.

Co-Pay Waiver
Elixir offers a Co-Pay Waiver program which allows Individuals to obtain up to a six (6) month supply of select Generic Drugs at a $0 Cop-Pay. If the Covered Person is prescribed a Brand Name Drug and is interested in trying a lower costing Generic Drug, ask the pharmacist if the medication is eligible for the Co-Pay Waiver program.

ScriptChoice and eScriptChoice
These programs are available as part of the Elixir Right Choice Program and are a valuable resource for Covered Persons. ScriptChoice is a direct mail program that informs members about available savings on select drug options. eScriptChoice is an on-line resource which is an education tool about lower costing drug alternatives.

Contracting Prescription Network Pharmacies
Payment will be the allowable charge for Covered Services, subject to your out-of-pocket maximum. Payment will be sent directly to the Pharmacy. You will have no claims to file.

Payer Matrix
Payer Matrix provides a list of over 350 high cost specialty medications which will reject at the point of sale. Elixir will only authorize any medications on the Payer Matrix list if directed to do so by Payer Matrix. Payer Matrix will help Covered Persons enroll in any applicable alternate funding program that is eligible for the drug therapy prescribed with the goal of helping individuals avoid any out-of-pocket expense for the Specialty Drug.

If a Covered Person is eligible for a Payer Matrix identified alternate funding program, and chooses not to enroll in the program, the Covered Person will be responsible for the full cost of the applicable Specialty Drug, and this expense will not apply toward the annual out-of-pocket maximum.

If the Covered Person participates in the cost avoidance program and the Specialty Drug is not eligible for any alternate funding through the Payer Matrix program, the Specialty Drug will be subject to the appropriate Deductible, Co-Insurance, or Co-Payment. The Specialty Drug must be an otherwise Covered Charge and not subject to a Plan exclusion or limitation.

Performance 90 Program
Select retail Pharmacies in the Network are designated as Performance 90 Pharmacies. These Pharmacies provide 90-day fills for certain listed maintenance medications (those that are taken for long periods of time) at reduced costs. When purchasing maintenance medications from a retail Pharmacy, use a Performance 90 Pharmacy to obtain the lowest costa and greater out-of-pocket savings. Contact Elixir via phone at (800) 771-4648, or use their on-line look-up at www.elixirsolutions.com, to locate Performance 90 Pharmacies.

Mail Order Drug Benefit
The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time). Purchasing medications through the mail is easy, convenient and offers the best discounted price. For instruction on how to purchase Prescription Drugs through the Mail Order program or online, refer to the prescription packet provided at enrollment, visit the Pharmacy Benefit Manager's website, or contract them via phone for more information.

90/91 Day Packaged Products at Retail
Certain medications are packaged and sold in 90/91 day supplies. These medications-usually contraceptives and 90-day Estrogen- are subject to one Maintenance Medication Co-Payment for each supply. Generic contraceptives are covered at 100% without cost-sharing when purchased at a Network Pharmacy.

Compound Medications
Compound medications are medications whose ingredients have been combined, mixed or altered to create a medication tailored to the needs of an individual patient.

Vaccines
Certain Pharmacies in the Elixir Network administer vaccines and such vaccines are Covered Charges without cost-sharing. The type of vaccine available is limited; talk to the Pharmacy to learn more about its vaccine capabilities. Contact Elixir at the phone number listed on the Covered Person's ID card to find out which Pharmacies participate in the Elixir Network.

Specialty Drugs
Specialty Drugs means high-cost, complex pharmaceuticals (usually injectable) that have unique clinical, administration, distribution, or handling requirements that are not commonly available in traditional community and mail-order Pharmacies. Prior Authorization is required for most Specialty Drugs. Contact Elixir for a Best In Class "BIC" Specialty Pharmacy or Payer Matrix will contact the member.

BIC Align Program
The *BIC Align Program* is designed to reduce Prescription Drug out-of-pocket expense for the Covered Person and Plan costs on Specialty Drugs at "BIC" (best in class) specialty Pharmacies by maximizing manufacturer Co-Pay assistance for conditions such as Hepatitis C, HIV, Inflammatory Conditions and Multiple Sclerosis. The Covered Person will pay no more than the Brand Name drug flat Co-Payment for Specialty Drugs when active in the program.

Health Care Reform-
Under the Affordable Care Act, certain medications are covered by the Plan without cost-sharing. These medications are subject to change without notification. Following is a list of medications available without cost-sharing when prescribed by a Physician and purchased with the Prescription Drug card:

(1) Aspirin for men from ages 45 through 78 and women ages 11 through 78.
(2) Folic acid supplementation for women of childbearing age.
(3) Oral fluoridation supplementation for Children 6 months of age up to 6 years.
(4) Iron supplementation for Children 6 months of age up to 13 months of age.
(5) Tobacco deterrents by prescription only (limitations may apply).
(6) Contraception and sterilization agents (limitations may apply).
(7) Vitamin D2 and D3 products and calcium Vitamin D <1,000 IU limited to ages 65 and older.
(8) Bowel preps from age 50 up to age 76. (Bisacodyl, Mag Citrate, Milk of Magnesia, PEG 3350- Electrolyte.)
(9) Risk-reducing medication for breast cancer in women who are at increased risk and at low risk for adverse medication effects such as tamoxifen or raloxifene. Limitations may apply.
(10) Statin drugs for individuals ages 40 through 74 years. Limitations may apply.

Provider Network-
Pharmacy products and services must be prescribed by a Health Plan prescriber in connection with Covered Services provided in the benefit schedule. Pharmacy products and services must be filled at a participating Pharmacy chosen by the covered member.

Approval
This Pharmacy Benefit Plan has been approved by the Plan Sponsor. Plan Sponsor is designating Elixir as its exclusive agent to administer the Pharmacy Benefit Plan for and on behalf of the Plan Sponsor.

Expenses Not Covered
The Plan Administrator reserves the right to review medications for coverage or exclusion by the Plan. Contact the Elixir on the Covered Person's ID card for more information about prescription drug coverage by the Plan.

(1) Drugs other than Prescription Drugs as defined above and/or not approved by the Food & Drug Administration.

(2) Prescription Drug refills dispensed more than 12 months after the date of the prescriber's original order; refills in excess of the number written by the prescriber.

(3) A charge for Prescription Drugs which may be properly received without charge under local, state, or federal programs.

(4) 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) Medication for which the cost is recoverable under any worker's compensation or occupational disease law or any State or Government Agency or medication furnished by any other drug or medical service for which no charge is made to the member.

(6) Any drug Labeled, "Caution – Limited by Federal Law to Investigational Use," or Experimental or other drugs which are prescribed for unapproved uses.

(7) Any charge for the administration of any drug. This exclusion does not apply to the Pharmacy charge for the administration of vaccines.

(8) Medication which is to be taken by or administered to the member, in whole or in part, while he or she is a patient in a Hospital. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(9) Drug charges exceeding the costs for the same drug in conventional packaging (e.g., unit dose).

(10) Drugs administered by a prescriber, or consumed at the place where is it dispensed.

(11) Drugs available in an equivalent dose over-the-counter which do not require a prescription order by federal or state law (Insulin and diabetic supplies are covered).

(12) Any medication related to injuries resulting from a motor vehicle accident to the extent that such services are payable under any automobile insurance policy.

(13) Antigens, allergy and biological sera, blood or blood plasma, parenterals, radiologicals.

(14) Legend drugs prescribed for cosmetic or other non-medicinal purposes, including but not limited to Rogaine, Botox (all forms), anabolic steroids, or Retin A.

(15) Appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription and vitamins D & K with prior authorization. This exclusion does not apply to anti-obesity drugs for the treatment of diabetes or Morbid Obesity when prior authorization is obtained.

(16) Abortifacients.

(17) Infertility drugs, including but not limited to Clomid (Clomiphnen).

(18) A charge for Prescription Drugs obtained outside the United States for consumption in the United States. This exclusion is not applicable to medications purchased through the Prescription Savings Program independent of Elixir.

(19) Specialty Drugs. The full amount charged or otherwise payable for any Specialty Drug for which another source of payment is available, including but not limited to manufacturer and copay assistance programs. For clarity, this exclusion applies to the full amount charged or otherwise payable by the Plan for any such drug, not just the amount of alternate assistance potentially available, and applies regardless of whether such alternate assistance is received or pursued.

(20) Products used to treat erectile dysfunction, including but not limited to Viagra.

(21) Any medication refilled before 60% of the previous fill's days supply has expired.

(22) Growth Hormones. Charges for drugs to enhance physical growth or athletic performance of appearance.

(23) Such other exclusions selected by the Plan Sponsor and applied by the Pharmacy Benefit Manager pursuant to the implementation documents of the Plan, which may be updated on an annual basis. For information related to specific exclusions, please contact the Pharmacy Benefit Manager.

Prescription Drugs purchased with the drug card are not eligible for secondary coverage including coverage under Medicare Part D. The Plan will not coordinate benefits or consider Deductible, Co-Payments, or other out-of-pocket expenses that are the responsibility of the Covered Person under another plan.

Select Prescription Drugs may require prior authorization by the Pharmacy Benefit Manager. Contact Elixir for more information.

DENTAL BENEFITS

Eligibility Verification. Call 620-792-9151 or 866-792-9151 to verify eligibility for benefits **before** the charge is Incurred.

This benefit applies when dental Covered Charges are Incurred by a person while covered under this Plan. All benefits described in this Dental Benefits Section are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's or delegated party's determination that: care and treatment is Medically Necessary; charges are the Allowed Amount; services, supplies, and care are not Experimental and/or Investigational.

Benefit Payment
Each Plan Year benefits will be paid to a Covered Person for dental charges. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits.

Maximum Benefit Amount
The Maximum amount payable for Dental Benefits is shown in the Schedule of Benefits.

Dental Charges
Dental charges are the Allowed Amount charged by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

In order for benefits to be payable, the person must be covered on the date the dental treatment is received. Most dental treatment is considered to have been received on the date the work is done. However, there are some kinds of treatment that take more time to complete. In these cases, treatment is considered to have been received on the dates shown below.

- **(a)** As to fixed bridgework, crowns, inlays, onlays and gold restorations, the date the tooth or teeth are first prepared.
- **(b)** As to full or partial removable dentures, the date the impression is taken.
- **(c)** As to root canal work, the date the pulp chamber is opened.
- **(d)** As to an appliance or modification of an appliance, the date the impression is taken.

A dental charge is Incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro-rata charge will be considered to be Incurred as each visit or treatment is completed. Charges are limited to Usual, Customary and Reasonable Fees.

Order of Claims
If a service is covered by both the Medical and Dental Benefits, the Medical benefits are considered first. The Allowed Amount for Dental Benefits is considered after the Medical Benefits.

Percentage payable by the Plan Participant, per Plan Year

Preventive Services	100%
Basic Services	80%
Major Services	50%
Plan Year Maximum	$1,500
Orthodontia Services	None

Deductible payable by the Plan Participant, per Plan Year:

Individual	$50
Family	$100

Dental Deductible per covered Person applies to Basic and Major Dental Procedures. Preventive Dental Procedures are NOT subject to the Deductible.

Preventive Dental Procedures –

The limits on Preventive Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams and prophylaxis. This includes the cleaning, scaling and polishing of teeth. Limit of two exams per Covered Person each Plan Year. Cutterage and scaling performed in conjunction with and on the same day as a routine exam will be considered part of the routine exam procedure.

(2) Dental imaging services required to treat or diagnose diseases or abnormalities of the teeth, surrounding tissue, and cavity detection, including those provided in association with a covered dental implant limited as follows:

- **(a)** Bitewing x-ray series limited to two (2) times per Plan year,
- **(b)** One full-mouth or panoramic x-ray as part of a routine oral exam two (2) times per Plan year.
- **(c)** All other dental imaging services as Dentally Necessary.
- **(d)** If full-mouth/panoramic and bitewing x-rays are performed in conjunction with each other, the total amount payable will be based on the Usual and Reasonable Charge for a full-mouth/panoramic x-ray.

(3) Sealants on the occlusal surface of a permanent posterior tooth for Dependent Children, under the age of nineteen (19) once every three (3) years.

(4) Topical application of fluoride for Dependent Children under age nineteen (19), two (2) times per Plan Year.

(5) Problem focused exams.

Basic Dental Procedures –

(1) Extractions. This includes local anesthesia and routine post-operative care.

(2) Silver (amalgam), silicate, acrylic, synthetic, resin, porcelain and composite filling to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible.

(3) Space maintainers for covered Dependent children to replace primary teeth. No payment will be made for duplicate space maintainers.

(4) Periodontics (gum treatments).

(5) Endodontics (root canals).

(6) General and local anesthetics, upon demonstration of Medical Necessity.

(7) Diagnostic casts, laboratory tests and other diagnostic exams.

(8) Biopsy and examination of oral tissue.

(9) Antibiotic drugs administered in an office setting.

(10) Emergency palliative treatment for pain.

(11) Re-cementing bridges, crowns or inlays

(12) Oral surgery, limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch.

Major Dental Procedures–

(1) Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Dental Implants

(3) Repair of crowns, bridgework and removable dentures.

(4) Installation of crowns, inlays and abutments.

(5) Installing precision attachments for removable dentures.

(6) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during a six-month period following the installation.
(7) Addition of clasp or rest to existing partial removable dentures.
(8) Initial installation of fixed bridgework to replace one or more natural teeth.
(9) Rebasing or relining of removable dentures over six (6) months old once every thirty-six (36) months. If the benefits pay for new dentures, it will not pay to rebase or reline the old dentures..
(10) Replacing an existing full or partial removable denture, new bridgework, or the addition of teeth to an existing full or partial removable denture or bridgework. However, only replacement and additions that meet the "Prosthesis Replacement Rule" below will be covered.

PROSTHESIS REPLACEMENT RULE

This rule requires that satisfactory evidence be furnished to show that one of the following criteria applies:

(a) The replacement or addition of teeth is required to replace teeth that were extracted after the existing denture was installed and while the individual was covered under the plan.
(b) The existing denture cannot be made serviceable and was installed at least five (5) years prior to its replacement; or
(c) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of the initial installation of the immediate temporary denture.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause, which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, then benefit payment will be based on the cost of the treatment, which provides professionally satisfactory results at the most cost-effective level.
For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

Exclusions and Limitations:

(1) Administrative costs of completing claim forms or reports or for providing dental records.
(2) Bone grafts for alveolar ridge augmentation.
(3) Charges for broken or missed dental appointments.
(4) Chemotherapeutic agent(s) inserted into a periodontal pocket.
(5) Cosmetic dentistry. Facings on crowns or pontics beyond the second bicuspid are considered cosmetic, except for Injuries or Medically Necessary care and treatment of cleft lip and palate.
(6) Charges incurred for treatment, services or supplies which constitute personal comfort, beautification or cosmetic procedures.
(7) Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
(8) Excluded under Medical. Services that are listed as excluded under Medical Benefits section of the Plan.
(9) Dentist charges for travel expenses, mileage, traveling time, telephone calls, or for services provided over the telephone.
(10) The charges for services of anyone who is not a licensed Dentist or Dental Hygienist.
(11) Home Sealant Kits.
(12) Instructions for plaque control, oral hygiene, or diet.
(13) Services related to: Bite registration, equilibration, or occlusal analysis.
(14) Treatment or service to alter or maintain vertical dimension or restore occlusion.

(15) Treatment or service to duplicate or replace a lost or stolen prosthetic device or to duplicate or replace a lost or stolen appliance.
(16) Treatment, service, or material that does not meet professionally recognized standards of quality.
(17) Treatment or service for provisional or permanent splinting. Crowns, fillings or appliances that are used to connect (splint)teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
(18) Orthodontic treatment, service, appliance or bands not specified in the Schedule of Benefits.
(19) Hospital, healthcare facility or medical emergency room charges.
(20) Orthognathic surgery. Surgery to correct malposition in the bones of the jaw.
(21) Treatment or service which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three (3) years.
(22) Patient education services.
(23) Personalization of dentures.
(24) Charges that are payable under the Major Medical Expense Benefit of the Plan.
(25) Recall visits for checking sealant application.
(26) Services which are not included in the list of covered dental services.
(27) Charges for the treatment of Temporal Mandibular Joint dysfunction (TMJ).

COST MANAGEMENT SERVICES

Cost Management Services Contact Information: (Identified on your ID Card)
MedWatch, LLC
800-432-8421

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made in advance of services being rendered or within three (3) business days after a Medical Emergency.

Providers must submit chemotherapy, radiation, and surgical treatment plans related to a cancer diagnosis to CancerCARE for treatment review prior to delivery to Covered Persons. Cancer-related diagnostic and staging tests are excluded from these review requirements.

IMPORTANT: Failure to submit treatment plans prior to delivery of care may result in penalties and/or denial of payment. Contact CancerCARE at (877) 640-9610 for treatment plan submission.

Any penalty due to failure to follow cost management procedures will not accrue towards the patient's maximum out-of-pocket amount. Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

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

The program consists of:

(1) Pre-certification of the Medical Necessity for the following non-emergency services:
- **(a)** Inpatient stays for medical and/or psychiatric or substance use
- **(b)** Outpatient surgery not performed in an office setting.
- **(c)** All services listed below regardless of place of service:

i. Observation stays that exceed 48 hours*
ii. Any drug above $1,500 per dose
iii. Biologic Drugs
iv. Chemotherapeutic Drugs
v. Deviated Septum/Nasal Surgery
vi. Dialysis
vii. Durable Medical Equipment over $2,500
viii. EBCT (Electron Beam Tomography)
ix. Endoscopic Procedures
x. Epidural/facet and trigger point injections
xi. Extended Nursing Facility
xii. Genetic Testing
xiii. Home Health Care
xiv. Hospice Care
xv. Infusions (Infusion therapy) of any type over $1,500
xvi. Long Term Acute Care (LTAC)
xvii. MRI/CT/Pet Scan- excluding bone density studies
xviii. Physical/Occupational/Speech Therapy
xix. Radiation Treatments
xx. Rehabilitation for Substance Abuse: Intensive Out-Patient, Residential, Partial Hospitalization Program
xxi. Skilled Nursing Facility
xxii. Inpatient Rehabilitation
xxiii. Varicose Vein Ligation
xxiv. On-going wound care

**After 48 observation hours, a confinement will be considered an Inpatient confinement. Observation in excess of 48 hours require pre-certification as an Inpatient stay. Pre-certification penalties may apply if observation exceeds 48 hours and is not pre-certified.*

(2) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(3) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

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

Pre-certification is the process of obtaining Medically Necessary certification. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

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

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

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

Here's how the program works. * Pre-certification DOES NOT guarantee payment of benefits.

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person or the Provider. Contact the utilization review administrator at the number provided above **in advance of the date** the services are scheduled to be rendered with the following information:

(1) The name of the patient and relationship to the covered Employee.
(2) The name, Employee identification number and address of the covered Employee
(3) The name of the Employer
(4) The name and telephone number of the attending Physician
(5) The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
(6) The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact MedWatch, LLC **within (3) three business days** after the admission.

The utilization review administrator will determine the Medically Necessary number of confinement days or whether the outpatient care, treatment, or services is appropriate for the condition being treated. **Failure to follow this procedure could reduce reimbursement received from the Plan.**

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.
If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

Post-Service Claim Review

The Plan reserves the right to conduct claim review to ensure that appropriate billing and coding guidelines are applied to Covered Charges. This includes, but is not limited to, guidelines as stipulated by the Centers for Medicare and Medicaid, the American Medical Association, and the Federal Register. Code edits including, but not limited to, reduction and/or denials based on the aforementioned guidelines may be applied.

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

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.

Pre-Admission Testing Service

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

(1) Performed on an Outpatient basis within seven days before a Hospital confinement;
(2) Related to the condition which causes the confinement; and
(3) Performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable at the applicable Deductible and Co-Insurance even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," 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.

The Case Manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

(1) personal support to the patient;
(2) contacting the family to offer assistance and support;
(3) monitoring Hospital or Skilled Nursing Facility;
(4) determining alternative care options; and
(5) assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

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

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses Incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommend for any other patient, even one with the same diagnosis. Large Case Management is provided through MedWatch, LLC.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized. Any terms not listed shall be understood by its normal meaning within the context in which it is used.

Active Employee is an Employee who performs all of the duties of his or her job with the Employer on a Full-Time basis.

Actively at Work means the active expenditure of time and energy in the service of the Plan Administrator. An individual will be considered Actively at Work on each day of a regular paid vacation or on a regular non-working day on which he/she is on a paid or unpaid Leave of Absence, provided he/she was Actively at Work on the last preceding regular working day. The Plan will not discriminate against a Plan Participant due to a medical condition, as defined by HIPAA.

Adverse Benefit Determination means any of the following:

(1) a denial in benefits;
(2) a reduction in benefits;
(3) a rescission of coverage;
(4) a termination of benefits; or
(5) a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan.

Affordable Care Act means the "Patient Protection and affordable Act" enacted on March 23, 2010 and any amendments thereto.

Alcohol Dependency Treatment Center is a specialized facility that provides a program for the treatment of alcoholism by means of a written treatment plan that is approved and monitored by a Physician. This facility must be:

(1) affiliated with a Hospital under a contractual agreement with an established
(2) system for patient referral; accredited by the Joint Commission on Accreditation of Hospitals licensed, certified, or approved as an alcohol treatment program or center by any other state agency that has the legal authority to do so.

Allowed Amount means the amount that the Plan determines to be the maximum amount payable for a service or supply provided. For services provided by Network Providers, the Allowed Amount is a negotiated amount that the Network Providers have agreed to accept as payment in full for services received by a Covered Person. For services received from providers who are not participating in the Network, the Plan will either limit the amount it allows for Covered Charges to the lessor (i) the provider's billed charge or (ii) an amount equal to 120% of the current Medicare allowable fee for the appropriate area, as such information is made publicly available. The Plan Administrator may, in its discretion, elect to issue an additional payment, in an amount not to exceed the Usual and Customary and Reasonable and Appropriate amount, if doing so is found to be in the best interest of the Covered Person. If there is no corresponding Medicare reimbursement rate for a charge from a non-network provider, the Allowed Amount will be an amount which is Usual and Customary and Reasonable and Appropriate. The Covered Person is responsible for payment of Deductible, Copayment/Co-Insurance amounts and non-covered services.

Alternate Care means medical treatment or care that is provided in lieu of the benefits specified in this Plan, because it may be provided in a less comprehensive setting or because it is less expensive. Alternate Care must be recommended by the Case Manager for a Covered Person whose condition would otherwise require Hospital care, Medically Necessary and approved by the Plan Administrator.

If the Plan Administrator determines that medical treatment or care is Alternate Care for a Covered Person in one instance, it shall not be obligated to determine that the same medical treatment or care is Alternate Care for other Covered Persons under this Plan in any other instance.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from your home, scene of accident or Medical Emergency to a Hospital, between Hospitals, between Hospital and Skilled Nursing Facility, or from a Hospital or Skilled Nursing Facility to your home. Surface trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none are available, you are covered for trips to the closest such facility outside your local area. Air transportation is covered when such transportation is Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for Inpatient care.

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

Amendment is a formal document that changes the provisions of the Plan Document.

Approved Clinical Trial means a phase I, II, III or IV trial which is:

(1) Conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, and

(2) Is one of the following:

- **(a)** Federally funded, or
- **(b)** Is either:
  - i. Conducted under an investigational new drug application (IND) reviewed by the Food and Drug Administration, or
  - ii. A drug trial that is exempt from the IND application requirements

Assignment of Benefits is an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Assisted Reproductive Technology (ART) means any combination of chemical and/or mechanical means of obtaining gametes and placing them into ta medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples a ART include, but are not limited to, invitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transport, selective reduction, and cryo-preservation.

Benefit Period or Plan Year means the period of time during which covered charges may be calculated and paid under this Plan if such charges are Incurred during the twelve-month period beginning after the Plan Participant's Enrollment (their anniversary date) Date. Such Enrollment Date will be defined by the enrollment form or other confirming billing or payroll records.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.
The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Case Manager is an individual or entity that reviews the cost effectiveness or prescribed courses of treatment for the Covered Person and evaluates and recommends more cost-effective alternative courses of treatment under the terms or an agreement with the Employer.

Chemical Abuse means the pathological use or abuse of chemicals, alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functions and which constitutes chemical, alcohol or drug dependency.

Child means, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a QMCSO as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster Child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

CHIP refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Claims Administrator is the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the administration, consideration, investigation and settlement of claims, maintain records, COBRA Administration, submit reports and other such administrative functions as may be set forth in a written administration agreement. Both the ultimate responsibility for the administration of this Plan and the authority to interpret the Plan shall remain with the Plan Administrator.

Clean Claim means a claim that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

Close Relative means the Spouse, parent, brother, sister, Child or Spouse's parent of the Covered Person.

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

Congenital Abnormality is a medical condition that existed at birth and is diagnosed within the first five (5) years of life.

Cosmetic Surgery, Cosmetic Reasons means medically unnecessary treatment and surgical procedures, usually, but not limited to, plastic surgery, directed toward preserving beauty or correcting scars, burns or disfigurements.

Cosmetic Dentistry means dentally unnecessary procedures.

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

Covered Expenses means an Allowed Amount or Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant's health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.
All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

Covered Person is an eligible individual and his/her Dependents who satisfy the eligibility conditions and has entered the Plan.

Creditable Coverage shall have that definition contained in ERISA Section 701(c). Under this provision, Creditable Coverage generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental and church plans) that are not followed by a Significant Break in Coverage. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits.

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.

Deductible is a specified dollar amount of Covered Expenses not payable under the Plan which must be Incurred in each Plan Year before Covered Expenses, in excess of such amount, can be considered for payment at the Co-Insurance level. Before benefits can be paid in a Plan Year a Covered Person must meet the Deductible(s) shown in the Schedule of Benefits.

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

Designated Transplant Facility means a facility participating in a national transplant network, and the facility is available to deliver transplant services to a Covered Person based on a pre-arranged agreement with the Plan. A Designated Transplant Facility may or may not participate in the Plan's Preferred Provider Organization.

Disability means a physical state of a Covered Person resulting from an Illness or Injury which:

(1) in the case of a Participant, wholly prevents the Participant from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and

(2) in the case of a Dependent, wholly prevents the Dependent from performing the normal activities of a person of like age and sex in good health.

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 means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

(1) a medical screening examination (as required under section 1867 of the Social Security Act,42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

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.

Employer is Barton County Community College and any other entity defined as a controlled group entity as defined by the Internal Revenue Service and the U.S. Department of Labor Employee Benefits Security Administration.

Enrollment Date means the first day of coverage under this Plan, or if earlier, the beginning of any applicable Waiting Period hereunder.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits means, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and Newborn care; mental health and substance abuse disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care

Experimental and/or Investigational means a drug, device, medical treatment or procedure that meets any of the following protocols:

(1) The drugs or dosages, devices, equipment, services, supplies, tests or medical treatment or procedures (generally, individually or collectively called ("Regimens")) have not received final approval from the U.S. Food and Drug Administration for the lawful marketing of the Regimens for the specific Injury or Illness to be treated.
(2) The Regimens have not received the approval or endorsement of the American Medical Association (AMA) for the lawful marketing of the Regimens for the specific Injury or Illness to be treated.
(3) The Regimens have not received the approval or endorsement of the National Institutes of Health (NIH) or its affiliated institutes for the specific Injury or Illness to be treated.

(4) The Regimens are to be or are being used or studied in proposed or ongoing clinical research or clinical trials as evidenced by an Informed Consent or treating facility's protocol; or are part of a proposed or ongoing Phase I, II, Or III clinical trial; or are the subject of proposed or ongoing research or studies to determine their dosage, safety, toxicity, efficacy, or their efficacy as compared to other means of treatment or diagnosis.

(5) The opinion of medical or scientific experts (as reflected in published reports or articles in medical and scientific literature; or the written protocol(s) used by the treating facility of other facilities studying substantially the same or similar drugs, devices, services, supplies, tests, treatments or procedures) indicates that further studies, research, or clinical trials of the Regimens are necessary to determine their dosage, safety, toxicity, efficacy, or their efficacy as compare to other means of treatment or diagnosis.

(6) The Regimens have not been proven effective for the specific Injury or Illness as of the date the treatment is provided.

(7) **Except,** A drug shall not be considered Experimental and Investigational if all of the following criteria are satisfied:

(a) The drug is approved by the U.S. Food and Drug Administration regardless of the Injury, Illness or diagnosis; and

(b) The drug is appropriate and is generally accepted for the condition being treated by two of the following:

i. American Hospital Formulary Service Drug Information;
ii. National Comprehensive Cancer Network's (NCCN) Drugs & Biologics Compendium;
iii. Thomson Micromedex DrugDex;
iv. Elsevier Gold Standard Clinical Pharmacology.

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

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Full-Time is an Employee who is considered Actively at Work with the Employer, who works an average of 30 hours per week or more on an annual basis, and who is considered an Employee under the U.S. Internal Revenue Service. An individual will be considered a Full-Time Employee while on paid vacation or on a regular non-working day on which he/she is on approved paid or unpaid Leave of Absence, provided he/she was Actively at Work on the last preceding regular working day.

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 U.S. 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 the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic Information does not include information about the age or gender of an individual.

HIPAA means The Health Insurance Portability and Accountable Act of 1996 as passed by Congress and the rules and regulations promulgated by the Department of Labor and other federal agencies.

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 thirty (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 a legally operate institution which meets at least one of these criteria:

(1) Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or

(2) Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments in accordance with the provisions of Medicare, or

(3) Is supervised by a staff of Physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:

- **(a)** General Inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control, or
- **(b)** Specialized Inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.
- **(c)** A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.
- **(d)** A free-standing treatment facility, other than a Hospital, whose primary function is the treatment of alcoholism or Substance Abuse provided the facility is duly licensed by the appropriate governmental authority to provider such service.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:

(1) Is primarily a facility for convalescence, nursing, rest, or the aged, or

(2) Furnishes primarily domiciliary or Custodial Care, including training in daily living routines, or

(3) Is operated primarily as a school.

Illness(es) means a bodily disorder, disease, physical Sickness, mental infirmity, or Pregnancy of a Covered Person. A recurrent Illness will be considered an Illness. Concurrent Illnesses will be considered an Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously, which are due to the same or related causes, shall be considered one Illness.

Incurred expenses will be deemed Incurred on the date the Covered Person receives the treatment, service, or supply that gives rise to the expense.

Infertility means incapable of producing offspring.

Injury(ies) means an accidental physical Injury to the body caused by unexpected external means. It does not include disease or infection (unless it's pus-producing infection that occurred from an accidental cut or wound); hernia; or Injuries caused by biting or chewing.

Inpatient means a Covered Person who receives care as a registered and assigned bed patient while confined in a Hospital, other than its Outpatient department, Skilled Nursing Facility, Birthing Center or other Medical Care Facility where a room and board is charged by the facility which is properly licensed in the state for the services being rendered. Observation hours in excess of 48 hours will be considered an Inpatient admission.

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 an individual who is enrolled for coverage after the initial eligibility date. Note, however, a Special Enrollee shall not be considered a Late Enrollee.

Leave of Absence is any Employee who is off work or temporarily working less than a normal schedule with the approval of the Employer for medical leave or personal time off will be on a Leave of Absence. The length of leave will be defined by the Employer, but shall not exceed 3 months.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure, or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

Maximum Amount and/or Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

(1) the Usual and Customary amount;

(2) the Allowed Amount specified under the terms of the Plan;

(3) the negotiated rate established in a contractual arrangement with a provider; or

(4) the actual billed charges for the Covered Services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable and Appropriate service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body type organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisoning, loss of consciousness or respiration, convulsions or other such acute medical conditions.

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

Medical/Surgical Supplies means items for medical use other than drugs, Prosthetic or Orthotic Appliances, Durable Medical Equipment, or orthopedic footwear which have been ordered by a Physician in the treatment of a specific medical condition and which are usually:

(1) Consumable;
(2) Non-reusable;
(3) Disposable;
(4) For a specific rather than incidental purpose; and
(5) Generally have no salvageable value

Medically Necessary care and treatment is recommended or approved by a Physician (or Dentist, with regard to dental care); is consistent with the patient's condition or accepted standards of good medical (and dental practice) care; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider; 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 Record Review is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the medical record review and audit results.

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

Mental Health Parity means that pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

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 listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Municipal Health Department means a local health department serving a municipality that meets the requirements of State public health laws and regulations.

Newborn means an infant from the date of birth until the initial Hospital discharge or until the infant is fourteen (14) days old, whichever occurs first.

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

Occupational Therapy is a process to restore or develop the working ability of the physically, emotionally or mentally disabled patient to the extent that they may become gainfully employed. This may include services provided to determine eligibility or provide treatment for vocational rehabilitation or Occupational Therapy, to include but not limited to, counseling, work trials and driving lessons.

Open Enrollment Period is, unless otherwise specified in the Schedule of Benefits, the one-month period prior to the beginning of each Plan Year.

Orthotic Appliance is an external device intended to correct any defect in form or function of the human body.

Other Plan shall include, but is not limited to:

(1) any primary payer besides the Plan;

(2) any other group health plan;

(3) any other coverage or policy covering the Participant;

(4) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(5) any policy of insurance from any insurance company or guarantor of a responsible party;

(6) any policy of insurance from any insurance company or guarantor of a third party;

(7) worker's compensation or other liability insurance company; or

(8) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Outpatient or Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital, Medical Care Facility, or Birthing Center 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 Ambulance Surgical Center, or the patient's home.

Outpatient Dialysis Treatment, when used in this document, shall mean any and all products, services, and/or supplies provided to a Covered Person for purposes of, or related to, Outpatient dialysis.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan Administrator is Barton County Community College. Such Company shall be responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan related services.

Plan Participant is any Employee or Dependent who meets the eligibility requirements and who is properly enrolled in the Plan.

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

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

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

Preventive Care means certain preventive care services.

Prior to Effective Date or **After Termination Date** are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Prosthetic Device means a device which replaces all or part of a missing body organ and its adjoining tissue, or replaces all or part of the function of a permanently useless or malfunctioning organ. Prosthetic Devices do not include devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, Orthotic Devices, trusses, or examinations for their prescription or fitting.

Reasonable and Appropriate means an amount of Covered Charges that is identified as eligible for payment by the Plan Administrator in accordance with the terms of the Plan. These amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to, amounts the provider most often agrees to accept as payment in full either through direct negotiation or through a preferred provider organization network, average wholesale price, and/or manufacturer's retail pricing, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, rates negotiated with the Plan, and/or Medicare reimbursement rates. Medicare rates plus 20% are generally considered to be the Reasonable and Appropriate; however, the plan Administrator may in its discretion, taking into consideration specific circumstances and negotiated terms, deem a greater amount to be payable. For purposes of defining "Reasonable and Appropriate," the term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, person or organizations rendering such treatment, services, or supplies for which a specific charge is made.
Reasonable and Appropriate claims shall be limited to those claims that, in the Plan Administrator's discretion, are services or supplies or fees for services or supplies that are necessary for the care and treatment of Illness or Injury not unreasonably caused by the treating provider. The determination whether fee(s) or services are Reasonable and Appropriate will be made by the Plan Administrator, taking into consideration such factors as, but not limited to, the findings and assessments of the following entities: (A) national medical associations, societies, and organizations; and (b) the Food and Drug Administration. To be Reasonable and Appropriate, services and/or fee(s) must be in compliance with generally accepted billing practices for the unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable and Appropriate. The Plan Administrator retains discretionary authority to determine whether services and/or fee(s) are Reasonable and Appropriate based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for services and/or fee(s) to be considered not Reasonable and Appropriate.

Reconstructive Surgery means surgery that is incidental to an Injury, Illness, or Congenital Abnormality when that primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such surgery as cosmetic when a physical impairment exists, and the surgery restores or improves function. The fact that a Covered Person may suffer psychological consequences, or socially avoidant behavior as a result of an Injury, Illness, or Congenital Abnormality does not classify surgery done to relieve such consequences or behavior as Reconstructive Surgery.

Sickness (Sick) is a person's Illness, disease or Pregnancy (including complications).

Significant Break in Coverage means a period of sixty-three (63) (or more) days without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into consideration for purposes of determining whether a Significant Break in Coverage has occurred.

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, those with mental disability, Custodial (or educational) Care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar nomenclature.

Special Enrollee means an Employee or Dependent who is entitled to and who requests Special Enrollment within thirty (30) days of losing other health coverage, or for a newly acquired Dependent, within thirty (30) days of the marriage, birth, adoption, or placement for adoption.

Specialist means a Physician who concentrates on medical activities in a particular specialty of medicine, based on education and qualifications. A Specialist is not a General Medicine Practitioner, Internal Medicine Practitioner, Pediatrician, Family Practice Physician, Obstetrician, Gynecologist, Mental Health or Substance Abuse Practitioner.

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 columns.

Substance Abuse shall mean any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in

social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

(1) a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(a) recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);

(b) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);

(c) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or

(d) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with Spouse about consequences of intoxication, physical fights);

(2) the symptoms have never met the criteria for Substance Dependence for this class of substance.

Telemedicine means the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telemedicine facilitates patient self-management and caregiver support for patients and includes synchronous interactions an asynchronous store and forward transfers.

Temporomandibular/Craniomandibular Joint Dysfunction (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/Craniomandibular Joint.

Total Disability means a physical state of a Covered Person resulting from an Illness or Injury which:

(1) In the case of a Participant, wholly prevents the Participant from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and

(2) In the case of a Dependent, wholly prevents the Dependent from performing the normal activities of a person of like age and sex in good health.

Urgent Care Facility means a facility location, distinct from a Hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat Illness of Injury for unscheduled, ambulatory patients seeking immediate medical attention.

Usual and Customary (U&C) shall mean Covered Charges which are identified by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services or supply, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a Physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Walk-in Retail Health Clinic/Convenience Care means a walk-in health clinic, other than an office, Urgent Care Facility, Pharmacy or independent clinic and not described by any other Place of Service code adopted by the Centers for Medicare and Medicaid Services that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.

Waiting Period means the period that must pass under this Plan (or for purposes of determining Creditable Coverage the Waiting Period under any other health plan) before an Employee or Dependent is eligible to enroll in the Plan.

HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for payment that person must:

(1) Make certain a current enrollment form/claim form is provided to the Claims Administrator each Plan Year.

(2) ALL QUESTIONS ON THE ENROLLMENT FORM/CLAIM FORM MUST BE ANSWERED.

(3) For Plan reimbursements, submit bills for services rendered. ALL BILLS MUST SHOW:

- **(a)** Name of Plan
- **(b)** Group number of Plan
- **(c)** Employee's name
- **(d)** Name of patient
- **(e)** Name, address, telephone number of the provider of care
- **(f)** Diagnosis
- **(g)** Type of service rendered, with diagnosis and/or procedure codes
- **(h)** Date of service
- **(i)** Charges

(4) Send the above to the Claims Administrator at this address:

FREEDOM CLAIMS MANAGEMENT, INC.
P.O. BOX 1365
GREAT BEND, KS 67530
(866) 792-9151 or (620) 792-9151

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator at the time services are Incurred. Benefits are based on the Plan's provisions and the Stop Loss Contract at the time the charges were Incurred. Charges are considered Incurred when a treatment or care is given or a procedure performed. Claims filed later than that date may be declined or reduced **unless**:

(1) It is not reasonably possible to submit the claim in that time; and
(2) Upon termination of self-funded plan.

The Claims Administrator will determine if enough information has been submitted to determine the type of claim and enable proper consideration of the claim. If not, more information may be requested. If the Plan fails to pay any covered medical expense, the Plan Participant is responsible for payment.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims – Urgent Care Claim, Pre-Service Claim, and Post-Service Claim - and each one has a specific timetable for either approval, payment, request for further information, or denial of the claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of claims and the timetables are:

URGENT CARE CLAIM:
A claim involving Urgent Care is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

A Physician with knowledge of the claimant's medical condition may determine if a claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours

Insufficient information on the claim, or failure to follow the Plan's procedure for filing a claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an Adverse Benefit Determination on a claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

PRE-SERVICE CLAIM:
A Pre-Service Claim means any claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, claims subject to pre-certification. Please see the "Cost Management" section for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a claim	5 days
Ongoing courses of treatment:	
reduction or termination before the end of the treatment	15 days
request to extend course of treatment	15 days
Review of Adverse Benefit Determination	30 days

POST-SERVICE CLAIM:
A Post-Service Claim means any claim for a Plan benefit that is not a claim involving Urgent Care and/or a Pre-Service Claim. In other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
notification of	15 days
response by claimant	45 days
Review of Adverse Benefit Determination	60 days

NOTICE TO CLAIMANT OF ADVERSE BENEFIT DETERMINATIONS

Except with Urgent Care Claims, when the notification may be orally followed by written or electronic notification within three (3) days of the oral notification, the Plan Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the claimant:

- The specific reason or reasons for the Adverse Benefit Determination.
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on the Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

APPEALS

When a claimant receives an Adverse Benefit Determination, the claimant has one-hundred-eighty (180) days following issuance of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which an Adverse Benefit Determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the Adverse Benefit Determination.
- was submitted, considered, or generated in the course of making the Adverse Benefit Determination, without regard to whether it was relied upon in making the Adverse Benefit Determination.
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants. or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall consider all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the Adverse Determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

ASSIGNMENTS

Benefits for medical expenses covered under this Plan may be assigned by a Plan Participant to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Plan Participant shall at any time, either during the time in which he or she is a participant in the Plan, or following his or her termination as a Plan Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

NON U.S. PROVIDERS

Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

(1) Benefits may not be assigned to a non-U.S. Provider;
(2) The Plan Participant is responsible for making all payments to non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
(3) Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred date;
(4) The non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
(5) Claims for benefits must be submitted to the Plan in English.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or Dependent on whose behalf such payment was made.

A Plan Participant, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

(1) In error;
(2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
(3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
(4) With respect to an ineligible person;
(5) In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or

(6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his or her covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.
If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

MEDICAID COVERAGE
A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Excess Insurance. If at the time of Injury, Sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

(1) Any primary payer besides the Plan;
(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
(3) Any policy of insurance from any insurance company or guarantor of a third party;
(4) Worker's compensation or other liability insurance company; or
(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Allowable Expenses. Allowable Expenses shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Plan Participant does not use an HMO Provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Plan Participant used the services of an HMO Provider.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

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. If two (2) plans cover the Employee as primary, the benefits of the benefit plan which has covered the Employee for the longer time are determined before those of the benefit plan that became effective at a later date.

(2) Plans with a coordination provision will pay their benefits by these rules up to the allowable charge.

(a) The benefits of the plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent; except that: if the person is also a Medicare beneficiary, and

as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

(i) Secondary to the plan covering the person as a Dependent, and

(ii) Primary to the plan covering the person as other than a Dependent (e.g. a Retired Employee),

then the benefits of the plan covering the person as a Dependent are determined before those of the plan covering that person as other than a Dependent.

(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 not separated or divorced, 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 patient 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 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.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

(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 benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

Claims Determination Period. Benefits will be coordinated on a Plan 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. Whenever payments have been made by this Plan with respect to Covered Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Covered Expenses, and any future benefits payable to the Plan Participant or his or her Dependents.

RIGHT OF SUBROGATION AND REFUND

Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

(2) Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

(3) In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

(4) If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

(2) If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

(3) The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) If the Plan Participant(s) fails to file a claim or pursue damages against:

(a) The responsible party, its insurer, or any other source on behalf of that party;
(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
(c) Any policy of insurance from any insurance company or guarantor of a third party;
(d) Worker's compensation or other liability insurance company; or
(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

(1) The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

(2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

(3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

(1) If at the time of Injury, Sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

(a) The responsible party, its insurer, or any other source on behalf of that party;

(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
(c) Any policy of insurance from any insurance company or guarantor of a third party;
(d) Worker's compensation or other liability insurance company; or
(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

(1) Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

(1) In the event that the Plan Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

Obligations

(1) It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
(b) To provide the Plan with pertinent information regarding the Sickness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
(c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
(d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
(f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

(2) If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

(3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

(1) Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

Minor Status

(1) In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

(1) The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

(1) In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

COBRA CONTINUATION OPTIONS

Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by the continuing person. Coverage will end if the covered individual fails to make timely payment of contributions or premiums (within a maximum of forty-five (45) days during initial premium/contribution and thirty (30) days thereafter). This law is referred to as "COBRA", which stands for The Consolidated Omnibus Budget Reconciliation Act of 1985. Generally, COBRA applies to Employers with twenty (20) or more full and/or part-time Employees. Employees should check with their Employers to see if COBRA applies to them.

For the purpose of this COBRA Continuation Options provision, the following definitions apply:

(1) "COBRA" means The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) "Code" means the Internal Revenue Code of 1986, as amended.

(3) "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.

(4) "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.

(5) "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.

(6) "Qualified Beneficiary" means:

(a) A Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the Plan; and

(b) A covered Spouse or Dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below; and

(7) "Qualifying Event" means the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

(a) Termination of a Covered Employee's employment (other than for gross misconduct) or reduction in hours of employment;

(b) The death of a Covered Employee;

(c) The divorce or legal separation of the Covered Employee from his Spouse;

(d) The Covered Employee becoming entitled to Medicare coverage; or

(e) A Child ceasing to be eligible as a Dependent Child under the terms of the Group Health Plan.

(8) "Totally Disabled" or "Total Disability" means Totally Disabled as determined under Title II or Title XVI of the Social Security Act.

RIGHT TO ELECT CONTINUATION COVERAGE
If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution. A Qualified Beneficiary must elect the coverage within the sixty (60) day period on the later of:

(1) the date of the Qualifying Event; or

(2) the date he was notified of his right to continue coverage.

NOTIFICATION OF QUALIFYING EVENT
If the Qualifying Event is divorce, legal separation or a Dependent Child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company of the Qualifying Event within sixty (60) days of the event in order for coverage to continue. In addition a Totally Disabled Qualified Beneficiary must notify the company in accordance with the Section below entitled "Total Disability" in order for coverage to continue. Failure to provide such notice(s) will result in a loss of COBRA entitlement hereunder.

LENGTH OF CONTINUATION COVERAGE
(1) A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Group Health Plan for up to eighteen (18) months from the date of the Qualifying Event.

(2) A Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, legal separation or entitlement to Medicare, and Dependent Children who have become ineligible for coverage may continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the Qualifying Event.

TOTAL DISABILITY
(1) In case a Qualified Beneficiary who is determined under Title II or XVI of Social Security Act (hereinafter the "Act") to have been Totally Disabled prior to or within sixty (60) days of the COBRA effective date, that Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the Employer.

(a) Prior to the end of eighteen (18) months of Continuation Coverage that he or she was disabled as of the date of the Qualifying Event; and
(b) Within sixty (60) days of the determination of Total Disability under the Act.

(2) The Employer will charge the Qualified Beneficiary an increased premium for Continuation Coverage extended beyond eighteen (18) months pursuant to this Section.

(3) If during the period of extended coverage for Total Disability (Continuation Coverage months 19-29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

(a) The Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days; and
(b) Continuation Coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

TERMINATION OF CONTINUATION COVERAGE
Continuation Coverage will automatically end earlier than the applicable eighteen (18), twenty-nine (29), or thirty-six (36) month period for a Qualified Beneficiary if:

(1) The required monthly contribution for coverage is not received by the Company within thirty (30) days following the date it is due;

(2) The Qualified Beneficiary is or becomes covered under any other Group Health Plan as an Employee or otherwise. If the other Group Health Plan contains an exclusion or limitation relating to a Pre-Existing Condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the Pre-Existing Condition applies to the Qualified Beneficiary (or, if sooner, until the expiration of the applicable eighteen (18), twenty-nine (29), or thirty-six (36) month COBRA period).

(3) For Totally Disabled Qualified Beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following (30) days from the date of a final determination by the Social Security Administration that such Beneficiary is no longer Totally Disabled; or

(4) The Company ceases to offer any Group Health Plans.

MULTIPLE QUALIFYING EVENTS

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) or twenty-nine (29) months, and a second Qualifying Event occurs during the eighteen (18) or twenty-nine (29) month period, the Qualified Beneficiary may elect, in accordance with the Section entitled "Right to Elect Continuation Coverage," to continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the first Qualifying Event. In addition, if a Qualified Beneficiary who was a Covered Employee becomes entitled to benefits under Medicare (whether or not this is a Qualifying Event), a Qualified Beneficiary (other than the Covered Employee) may elect to continue coverage for a maximum of thirty-six (36) months from the date of the initial Qualifying Event, to the extent another period of Continuation Coverage is not required by law under COBRA.

CONTINUATION COVERAGE

The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Group Health Plan offered to similarly situated Covered Employees and their Dependents. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add Dependents for continuation Coverage, such Dependents must meet the definition of Dependent under the Group Health Plan.

CARRYOVER OF DEDUCTIBLES AND PLAN MAXIMUMS

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable Deductible and Co-Insurance features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

PAYMENT OF PREMIUM

(1) The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

(a) The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.

(b) For Qualified Beneficiaries whose coverage is continued pursuant to the Section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay

a contribution for coverage that does not exceed one-hundred-fifty percent (150%) of the applicable premium for continuation coverage months nineteen (19) through twenty-nine (29).

(2) Contributions for coverage may, at the election of the Qualified Beneficiary, be paid in monthly installments:

(a) If continuation Coverage is elected, the monthly contribution for coverage for those months, up to and including the month in which the election is made, must be made within forty-five (45) days of the date of election.

(3) Without further notice from the Employer, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the company within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the Section entitled "Termination of Continuation Coverage," Subsection 1. This thirty (30) day grace period does not apply to the first contribution required under 2. above. 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 thirty (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 fifty dollars ($50) or ten percent(10%) of the required amount.

(4) No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

If needed, further information on COBRA can be obtained through the Plan Administrator free of charge.

For further information contact:
Freedom Claims Management, Inc.
P. O. Box 1365
Great Bend, KS 67530
620-792-9151

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Plan is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Barton County Community College, and any controlled group of the corporation, 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, a new Plan Administrator shall be appointed 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 Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

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

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.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying reasonable expenses of administering the Plan. Theses are duties which must be carried out:

(1) With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
(2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
(3) In accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary establishing the procedures to appoint the fiduciary or continuing either the appointment of the procedures; or

(2) The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and at the request of the Employer, funding from the Employee. The Plan Administrator may at some time require a contribution from Participants in order to maintain Employee participation and the participation of any Dependents in the Plan. Eligible Participants will be advised of any required contributions at the time they apply for enrollment in the Plan. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required contribution amount. Participants in a Plan that do not require Participant contribution at the time they enrolled, will be notified by the Plan Administrator prior to the date a contribution requirement is made effective.

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

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 intends to maintain this Plan indefinitely; however, it 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).

CONFORMITY WITH LAW

If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

CERTAIN EMPLOYEE RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

(1) Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(3) Continue health care coverage for a Plan Participant, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or Dependents may have to pay for such coverage. Review of the summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan, and does not receive them within thirty (30) days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to one-hundred-ten dollars ($110) a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a Claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these court costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, that Plan Participant should contact the nearest area office of the U.S. Pension and Welfare Benefits Administration, Department of Labor.

FREEDOM CLAIMS MANAGEMENT, INC.
PO BOX 1365
GREAT BEND, KS 67530
620-792-9151 OR 866-792-9151
WWW.FREEDOMCLAIMSINC.COM