DOUGLAS COUNTY
EMPLOYEE BENEFIT TRUST

Restated Effective June 1, 2021

TO OUR ELIGIBLE EMPLOYEES:

Welcome. By electing to participate in this Plan, you have put quality, dependability and experience on your side. Benefits are big news these days, especially health care benefits. As health care costs continue to rise, your health care coverage becomes even more critical. This Plan has been designed to provide you and your family with both comprehensive and affordable coverage.

Please read the following pages carefully. Familiarize yourself with the Benefits available, and then use the Plan to meet your needs; but use it wisely.

YOUR MEDICAL BENEFITS...WHAT YOU SHOULD KNOW

You have enrolled under the Douglas County Employee Benefit Trust. The Plan has contracted with a managed care network or networks of medical providers whose members have agreed to charge the Plan reduced or discounted charges for covered services provided to Covered Persons. Although you have the freedom to choose to receive care from any Physician, Hospital, or other medical care provider, as a general rule ***the amount or percentage of an otherwise Covered Expense payable by the Plan will vary, depending on whether the provider from whom you receive your care is a member of the provider network(s)***. Generally, the Plan will pay a higher percentage of a Covered Expense if the care is received by a network provider. Thus, in order to receive the highest Benefit level, medical services and supplies should be received from a network provider.

Please refer to the Cigna website, www.mycigna.com or call 800-990-9058 to verify Cigna provider information.

Claim Supervisor:

Trustmark Health Benefits, Inc.
6240 Sprint Parkway, Suite 400
Overland Park, KS 66251
913-685-4740
800-990-9058

ONLINE PAYMENT MANAGER

Claim Supervisor offers the Trustmark Health Benefits, Inc. Online Payment Manager service that enables eligible Covered Persons to pay their out-of-pocket obligations directly to providers.

MESSAGING SERVICES

Salesforce.com, Inc. or any other third party to provide telephonic messaging, including text messaging, to ***covered persons*** who opt into the service. Such messaging shall include, but not be limited to, information about services and benefits available under the ***Plan***, reminders on preventive care, surveys, and educational information.

Note: The Salesforce.com, Inc. program applies to *covered expenses* under the *Medical Expense Benefit* section only
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TABLE OF CONTENTS

ARTICLE I
INTRODUCTION

This is the Plan Document. It also represents what is referred to as a Summary Plan Description. It describes the Benefits to which you and your covered Dependents are entitled, to whom Benefits are payable and other provisions, which govern or control the way in which Benefits are provided.

PLAN SPONSOR. The Plan Sponsor is ***Douglas County***. The Plan Sponsor has the authority to control and manage the operation and administration of the Plan; to establish Plan Benefits and provisions; to amend the Plan; to determine its policies; to appoint and remove the Claim Supervisor, and to exercise general administrative authority over the Supervisor.

CLAIM SUPERVISOR. The Claim Supervisor of the Plan is ***Trustmark Health Benefits, Inc***.

CONTRIBUTIONS TO THE PLAN. The Employer makes contributions to the Plan so that the Plan may make Benefit payments to you and your Dependents. You may also be required to make contributions to the Plan for your coverage or for coverage of your Dependents, or for both you and your Dependents' coverage. For more information concerning the funding of this Plan, see the section titled, *General Information--Funding Method*.

CLAIM PROCEDURES. Claim payments are made based on data furnished by you or your health care provider. In order to collect Benefits under the Plan, you or the provider must first provide information as to the validity of the claim for Benefits. For ease of administration, you may have to file a "claim form" for you and your Dependents. This form contains essential information necessary for the Claim Supervisor to determine the validity of a claim for Benefits. Occasionally, further information may be necessary and you should provide this information to the Claim Supervisor as requested.

CLAIM DETERMINATION. A determination regarding payment of eligible Benefits will normally be made within 30 days from the Claim Supervisor's receipt of all necessary information regarding the claim for Benefits. All interpretations of the Plan's terms regarding Benefits will be made by the Plan Sponsor.

CLAIM FILING DEADLINE. A claim will not be considered unless it is filed within ninety (90) days after the close of the Plan Year in which the expense is incurred. Terminated Employees (and their Dependents) must file all incurred but unfiled claims within ninety (90) days after the close of the Plan Year after the termination of their coverage. In the event of the Plan's termination, you must file all incurred but unfiled claims within ninety (90) days after the close of the Plan Year after the Plan's termination.

See the section of this booklet titled, *Claim Appeal Procedures*, for more information about your rights with respect to claims and appeals of determinations that are made with respect to claims.

ARTICLE II
ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for you and your Dependents will be in accordance with the eligibility, Effective Date and termination provisions that follow below.

EMPLOYEE ELIGIBILITY. In order to be eligible for coverage under this Plan you must be both an Employee and an *eligible* Employee. Generally, an *Employee* is a person employed by the Employer in a classification of employment that qualifies him for participation in the Plan. See the definition of "*Employee*" in the section of this booklet titled, *Definitions*. Generally, an *eligible* Employee is an Employee who has met any service requirements that the Employee must meet in order to become eligible. Those service requirements, if they apply, are described in the following paragraph.

An Employee is considered an eligible Employee if he has a full time equivalency of working 20 hours or more per week (as defined by the Douglas County Personnel Policy) who is directly employed in the regular business of and compensated for services by the Employer; or is a retired elected official who has served a minimum of five (5) consecutive years and meets the age requirements as defined in the retirement plan in which they are participating; or a Retired Employee who has served a minimum of five (5) years who meets the age requirements as defined in the retirement plan in which the retiree is participating.

All full-time Employees regularly scheduled to work at least twenty (20) hours per week shall be eligible to enroll for coverage under the Plan. This does not include temporary or seasonal Employees.

If applicable under the Affordable Care Act, an Employee of the Employer who is not currently working the minimum number of hours, but was working on average the minimum number of hours during the Employer's Measurement Period and is eligible during the Employer's Stability Period, as documented by the Employer and consistent with the Affordable Care Act, applicable regulations and regulatory guidance, is eligible to enroll under the Plan, provided the Employee is a member of a class eligible for coverage and has satisfied any waiting period that may be required by the Employer.

DEPENDENT ELIGIBILITY. Your Dependents are eligible for coverage under the Plan on the date you become eligible for Employee coverage, or the date on which the Dependents become your Dependents, whichever occurs last. *However, under no circumstances may you enroll your Dependents if you are not also enrolled under the Plan*. If both you and your spouse are Employees, and both are eligible for Dependent coverage, either you or your spouse, but not both, may elect Dependent coverage for your other eligible Dependents (e.g., Dependent Children). No person may be covered under this Plan as both an Employee and as a Dependent. Dependent eligibility is also subject to the following rules:

Newborns. Your newborn Children will be eligible for enrollment as of the moment of birth if you are an eligible Employee at that time (see the section of this booklet titled, *Dependent Effective Date*). Generally, coverage of newborn Children includes coverage for care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity; and for any routine nursery care provided under this Plan. See the description of Covered Expenses in the section of this booklet titled, *Covered Expenses*.

New Spouse. Your spouse will be considered an eligible Dependent as of the date of marriage, if you are an eligible Employee at that time.

Other New Dependents. If you acquire a Dependent (other than your spouse) due to marriage, legal adoption or legal guardianship, that Dependent shall be considered an eligible Dependent as of the date of such occurrence, if you are an eligible Employee at that time. Legal documentation verifying adoption or guardianship is required. A Child will be considered adopted on the date the Child's adoption becomes final or on the date the Child is placed for adoption (a Child is considered placed for adoption when you assume and retain a legal obligation for total or partial support of the Child in anticipation of adoption; the Child's placement terminates upon termination of such legal obligation).

Continuing Coverage for Disabled Dependent Children. An unmarried Child who is a Dependent and who reaches the Plan's limiting age for Dependent Children while covered under this Plan will remain eligible for coverage to the extent he is at that time incapable of self-sustaining employment and is dependent upon you for support due to a mental or physical illness or disability. He will remain eligible for coverage under this provision to the extent you remain eligible for Dependent coverage and he remains incapable of self-sustaining employment and dependent upon you for support due to the disability. Notification of incapacitation must be provided within thirty (30) days

after the Child attains age 26. Proof of incapacitation may be required to determine whether or not the Child qualifies as disabled and may be required on an annual basis.

Qualified Medical Child Support Orders. The Plan will honor the terms of a Qualified Medical Child Support Order. A Qualified Medical Child Support Order is an order that is typically issued in or after divorce proceedings, and may create or recognize the right of your Child to be covered under this Plan. Such an order must be qualified and issued by a court of competent jurisdiction or authorized state agency in order for this Plan to be bound by it. Please contact your human resources or personnel (or similar) department for more information regarding whether or not a medical child support order is "qualified". That department will "process" the order as follows:

- Your Employer, promptly after receiving a medical child support order, will notify you of each Child designated in the order. The notification will contain information that permits the Child to designate a representative for receipt of copies of notices that are sent to the Child with respect to a medical child support order.
- Within forty (40) business days after receipt of the order (or, in the case of a national medical support notice, the date of the notice) the Employer will determine whether the order is a "qualified" medical child support order. Upon determination of whether a medical child support order is or is not qualified, the Employer will send a written copy of the determination to you and each Child (or, where an official of the state agency issuing the order is substituted for the name of the Child, notify such official).
- If the Employer determines that the medical child support order is qualified, you, the Child or his representative must furnish to the Employer any required enrollment information. In the case of a national medical support notice, the Employer will (i) notify the state agency issuing the notice whether coverage is available to the Child under the Plan and, if so, whether such Child is covered under the Plan and either the Effective Date of such coverage or any steps to be taken by the Child's custodial parent or an official of the state agency that issued the notice to effectuate such coverage, and (ii) provide the custodial parent (or, where an official of the state agency issuing the order is substituted for the name of the Child, notify such official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.
- Typically you must provide such information to the Plan within forty-five (45) days immediately following the date the determination was made that the order was a Qualified Medical Child Support Order. In the case of a national medical support notice, if there are multiple coverage options available to the Child under the Plan the state agency issuing the notice will select an option, but if it fails to do so within twenty (20) days after the Employer's notice described in the preceding paragraph, the Child will be enrolled under the Plan's default option (if any).
- Unless the Qualified Medical Child Support Order provides otherwise, you will be responsible to make any required contribution to pay for such coverage.
- In no event will coverage provided under a Qualified Medical Child Support Order become effective for a Child prior to the date the Order is received by the Plan.
- If the Employer determines that the medical child support order is not "qualified", a written determination to that effect will be furnished to you and the Child or the Child's representative. You or the Child (or the Child's representative) may appeal the determination to the Employer. Any request for review of a determination must be filed with the Employer within sixty (60) days after the Employer issues its original determination.

ARTICLE III
EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE. Your coverage is effective as follows:

Enrollment when first eligible. If you complete and file with us the required enrollment forms no later than 31 days after the date you first become eligible, coverage will be effective at 12:01 a.m. on the first day of the month coincident with or first following the date you become eligible. If your coverage Effective Date is later than the date you became eligible, you must still be eligible on your coverage Effective Date in order for coverage to begin.

Late Enrollment. If you decline to enroll within the first 31 days after you initially become eligible, you may enroll thereafter only by completing and filing with us the required enrollment forms either (1) within 31 days after experiencing a special enrollment event (60 days for special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009), described below in the section titled, *Special Enrollment Events*, or (2) during the Plan's annual enrollment period. The Plan's annual enrollment period is from May 1 to May 31 each year.

If you enroll within 31 days after a **special enrollment event** (60 days for special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009), the date your coverage is effective depends on the type of special enrollment event. If the event is your acquisition of a Dependent Child by virtue of birth, adoption, placement for adoption or legal guardianship, your coverage is effective as of the date of that event. If the event is loss of other coverage or your acquisition of a Dependent by virtue of marriage, your coverage is effective not later than the first day of the month following the month in which you file the required enrollment forms with us. In either case you must be eligible for coverage on the date your coverage would become effective.

If you enroll during the annual enrollment period, your coverage will be effective on the first day of the first month beginning after the end of the enrollment period (provided you are then still eligible).

DEPENDENT EFFECTIVE DATE.
Enrollment when first eligible (including newborns). If you are already enrolled for Dependent coverage at the time you acquire a Dependent, coverage of the Dependent is effective on the date the Dependent became an eligible Dependent. In other cases, you must complete and file with us the required enrollment forms no later than 31 days after the date your Dependent first becomes eligible, in which case coverage of the Dependent will be effective at 12:01 a.m. on the date the Dependent became eligible (where the eligible Dependent is a newborn Child, coverage will be effective as of the date of birth, if this date is different than the date described above), provided your coverage is then in effect.

Late Enrollment. If you are not already enrolled for Dependent coverage at the time you acquire a new Dependent, and you decline to enroll the Dependent within the first 31 days after the Dependent initially becomes eligible, you may enroll the Dependent thereafter by completing and filing with us the required enrollment forms within 31 days after *the Dependent* experiences a special enrollment event which is a loss of other coverage, or within 31 days after *you* experience a special enrollment event which is the acquisition of a Dependent Child by virtue of birth, adoption, placement for adoption or legal guardianship, marriage, or within 60 days for special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009. Special enrollment events are described below, in the section titled, *Special Enrollment Events*.

You may also enroll the Dependent during the Plan's annual enrollment period. The Plan's annual enrollment period is from May 1 to May 31 each year.

If you enroll the Dependent due to a **special enrollment event**, the Effective Date of the Dependent's coverage depends on the type of special enrollment event. If the event is your acquisition of a Dependent Child by virtue of birth, adoption, placement for adoption or legal guardianship, marriage, coverage of the Dependent will be effective as of the date of that event. If the event is the loss of other coverage, the Dependent's coverage is effective not later than the first day of the month following the month in which you file the required enrollment forms with us. In either case, however, the Dependent's coverage will not be effective unless you are covered on the date the Dependent's coverage would become effective.

In all cases, we require proof of dependency (and, in the case of, an adopted Child, a Child placed with you for adoption or legal guardianship, proof of the adoption, placement for adoption or legal guardianship) as a condition to enrolling an eligible Dependent.

ENROLLMENT CHANGES UNDER FLEXIBLE BENEFITS PLAN. In addition to the changes in enrollment elections described above, you may also be eligible to change your enrollment election (to add, drop or change coverage for yourself, your Dependents, or both you and your Dependents) by changing your health coverage election under the Employer's flexible benefits plan, in accordance with the procedures described in that Plan.

SPECIAL ENROLLMENT EVENTS. For purposes of the enrollment rules described above, "special enrollment events" are:

Loss of Other Coverage. You or an eligible Dependent will be considered to have experienced this special enrollment event if:

- you or the eligible Dependent declined a previous opportunity to enroll or be enrolled under the Plan;
- at the time you or the eligible Dependent were previously offered the opportunity to enroll or to be enrolled you declined to enroll yourself (or, in case of an eligible Dependent, to enroll the eligible Dependent) because you had (or, in the case of an eligible Dependent, the eligible Dependent had) other health coverage; *and*
- that other coverage was either (1) COBRA Continuation Coverage which is now exhausted (other than for failure to pay premiums or for fraudulent behavior); (2) non-COBRA Continuation Coverage under a group health plan or other health insurance which has been terminated due to loss of eligibility (other than for failure to pay premiums or for fraudulent behavior) or termination of employer contributions toward such other coverage (for this purpose, a "loss of eligibility" includes (but is not limited to) a loss of eligibility for coverage as a result of (i) legal separation, (ii) divorce, (iii) cessation of Dependent status, (iv) death of an Employee, (v) termination of employment, (vi) reduction in hours, (vii) no longer residing or working in a required service area, or (viii) a situation where a plan no longer provides any Benefits to a class of similarly-situated individuals as yourself); (3) State Children's Health Insurance Program coverage; or (4) Medicaid coverage. Note: for both State Children's Health Insurance Program and Medicaid, Children or their parents have 60 days in which to request special enrollment under this Plan.

Loss of eligibility includes but is not limited to:

- loss of eligibility for coverage as a result of ceasing to meet the Plan's eligibility requirements (i.e., legal separation, divorce, cessation of Dependent status, death of an Employee, termination of employment, reduction in the number of hours of employment);
- loss of HMO coverage because the Covered Person no longer resides or works in the HMO service area and no other coverage option is available through the HMO Plan Sponsor; and
- elimination of the coverage option a Covered Person was enrolled in, and another option is not offered in its place.

For purposes of determining whether you had "non-COBRA Continuation Coverage" as described above, the term "group health plan" means a plan maintained or contributed to by an Employer or Employee organization (e.g., a union) to provide health care for employees and their families. The term "other health insurance" means benefits consisting of medical care under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or HMO contract, offered by an insurance company, service, or organization required to be licensed to engage in the business of insurance in a state and that is subject to state insurance law.

Acquisition of a Dependent by Virtue of Marriage, Birth, Adoption, Placement for Adoption or Legal Guardianship. This special enrollment event occurs where you acquire a Dependent spouse or Child by virtue of marriage, or you acquire a Dependent Child by virtue of birth, adoption, placement for adoption or legal guardianship.

Special Enrollment Period (Children's Health Insurance Program (CHIP) Reauthorization Act of 2009)

The ***Plan*** intends to comply with the Children's Health Insurance Program Reauthorization Act of 2009.

An ***employee*** who is currently covered or not covered under the ***Plan*** may request a special enrollment period for himself, if applicable, and his ***dependent***. Special enrollment periods will be granted if:

1. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance program or Medicaid; or,

2. the individual is eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage or from the date the individual becomes eligible for any applicable premium assistance.

Premium Assistance. This special enrollment event occurs where an eligible Child (and, under certain circumstances, the Child's parent-Employee) becomes eligible for premium assistance through State Children's Health Insurance Program or Medicaid. Children or their parents have 60 days in which to request special enrollment under this Plan.

DEFERRED EFFECTIVE DATE PROVISIONS. If you are not Actively at Work on the date your coverage would otherwise become effective, for reasons other than a health status-related reason, coverage will not become effective until you return to Active Work, provided you still meet the eligibility requirements at the time you return to Active Work. Notwithstanding the foregoing, if you have been hired but have never reported for work and are not Actively at Work due to a health status-related reason *or any other reason*, your coverage will not become effective prior to the date you report for work, and you will not be treated as having commenced your employment prior to the date you actually report for work.

CHANGES IN COVERAGE. Should you change classifications which results in a coverage change, or should Benefits under this Plan be increased by a Plan change, the Effective Date of such change shall coincide with the date of the Benefit or classification change; however, if you are not Actively at Work, for reasons other than a health status-related reason, on the date the amount of your coverage would otherwise increase, such increase shall not become effective until the next following day on which you are Actively at Work.

Should Benefits under this Plan be decreased or deleted, the Effective Date of change will be the Effective Date of the decrease or deletion.

ARTICLE IV
TERMINATION OF COVERAGE

TERMINATION OF COVERED EMPLOYEE'S COVERAGE. Except as provided in the Plan's coverage continuation provision, and any extension of Benefits provision in this Plan, your coverage as an Employee will terminate on the earliest of the following dates:

- If you fail to remit required contributions for your coverage when due, the last day of the month ending the period for which the last timely contribution was made.
- The last day of the month in which you are no longer an Employee.
- The last day of the month in which your employment in an eligible class ceases; employment is considered to cease on the last day worked within the eligible class.
- The last day of the month in which you enter the military, naval or air force of any country or international organization on a full-time basis (after 90 days of military leave) other than scheduled drills or other training not exceeding one month in any calendar year, subject to the requirements of the Uniformed Services Employment and Reemployment Rights Act or similar applicable federal laws.
- The date the Plan is terminated.
- The last day of the month in which you request your coverage to be terminated (subject, however, to any limitations, under an affiliated cafeteria plan under Section 125 of the Internal Revenue Code, on your right to change coverage elections prior to the end of the Plan Year).
- The date the Plan Sponsor determines, in its sole discretion, that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.

TERMINATION OF COVERED DEPENDENT'S COVERAGE. Except as provided in the Plan's coverage continuation provision, and any extension of Benefits provision in this Plan, your coverage as a covered Dependent will terminate on the earliest of the following dates:

- The date your sponsor's (the eligible Employee's) coverage terminates.
- If required contributions for your coverage are not remitted when due, the last day of the month ending the period for which the last timely contribution was made.
- The last day of the month in which you cease to meet the definition of a *Dependent Child.*
- The last day of the month in which in which you cease to meet the definition of *Spouse.*
- The last day of the month in which you enter the military, naval or air force of any country or international organization on a full-time basis (after 90 days of military leave) other than scheduled drills or other training not exceeding one month in any Calendar Year.
- The last day of the month in which you become covered as an Employee.
- The date Dependent coverage is discontinued under the Plan.
- The date the Plan is terminated.
- The date the Plan Sponsor determines, in its sole discretion that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.
- The date the Employee disenrolls a Child and enrolls that Child in State Children's Health Insurance Program.

ARTICLE V
DEFINITIONS

Accident/Accidental. A bodily Injury sustained independently of all other causes that is sudden, direct and unforeseen and is exact as to time and place. It does not include harm resulting from disease.

Active Work/Actively at Work. You must work for your Employer at your usual place of work or such other place or places as required by your Employer in the course of such work for the full number of hours and full rate of pay, as set by the employment practices of your Employer. An Employee shall be considered to be Actively at Work during periods the Employee is on vacation or otherwise absent from work with permission of the Employer and the Employee returns to work at the usual place of work required by the Employer as specified by the Employer following the end of such permitted absence.

Affordable Care Act. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 and all applicable regulations and regulatory guidance.

Ambulatory Surgical Center. A licensed institution or facility, either free standing or as a part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, is not an Ambulatory Surgical Center.

Amendment. A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Sponsor.

Attending Physician. The Physician who is in charge of, and who holds responsibility for, your medical care.

Benefit. The portion of Covered Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine your out-of-pocket expenses, if any, in excess of the deductible amount payable by you per Benefit Period, which are to be paid by you.

Benefit Period. The time period from June 1 through May 31. The Benefit Period terminates on the earliest of the following dates:

- the last day of the period so established; or
- the day you cease to be covered under the Plan.

Birthing Center. A facility, staffed by Physicians, which is licensed as a birthing center in the jurisdictions where it is located.

Child/Children. An Employee's:

- ***natural child, step-child***, or a ***child under the Employee's legal guardianship***;
- child who is ***adopted*** by or ***placed for adoption*** with the Employee, provided the adoption or placement occurs before the child reaches age 18; a child is considered placed for adoption with the Employee when the Employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption; the placement terminates upon the termination of such legal obligation;
- child to the extent required by a Qualified Medical Child Support Order; and
- child of grandfathered domestic partners (prior to 06/01/17) as long as the Employee has submitted the required documentation.

Note: See the section titled, *Eligibility for Coverage*, for Dependent eligibility requirements.

Chiropractic Care. Services as provided by a licensed Chiropractor, M.D., or D.O., for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claim Supervisor. The person or firm employed by the Plan Sponsor to provide services to the Plan Sponsor in connection with the operation of the Plan and any other functions properly delegated to it, including the processing and payment of claims. ***Trustmark Health Benefits, Inc.*** is the Claim Supervisor.

COBRA Continuation Coverage. The coverage provided under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

COBRA Qualified Beneficiary. Any formerly covered Employee or covered Dependent who has rights and is continuing participation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

Co-insurance. The ***Plan*** pays for ***covered expenses*** at a specified percentage of the Maximum Allowable Amount for N***onpreferred Pproviders***, or a specified percentage of the Negotiated Rate for ***Preferred providers***. That percentage is specified on the *Schedule of Benefits*.. For non-preferred providers, the Covered Person is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the billed amount. The Covered Person's portion of the Co-insurance represents the out-of-pocket expense limit.

Co-pay or Co-payment. A form of cost sharing whereby you pay a fixed dollar amount for certain covered services or supplies or treatment as shown on the *Schedule of Benefits.* The Plan pays the remaining Covered Expenses at the Negotiated Rate for Preferred Providers or the Maximum Allowable Amount for non-preferred providers. The Copay must be paid each time a treatment or service is rendered.

Cosmetic Dentistry. Care and treatment performed primarily to improve one's dental appearance.

Cosmetic Surgery. A procedure performed solely for the improvement of your appearance rather than for the improvement or restoration of bodily function.

Covered Expense. The portion of a medical expense incurred by or on behalf of a covered Employee or covered Dependent which is eligible for reimbursement under this Plan, but only to the extent the amount of the expense is the Usual, Customary and Reasonable (UCR) Amounts for the service or supply, as determined by the Plan, and provided further that the expense is for a medical service or supply which is:

- ordered by a Physician; and
- Medically Necessary for the treatment of the Sickness or Injury (except where the expense is for preventive care covered under the Plan); and
- not of a luxury or personal nature; and
- not excluded under the *General Exclusions and Limitations* section of this Plan.

An expense for a medical service or supply rendered or provided to a Covered Person shall be considered to have been incurred at the time or on the date the service or supply is actually provided.

Covered Person. A covered Employee or covered Dependent, or a participating COBRA Beneficiary who meets the eligibility requirements for coverage as specified in this Plan and is properly enrolled under the Plan.

Custodial Care. The type of care (which may or may not be recommended, prescribed or provided by a Physician) which is designed primarily to assist a covered individual, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, and preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Dentist. A licensed doctor of dental medicine (D.M.D.) or a doctor of dental surgery (D.D.S.) who is operating within the scope of his license, in the state in which he is licensed. The term "Dentist" also includes a duly qualified dental hygienist acting under the direction of a Dentist. The Dentist may not be a member of the Covered Person's Immediate Family.

Dependent. With respect to an Employee, is:

- the Employee's spouse, under a legally valid existing marriage, as defined by the state in which the Employee was legally married. A spouse ceases to be a spouse for purposes of this Plan on the date a decree of divorce or legal separation is entered by the court, or on the date of the spouse's death; or
- **Effective 06/01/17 and going forward, there is no coverage for domestic partners, same sex or opposite sex, except for existing grandfathered members.** The Employee's ***domestic partner*** (including a same sex domestic partner), Employee's Partner qualifies as a "dependent" pursuant to Internal Revenue Code §152(d)(2)(H) because (i) Employee provides over half of Employee's Partner's support and Employee's Partner is not a dependent of any other taxpayer; (ii) Employee's Partner resides in Employee's household; (iii) Employee's Partner does not earn more than the exemption amount annually ($3,950 for 2014); Employee is not a "dependent" of any other taxpayer, (iv) with limited exceptions, Employee's

Partner does not file a joint income tax return for the calendar year; (v) with limited exceptions, Employee's Partner is a U.S. citizen or resident; therefore, Employee requests those qualifying benefits which Employee has selected be withheld on a pre-tax basis. If we claim Employee's Partner is a dependent of Employee, we agree to provide information satisfactory to Douglas County to establish this claim, including but not limited to prior years' income tax returns, with financial information redacted; and whose relationship with the Employee must not be in violation of local law; the domestic partner and Employee must certify with a signed and notarized affidavit that:

- they are each at least 18 years of age and mentally competent to consent to a contract;
- they are each other's sole domestic partner, have shared the same permanent residence for the past 6 months, have an intimate, committed relationship, and plan to remain together indefinitely;
- they are not related by blood closer than would bar marriage in the State of Kansas;
- they are not married to anyone else
- they are financially interdependent and jointly responsible for our common welfare and share financial obligations which are incurred during the domestic partnership. We understand that Douglas County may require proof of financial interdependence, such as both partner's name on mortgage or rent agreements, utility bills, joint checking account, joint investments, other financial documents, or by naming each other as beneficiaries or agents under our estate planning documents;
- they understand that under applicable federal and state tax law, employer-provided benefits coverage of Employee's Partner may result in imputed taxable income to Employee, with such imputed taxable income being subject to income tax withholding and applicable payroll taxes, and we have been advised to seek legal and tax advice. This includes Employee's portion of any premium for Employee's Partner's coverage and the amount Douglas County contributes for the Employee's Partner's coverage;
- they understand that the imputed taxable income referenced in the preceding paragraph will apply unless Employee's Partner is a "dependent" under Internal Revenue Code §152(d)(2)(H) or Employee and Employee's Partner are legally married.

- the Employee's unmarried ***disabled Child***, regardless of age, provided that the Child is not able to support himself and with respect to whom a Physician has determined, prior to the Child's attainment of age 26, that the Child is mentally or physically incapable of working. Notification that the Child is disabled must be provided within 30 days after the Child attains age 26 in order for the Child to be considered a Dependent after attaining age 26. Proof of the Child's continuing disability may be required each year (after the Child attains age 26) and must be considered satisfactory by the Plan Sponsor in its sole discretion; or
- the Employee's ***Child*** to 11:59 p.m. on the last day of the month in which the Child attains age 26.

The term ***Dependent*** also does not include any person who:

- resides outside of the United States;
- is in the armed forces of any country; or
- is himself a covered Employee or is already considered a Dependent of another covered Employee (the Dependent will be considered the Dependent of only one such person).

Drug. Any medicinal substance the label of which is required by the Federal Food, Drug and Cosmetic Act to bear the legend: "Caution: Federal Law prohibits dispensing without prescription".

Durable Medical Equipment. Equipment which is able to withstand repeated use; primarily and customarily used to serve a medical purpose; and not generally useful to a person in the absence of Sickness or Injury.

Effective Date. The date your coverage becomes effective.

Emergency.
An accidental Injury**,** or the sudden onset of an illness where the acute symptoms are 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:

1. Placing the Covered Person's life (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or

2. Causing other serious medical consequences, or

3. Causing serious impairment to bodily functions, or

4. Causing serious dysfunction of any bodily organ or part..

Employee. Any person who is a regular, common law employee of the Employer, as determined from the Employer's books and records on a basis precluding individual selection, if he has a full time equivalency of working 20 hours or more per week (as defined by the Douglas County Personnel Policy) who is directly employed in the regular business of and compensated for services by the Employer; or is a retired elected official who has served a minimum of five (5) consecutive years and meets the age requirements as defined in the retirement plan in which they are participating; or a Retired Employee who has served a minimum of five (5) years who meets the age requirements as defined in the retirement plan in which the retiree is participating.

No person may be simultaneously covered under this Plan as both an Employee and a Dependent.

If, for any period of time, an individual has not been treated as a common law Employee on the books and records of the Employer (because he is paid through accounts payable rather than payroll, or for any other reason), and a court or government agency subsequently makes a determination that the individual was in fact a common law Employee during that period of time, such determination shall not entitle the individual to any retroactive rights under the Plan, and the individual's prospective rights under the Plan shall be determined solely in accordance with the terms of the Plan.

Employer. Douglas County and other eligible entities.

Essential Health Benefits.
Those benefits identified by the U.S. Secretary of Health and Human Services, including Benefits for covered expenses incurred for the following services:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment (mental and nervous disorder and chemical dependency);
6. Prescription drugs;
7. Habilitative services, rehabilitative services and habilitative and rehabilitative devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

Habilitative and Rehabilitative Devices. Medically Necessary devices that are designed to assist a Covered Person in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. Such devices include, but are not limited to, Durable Medical Equipment, orthotics, prosthetics, and low vision aids.

Habilitative Services. Medically Necessary health care services that help a Covered Person keep, learn or improve skills and functioning for daily living. Examples of Habilitative Services include therapy for a Dependent child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other Medically Necessary services for people with disabilities in a variety of inpatient and/or outpatient settings. Habilitative Services that are not Medically Necessary, for example when therapy has reached an end point and goals have been reached, will not be a Covered Expense.

Home Health Care Agency. A public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must:

- be primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- have policies established by a professional group associated with the agency or organization; this professional group must include at least one Physician and at least one registered Nurse (R.N.) to govern the services provided and must provide for full-time supervision of such services by a Physician or registered Nurse;
- maintain a complete medical record on each individual to whom it provides care;

- have a full-time administrator; and
- not provide Custodial Care or care and treatment of the mentally ill.

Home Health Care Plan. A program for care and treatment of the Covered Person established and approved by the Covered Person's Attending Physician, which is in lieu of continued confinement as an Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

Home Health Care Visit. A visit by a member of a home health care team. Each such visit that lasts for a period of four (4) hours or less is treated as one home health care visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one visit and any part of a four (4) hour period that remains is treated as one Home Health Care Visit.

Hospice. A health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel, which includes either a licensed doctor of medicine (M.D.), a doctor of osteopathy (D.O.) or a Physician Assistant (P.A.), and one registered Nurse (R.N.), and it must maintain central clinical records on all patients. A Hospice must meet applicable state licensing requirements.

Hospital. Either (1) an institution constituted, licensed and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of Sickness or Injury and which provides such treatment for compensation, by or under the supervision of Physicians on an Inpatient basis with continuous 24-hour nursing service by registered Nurses (R.N.s); or (2) an institution which is licensed and operated in accordance with the state laws pertaining to osteopathic hospitals, free standing surgical facilities, Birthing Centers, a place for alcoholics, drug addicts or rehabilitation centers and which is accredited by any nationally recognized accrediting program.

Immediate Family. With respect to a Covered Person, includes the spouse, mother, father, sister, brother, child or in-laws of the Covered Person.

Injury. A condition caused by Accidental means that results in damage to the Covered Person's body from an external force.

Inpatient. A confinement of a Covered Person in a Hospital, Hospice, or Extended Convalescent Care Facility as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for Room and Board.

Maximum Allowable Amount.

1. For services and supplies provided by a Nonpreferred Provider, the Maximum Allowable Amount is the lesser of:
   a. the amount billed; or
   b. the negotiated fee; or
   c. if a negotiated fee is not available:

200% of the Medicare reimbursement rate in effect at the time services were provided by a facility or professional provider, or an equivalent of what Medicare would reimburse based on the use of Medicare data and independent relative value unit or other data, for the services reported on the claim, established utilizing the most currently available Medicare, professional provider-specific or facility-specific reimbursement schedules and methodologies.

For injectable therapy and services, the lesser of two times the amount, as would be reimbursed to the facility or professional provider by Medicare, or an equivalent of what Medicare would reimburse based on the use of Medicare data and independent relative value unit or other data, or 110% of the average wholesale price determined by the manufacturer and published in, and updated weekly by, an industrywide data system that collects manufacturers' prices.

The right to appeal a Maximum Allowable Amount exists. However, it should be noted that the final reimbursement rate could result in a higher percentage than the appealed amount based on a negotiated settlement with the provider.

Measurement Period. The period of time, as determined by the employer and consistent with Federal law, regulation and guidance, utilized by the employer to determine whether a variable hour employee worked on average 30 hours per week for the employer.

Medically Necessary. Medical services, supplies or treatment:

- which are appropriate and required for the diagnosis or treatment of the Sickness, Accidental Injury or pregnancy;
- which are safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications; and
- provided there are not less intensive or more appropriate diagnostic or treatment alternatives that could have been used in lieu of the services or supplies given.

The Plan Sponsor may determine, at its discretion, if such services or supplies are "Medically Necessary" for the diagnosis or treatment of the Sickness, Accidental Injury or pregnancy. This determination, in part, is based on and is consistent with standards outlined above and approved by the Plan Sponsor.

Medicare. The program of benefits under Parts A and/or B of Title XVIII of the Social Security Act of 1965, as enacted or thereafter amended.

Mental and Nervous Care/Treatment. Care and treatment for mental and nervous disorders or conditions, as accepted by the general psychiatric community in the judgment of the Plan Sponsor.

Morbid Obesity

A diagnosed condition in which the body weight is one hundred (100) pounds or more over the medically recommended weight in the most recent Metropolitan Life Insurance Company tables for a person of the same height, age and mobility as the Covered Person, or having a BMI (body mass index) of forty (40) or higher, or having a BMI of thirty-five (35) in conjunction with any of the following co-morbidities: coronary artery disease, type II diabetes, clinically significant obstructive sleep apnea or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).

Negotiated Rate. The rate a Preferred Provider has contracted to accept as payment in full for Covered Expenses of the Plan (less any applicable patient responsibility amount).

Nurse. An individual who has received specialized nursing training and is authorized to use the designation "R.N." (registered nurse) or "L.P.N." (licensed practical nurse) and who is duly licensed by the state or regulatory agency responsible for such license in the state in which the individual performs the nursing services.

Occupational Therapy. A program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks to increase independent function, enhance development and prevent disability.

Out-of-Pocket Maximum Amount. The maximum dollar amount you will pay in any one Benefit Period for medical expenses covered by this Plan, unless otherwise specified elsewhere in the Plan.

Outpatient Psychiatric Facility. An administratively distinct governmental, public, private or independent unit or part of such unit that provides treatment by a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care for all patients.

Pervasive Developmental Disorders. A group of developmental conditions that affect children and involve delays or impairments in the development of many basic skills, most notably the ability to socialize with others, to communicate and to use imagination. Common types of Pervasive Developmental Disorders include Autism, Asperger Syndrome, Childhood Disintegrative Disorder and Rett Syndrome.

Pharmacy Benefit Manager (PBM). The entity that is responsible for administering prescription Drug Benefits for a plan. It is an organization that applies managed care principles and procedures to pharmacy Benefits to contain costs and improve quality. PBMs can include HMOs, PPOs, insurance companies and specialized prescription benefit management firms.

Physical Therapy. A plan of care provided by a qualified physical therapist to restore or improve a patient's motor functions. Physical Therapy includes evaluation by a qualified physical therapist of the patient's muscle tone, movement, balance, endurance, ability to ambulate and ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint), Physical Therapy includes

evaluation by the physical therapist of the patient's ability to use the equipment and a determination of the correct size and type of equipment for the specific patient.

Physician. Includes:

- an individual who is licensed to prescribe and administer Drugs or to perform surgery and who is operating within the scope of his license, includes a medical doctor (M.D.), a podiatrist (D.P.M.), an osteopath (D.O.), a physician assistant (P.A.), or a Dentist or dental surgeon (D.D.S., or D.M.D.);
- a chiropractor (D.C.) who is operating within the scope of his license; or
- a clinical psychologist (Ph.D., or Psy.D.) who is duly licensed or certified, who is working within the scope of such license or certification and who is referred by, or working under the supervision of, a person described in the first subparagraph above.

The term "Physician" also includes a person or other entity licensed where required and performing services within the scope of such license including but not limited to; a certified licensed nurse-midwife, a certified registered nurse anesthetist (CRNA), a social worker with the degree of "MSW", "C.S.W.", "L.C.S.W." or a "A.C.S.W." and an Advanced Registered Nurse Practitioner (ARNP) for the treatment of Mental and Nervous Disorders, alcoholism and drug abuse, but only to the extent any such individual is licensed as such pursuant to any applicable state licensing authority, and is acting within the scope of that license.

Plan. The Douglas County Employee Benefit Trust as herein set forth and as from time to time amended.

Plan Administrator. The entity responsible for the functions and arrangements of the Plan. The Plan Administrator may also employ persons or firms to process claims and perform other Plan-related services.

Plan Sponsor. Douglas County and other eligible entities.

Plan Year. The period beginning at 12:01 a.m. on the first day of the Plan's fiscal year and ending immediately prior to 12:01 a.m. on that same day of the following year. See the section of this Plan titled, *General Information*, for a description of the Plan's fiscal year.

Preadmission Testing. The program of tests conducted by a Hospital, at the direction of a Physician, with respect to a Covered Person on an outpatient basis, which are Medically Necessary prior to a scheduled Inpatient confinement at the same facility.

Preferred Provider. Any Physician, medical professional or medical facility listed in network directories under contract with the Plan.

Qualified Medical Child Support Order. A medical child support order issued by a court having proper jurisdiction, or issued under an administrative process established under state law that has the force and effect of law under applicable state law and which creates or recognizes the existence of a Child's rights to, or assigns to such Child the right to, receive Benefits for which a Dependent is eligible under this Plan, provided such order clearly specifies:

- the name and last known mailing address of the Employee, and the name and mailing address of each Child covered by the order (to the extent provided in the order, the name and mailing address of an official of the state agency issuing the order may be substituted for the name and mailing address of the Child);
- a reasonable description of the type of coverage to be provided by the Plan to each Child, or the manner in which coverage is to be determined;
- the time period to which such order applies; and
- the Plan's name, and meets other legal requirements.

A national medical support notice that meets (or, pursuant to federal regulations, is deemed to meet) the foregoing requirements will be considered a Qualified Medical Child Support Order.

Rehabilitation Facility. A legally operating institution or a distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post acute Hospital and rehabilitation Inpatient care and is duly licensed by the appropriate governmental agency to provide such services. It does not include institutions which provide only minimal care, Custodial Care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, Chemical Dependency, Substance Abuse or tuberculosis, except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of medical conditions or Chemical

Dependency or Substance Abuse in the jurisdiction where it is located, or is accredited as such facility by the Joint Commission for the Accreditation of Healthcare Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Rehabilitative Services. Medically Necessary health care services that help a Covered Person get back, or improve skills for daily living that have been lost or impaired after sickness, injury, or disability. These services assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. Rehabilitative Services include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and psychiatric rehabilitation

Room and Board. All charges commonly made by a Hospital on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

Skilled Nursing Facility. An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

- is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Sickness or Injury. 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 activities must not be provided;
- services are provided for compensation and under the full-time supervision of a Physician;
- provides 24 hour per day nursing services by licensed Nurses, under the direction of a full-time registered Nurse;
- maintains complete medical records on each patient;
- is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, custodial or educational care, or for the care of Mental and Nervous Disorders; and
- is approved and licensed by Medicare.

Sickness. Any physical illness or mental illness. The term "Sickness" shall include pregnancy, childbirth or resulting complications.

Specialty Drug. A specialty drug is a high-cost, complex pharmaceutical (usually injectable) that has unique clinical, administration, distribution and/or handling requirements and is not commonly available in traditional community and mail order pharmacies.

Speech Therapy. A program of care that evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist.

Stability Period. The period of time as determined by the employer and consistent with Federal law, regulation and guidance, after the measurement period has been completed.

Substance Abuse/Chemical Dependency. The physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine and caffeine are not included in this definition.

Substance Abuse Treatment. An institution that provides a program for diagnosis, evaluation and treatment of alcoholism and/or drug use or abuse; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by Nurses who are directed by a full-time registered Nurse (R.N.); and is a facility that meets applicable licensing standards.

Total Disability/Totally Disabled. Your physical state resulting from a Sickness or Injury, which wholly prevents you (as an eligible Employee) from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and in the case of your Dependent or a COBRA Beneficiary, prevents that person from performing the normal activities of a person of that age and gender who is in good health.

Variable Hour Employee. An employee as defined by Federal law, regulation and guidance

Waiting Period. The period of time during which you must be in an eligible class before becoming covered under this Plan.

We. The Plan Sponsor.

You/Your. Generally, a covered Employee, although depending on the context, may mean any person who is covered under the Plan as an eligible Employee or a Dependent, subject to the enrollment and contribution requirements of the Plan.

ARTICLE VI
COMPREHENSIVE MAJOR MEDICAL BENEFITS

DEDUCTIBLE AMOUNT. The deductible amount for each Covered Person is the amount of Covered Expenses that must be paid by you during each Benefit Period and while covered by the Plan before Benefits begin under the *Comprehensive Major Medical Benefits* provisions of this Plan. The deductible amount is shown in the Schedule of Benefits. The deductible may not apply to certain Benefits (that is, some Benefits may be paid even if you have not satisfied your deductible for the Benefit Period). See the Schedule of Benefits.

The Schedule of Benefits reflects a "family" deductible. When any two or more Covered Persons in the family pay, in the same Benefit Period and while covered by the Plan, the amount shown as the "family" deductible, then all Covered Persons in the family will be deemed to have satisfied their individual deductible amount for the Benefit Period. "Family" means you as the covered Employee and all your covered Dependents.

Some Benefits are payable only after you pay a special deductible amount. The special deductible amount may apply once per year, once per treatment, once per admission, etc., all as specified in the Schedule of Benefits or elsewhere in this booklet. Generally, the special deductible amounts must always be met in order for the particular Benefit to be payable, even if you have already met your individual deductible amount for the Benefit Period, or if your family has met any family deductible amount for the Benefit Period.

OUT-OF-POCKET MAXIMUM AMOUNT. The Schedule of Benefits reflects an "Out-of-Pocket Maximum Amount" payable by a Covered Person and his or her family. The Out-of-Pocket Maximum Amount is the amount of otherwise Covered Expenses that you must pay during a Benefit Period and while covered by the Plan before the Plan's Co-insurance payment percentage increases (typically, to 100%). Payments a Covered Person makes to satisfy his or her deductible amount are taken into account in determining whether a Covered Person has met the Out-of-Pocket Maximum Amount for the Benefit Period.

In some cases, as described in the Schedule of Benefits, the Plan will pay 100% of the Covered Expense even if the Covered Person has ***not*** met the Out-of-Pocket Maximum Amount for the Benefit Period.

Out-of-Pocket Expense Limit Exclusions
The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by the Plan, to include charges in excess of the maximum allowable amount, or negotiated amount, as applicable.

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The Schedule of Benefits reflects a "family" Out-of-Pocket Maximum Amount. When any two or more Covered Persons in the family pay, in the same Benefit Period and while covered by the Plan, the amount shown as the "family" Out-of-Pocket Maximum Amount, then all Covered Persons in the family will be deemed to have satisfied their individual Out-of-Pocket Maximum Amount for the Benefit Period. "Family" means you as the covered Employee and all your covered Dependents.

Where the Schedule of Benefits reflects Out-of-Pocket Maximum Amounts for both In-Network and Out-of-Network care, the Amounts apply in the aggregate. Thus, for example, if you have already satisfied your In-Network Out-of-Pocket Maximum Amount for the Benefit Period and have not incurred any expenses outside of the network, and then you receive care outside the network, your In-Network expenses that were applied to satisfy your In-Network Out-of-Pocket Maximum Amount are applied toward satisfaction of your Out-of-Network Out-of-Pocket Maximum Amount.

PREFERRED PROVIDER ORGANIZATIONS. The Plan may contract with certain preferred provider organizations. A Preferred Provider is a Physician, Hospital or ancillary service provider which has an agreement in effect with the Preferred Provider Organization (PPO) to accept a Negotiated Rate for services rendered to Covered Persons. In turn, the PPO has an agreement with the Plan Administrator or Trustmark Health Benefits, Inc. to allow access to Negotiated Rate by Covered Persons. The PPO's name and/or logo is shown on the front of the Covered Person's ID card. The preferred provider cannot bill the Covered Person for any amount in excess of the Negotiated Rate for the Covered Expenses. Claims that are participating with Cigna will not be sent for an independent bill review.

Preferred Provider Out-of-Pocket Expense Limit Exclusions
The following items do not apply toward satisfaction of the calendar year Preferred Provider out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the Preferred Provider out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by the Plan, including charges in excess of the Maximum Allowable Amount or Negotiated Rate, as applicable.

NON-PREFERRED PROVIDER. A non-preferred provider does not have an agreement in effect with the Preferred Provider Organization. The Plan will allow only the Maximum Allowable Amount as a Covered Expense. The Plan will pay its percentage of the Maximum Allowable Amount for the non-preferred provider covered expenses. The Covered Person is responsible for the remaining balance. This results in greater out-of-pocket expenses to the Covered Person.

BENEFIT MAXIMUMS. The Schedule of Benefits may reflect certain Benefit limits that apply under the Plan. If a Benefit limit is listed more than once in the Schedule of Benefits (for example, if listed once under the "In-Network" column, and listed again under the "Out-of-Network" column), the limit is an aggregate limit. For example, if a Benefit is limited to 30 days per year under the In-Network column, and 30 days per year under the Out-of-Network column, once a total of 30 days of Benefits have been paid (whether In-Network, Out-of-Network or part In-Network and part Out-of-Network), no further Benefits are payable for the remainder of the period.

INPATIENT PRE-ADMISSION CERTIFICATION/CONTINUED STAY REVIEW. It is your responsibility to initiate the process to satisfy the requirements of pre-admission certification. The Plan Sponsor has contracted with a medical review specialist to review the Medical Necessity of all Inpatient admissions and the length of that stay. Please refer to your Employee Health Care Plan ID card.

- Prior to the initiation of services, you or your Physician must contact the medical review specialist and have the proposed admission and treatment plan reviewed and approved or "pre-certified".
- Inpatient prophylactic surgery (for the prevention of breast or ovarian cancer) procedures must be pre-certified.
- Services will be denied that are not found to be Medically Necessary.

Inpatient
If you have been admitted on an Emergency or maternity basis, you must notify the medical review specialist within 48 hours of the admission.

Notwithstanding the foregoing, this Plan will not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child, following a normal vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a cesarean section. In addition, the Plan shall not require a Hospital, Physician or other medical provider to obtain authorization or pre-certification from the Plan Sponsor or its medical review specialist for prescribing any length of stay described above. However, these rules shall not apply where the decision to discharge the mother or her newborn Child prior to the expiration of the minimum length of stay periods described above is made by the mother's or Child's Attending Physician in consultation with the mother.

OUTPATIENT PRE-CERTIFICATION. The following outpatient services require pre-certification:

- Home Health Care
- Home Infusion Therapy
- Transplants
- Weight Loss Surgery

CASE MANAGEMENT. In a case where your condition is expected to be or is of a serious nature, the Plan Sponsor may arrange for review and/or case management services from a professional qualified to perform such services. Based on the review, the Plan Sponsor shall have the right to alter or waive the normal provisions of the Plan, including Benefit limits, when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care. For example, if you require Custodial Care rather than Inpatient Hospital care, but the Plan does not cover Custodial Care and, as a result, the only practical alternative covered by the Plan is Inpatient Hospital care, the Plan may agree to treat your Custodial Care expenses as Covered Expenses in lieu of having you remain or re-admitted as a Hospital Inpatient, where doing so is cost effective to the Plan and does not compromise the quality of your care. This provision shall also operate to the extent required by any reinsurance contract between the Plan Sponsor and the reinsurer.

ARTICLE VII
COVERED EXPENSES

The term "Covered Expenses" is defined in the Definitions section of this booklet, and generally includes all Negotiated Rate or Maximum Allowable Amounts for nonpreferred providers actually incurred for Medically Necessary and essential care and treatment for Sickness and Accidental Injury recommended by a licensed Physician which include but are not limited to the expenses listed below. The Claims Supervisor will use its discretion when determining whether to use a Negotiated Rate or Maximum Allowable Amounts when both are available.

1. ***COVERED MEDICAL EXPENSES***.

a. Hospital Charges for:

i) The actual Room and Board expenses incurred for a ward or semi-private room or the lowest private room rate for a Hospital that does not have semi-private accommodations. Private room expenses are limited to the average semi-private rate of the Hospital in which confined.

ii) The actual expense incurred for confinement in an intensive care unit, cardiac care unit or burn unit.

iii) Miscellaneous Hospital services and supplies during Hospital confinement.

iv) Inpatient charges for a well newborn baby for nursery Room and Board, and for professional service required for the healthy newborn. Covered Expenses also include charges for pediatric services and circumcision. Eligible expenses for the baby as a Dependent Child will be subject to a separate deductible. Benefits will be payable from the date of birth until the earliest of the date the mother is released; the date the Child is released; or the Child's fifth day of age. Newborn babies of Dependent Children are not covered.

b. Charges incurred for confinement in a Rehabilitation Facility, limited to the facility's average semi-private room rate.

c. Charges for a Medically Necessary surgical procedure.

d. Charges for the services of a legally qualified Physician for medical care and/or surgical treatments including office, home visits, Hospital Inpatient care, Hospital outpatient visits/exams, clinic care, and surgical opinion consultations.

e. Charges for the services of a Nurse for Inpatient private duty nursing up to the limits described in the Schedule of Benefits.

f. Charges for the treatment or services rendered by a licensed physical therapist under the direct supervision of a Physician in a home setting or at a facility or institution whose primary purpose is to provide medical care for a Sickness or Injury.

g. Charges of a legally qualified Physician or qualified speech therapist under direct supervision of a Physician for restorative Speech Therapy for speech loss or impairment due to a Sickness or Injury, Pervasive Developmental Disorder or due to surgery performed on account of a Sickness or Injury, other than a functional nervous disorder. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

h. Charges for professional ambulance service to the Hospital where treatment is given or between medical facilities when Medically Necessary, including air transport to and from the nearest facility qualified to render treatment.

i. Charges for Drugs requiring the written prescription of a licensed Physician; such Drugs must be necessary for the treatment of a Sickness or Injury. Note: This subsection is intended to describe generally the type and nature of Drugs covered by the Plan; if the Plan restricts Benefits for Drugs (either on the basis of the type of Drug, or the provider of the Drug) in other sections or subsections of this Plan, the rules of those other sections and subsections shall operate as a limitation on this subsection.

j. Charges for x-rays, microscopic tests, laboratory tests and radioactive isotopes.

k. Charges for radiation therapy or treatment and chemotherapy.

l. Charges for blood or blood plasma and its processing and administration.

m. Charges for oxygen and other gases and their administration.

n. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

o. Charges for the cost and administration of an anesthetic.

p. Charges for dressings, sutures, casts, splints, trusses, crutches, braces or other necessary medical supplies, with the exception of dental braces.

q. Charges for rental or purchase, whichever is less costly, of Medically Necessary Durable Medical Equipment, which is prescribed by a Physician and required for therapeutic use by the Covered Person. Repair or replacement of purchased Durable Medical Equipment, which is Medically Necessary due to normal use or a physiological change in the patient's condition, will be considered a Covered Expense. Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the Covered Person's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the Covered Person's medical needs.

r. Charges for the initial purchase of artificial limbs, eyes or larynx, to replace natural limbs, eyes or larynx. Repair or replacement of artificial limbs, eyes or larynx that is Medically Necessary due to normal use or a physiological change in the patient's condition will be considered a Covered Expense.

s. Charges for one sonogram per pregnancy. Additional sonograms will be covered if there is an indication of complications.

t. Charges for services for voluntary sterilization; reversal of sterilization is not covered.

u. Charges made by an Ambulatory Surgical Center or minor emergency medical clinic.

v. Charges for maternity care (including maternity care for covered Dependent Children) on the same basis as any Sickness covered under this Plan.

w. Charges incurred for preventive services which are not required due to Sickness and Injury, subject to the limits listed on the Schedule of Benefits.

x. Charges for preventive colonoscopy. Additional subsequent preventive colonoscopies are covered as described in the Schedule of Benefits.

y. Charges for routine vision examinations and routine eye refraction, limited to one per year per Covered Person and the purchase of eyeglasses or contact lenses up to the limits described in the Schedule of Benefits.

z. Charges made by a Hospital (excluding charges made by the Nurse or Physician) for laboratory and x-ray testing within seven days prior to a scheduled admission to that Hospital.

aa. Charges for an opinion as to whether or not a recommended surgery is appropriate, so long as the second opinion is given by a Physician who also personally examines the Covered Person and provides a written opinion; and that Physician does not perform the surgery or practice in association with the Physician making the initial recommendation.

bb. Charges for elective abortion.

cc. Charges for Christian Science treatment.

dd. Charges for allergy shots and testing.

ee. Charges for cochlear implants or other implants.

ff. Charges for examination to determine hearing loss.

gg. Charges for fitting, purchase and replacement of hearing aid up to the limits described in the Schedule of Benefits.

hh. Charges for wigs, hairpieces, hair transplants, or any Drug (whether prescribed by a Physician or not) used to eliminate baldness or stimulate hair growth, when due to medical treatment.

ii. Charges for warning devices, stethoscopes, blood pressure cuffs or other types of apparatus used for diagnosis or monitoring including glucose monitoring devices and supplies.

jj. Charges for FDA approved contraceptive methods.

kk. Charges for biofeedback.

ll. Charges for implanted nerve stimulators.

mm. Charges for family and marriage counseling.

nn. Charges for treatment of temporomandibular joint dysfunction.

oo. Charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

pp. Charges for prophylactic surgery, when Medically Necessary, for the prevention of breast or ovarian cancer (Inpatient procedures must be pre-certified).

qq. Charges for therapy treatment of Pervasive Developmental Disorders (also known as autism spectrum disorder) for which charges will be considered when documentation shows developmental progress.

rr. Charges for tobacco screening and counseling for all adults (including programs to stop using tobacco).

ss. Charges for diabetic education.

tt. Charges for mammograms, including 3-D imaging.

uu. Charges for urgent care services.

2. ***SKILLED NURSING FACILITY***. Charges incurred for confinement in a Skilled Nursing Facility up to the maximum stated in the Schedule of Benefits. However, such expenses are limited as follows:

a. charges will be considered only if confinement begins within fourteen (14) days after a Hospital confinement of at least three (3) consecutive days;
b. charges will be considered only if they are incurred in connection with care related to the Sickness or Injury for which you were confined;
c. charges will be considered only if documentation shows progress in rehabilitation or restoration; and
d. charges for Custodial Care are not covered.

3. ***HOSPICE CARE***. Charges related to Hospice care provided that the Covered Person has a life expectancy of six (6) months or less. Covered Hospice expenses are limited to:

a. room and board for confinement in a Hospice;
b. ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment, which is solely for treating a Sickness or Injury;
c. medical supplies, Drugs and medicines prescribed by the Attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
d. physician services and/or nursing care by a Nurse or a Licensed Vocational Nurse (L.V.N.);
e. home health aide services;
f. home care charges for home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Nurse or a home health aide;
g. medical social services by licensed or trained social workers, psychologists or counselors;
h. nutrition services provided by a licensed dietitian;
i. respite care;
j. bereavement counseling. Bereavement counseling is a supportive service provided by the Hospice team to Covered Persons in the deceased's Immediate Family after the death of such terminally ill person. Such visits are to assist the Covered Persons in adjusting to the death. Benefits will be considered for the charges provided that on the date immediately before his death, the terminally ill person was in a Hospice Care Program and a Covered Person under the Plan.

4. ***RECONSTRUCTIVE SURGERY***. Charges for Reconstructive Surgery, but only in the following situations:

a. the treatment is received within twelve (12) months of an Accidental bodily Injury, and the Reconstructive Surgery is for the purpose of restoring normal function immediately prior to the Accident; or
b. the surgery is necessary to correct significant deformity arising from, or directly related to, disease, trauma, or previous therapeutic process; or
c. the surgery is a correction of a congenital anomaly, for example, a birth defect in a Child; or
d. with respect to any Covered Person who is receiving Benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy:

    i) reconstruction of the breast on which the mastectomy was performed, including nipple and areola reconstruction and repigmentation;
    ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    iii) prostheses and physical complications with respect to all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the Attending Physician and the Covered Person.

5. ***ORGAN TRANSPLANT***. Charges for services and supplies in connection with human-to-human tissue and organ transplant procedures, subject to the following conditions:

a. Human-to-human tissue and organ transplants must be referred to and authorized by the Plan's medical review specialist prior to the patient receiving any such services. It is the responsibility of the patient to obtain pre-certification.

b. If the donor is covered under this Plan, Covered Expenses incurred by the donor will be considered for Benefits to the extent donor benefits are not provided under the recipient's Plan.

c. If the recipient is covered under this Plan, Covered Expenses incurred by the recipient will be considered for Benefits. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to participant eligibility requirements, will be considered Covered Expenses to the extent that such expenses are not payable by the donor's plan.

d. If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately.

e. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a Covered Expense under this Plan.

6. ***HOME HEALTH CARE***. Charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan up to the maximums stated in the Schedule of Benefits. Home Health Care is subject to pre-certification. Prior to the initiation of services, you or your Physician must contact the medical review specialist and have the proposed treatment plan reviewed and approved or "pre-certified". Such charges include expenses for:

a. part-time or intermittent nursing care by a Nurse or a vocational Nurse or public health Nurse who is under the direct supervision of a registered Nurse;
b. home health aides;
c. physical, respiratory, occupational or speech therapy; and
d. medical supplies, Drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if you had remained in the Hospital.

Specifically excluded from coverage under the Home Health Care Benefit are the following:

a. services and supplies not included in the Home Health Care Plan;
b. services of a person who ordinarily resides in your home, or is a member of your Immediate Family;
c. services of any social worker;
d. transportation services;
e. custodial care and housekeeping;
f. food, food supplements and home delivered meals;
g. nursing care services, except as specified; and
h. charges for services in excess of the maximum shown on the Schedule of Benefits.

7. ***MENTAL AND NERVOUS DISORDER AND SUBSTANCE ABUSE***. Charges for Mental and Nervous Disorder and Substance Abuse treatments for the following services and supplies:

a. hospital charges;
b. convulsive or shock treatment;
c. surgical charges;
d. psychiatric visits in the Hospital;
e. prescription Drugs; and
f. out-of-Hospital charges including covered Physician charges.

8. ***REHABILITATION SERVICES***. Charges for Inpatient rehabilitation services in a licensed Rehabilitation Facility and outpatient rehabilitation services (including, but not limited to, physical, occupational, speech and hearing therapy services), are covered only if such services are expected to result in significant improvement in the Covered Person's condition.

In no event will the Plan pay Rehabilitation Service Benefits in excess of the Benefits listed in the Schedule of Benefits.

9. ***PRESCRIPTION DRUG BENEFITS***. See *Appendix B, Prescription Drug Benefits*, for details of the Prescription Drug Benefits provided through the Pharmacy Benefit Manager.

10. ***DENTAL CARE***. Benefits for dental care, under these *Comprehensive Major Medical Benefits* provisions, are limited to:

a. Services provided for an Accidental Injury to sound, natural teeth incurred within 6 months of the Accident causing the Injury.

b. The following oral surgery:

i) surgical removal of impacted teeth;
ii) reduction of fractures of facial bones;
iii) excisions of mandible joints;
iv) treatment of lesions;
v) incision of accessory sinuses, mouth, salivary glands or ducts;
vi) plastic reconstruction or repair of the mouth or lips to correct Accidental Injury.

Effective January 1, 2019

i) surgical removal of residual soft tissue and bone; and
ii) removal of tooth structure and closure.

c. Anesthesia and facility charges associated with necessary dental services for the following groups who otherwise would not be able to receive the dental services:

i) covered Children under the age of 5;
ii) severely disabled members; or
iii) members with certain medical or behavioral conditions.

11. ***CHIROPRACTIC CARE***. Covered Expenses include initial consultation, x-rays and treatment, subject to the maximum Benefit, if any, shown on the Schedule of Benefits.

12. ***ROUTINE PATIENT COSTS FOR APPROVED CLINICAL TRIALS***.

Covered Expenses shall include charges for "routine patient costs" incurred by a "qualified individual" participating in an approved clinical trial**.** "Routine patient costs" do not include:

1. An investigational item, device or service;

2. An item or service provided solely to satisfy data collection and analysis needs, which are not used in the direct clinical management of the patient; or,

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Qualified Individual" means a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another "life-threatening disease or condition" and either;

1. The referring health care professional has concluded that the Covered Person's participation in such trial would be appropriate; or,

2. The Covered Person provides medical and scientific information establishing that the Covered Person's participation in such trial would be appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided by the Plan that is typically covered for a Covered Person who is not enrolled in a clinical trial.

13. ***SURGICAL TREATMENT OF MORBID OBESITY***

Covered Expenses shall include charges for surgical treatment of Morbid Obesity for Covered Persons with health problems that are aggravated by or related to the Morbid Obesity, including, but not limited to gastric by-pass, gastric stapling or gastric balloon when determined to be Medically Necessary.

14. ***NON-SURGICAL TREATMENT OF MORBID OBESITY***

Covered Expenses shall include charges for weight-loss programs, including nutritional counseling, that are administered and supervised by a Hospital or Physician's clinic to treat a medical condition by a decrease in the patient's weight. This program must not be a weight reduction program, but a program designed to treat health problems associated with high-risk Morbid Obesity. These health conditions may include hypertension, diabetes, cardiovascular disease, sleep apnea and degenerative joint disease. The patient must have demonstrated unsuccessful results in a weight loss program. Coverage is limited to Medically Necessary charges for treatment of Morbid Obesity.

15. ***GENDER DYSPHORIA***

Covered Expenses shall include treatment provided by a professional provider for gender dysphoria, a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Treatment includes Medically Necessary psychotherapy, hormone therapy, prescription drugs and surgery. Cosmetic services, including the following, are not covered:

1. Abdominoplasty;
2. Blepharoplasty;
3. Breast enlargement, including augmentation mammoplasty and breast implants;
4. Body contouring such as lipoplasty or liposuction;
5. Brow lift;
6. Calf implants;
7. Cheek, chin, nose implants;
8. Electrolysis;
9. Injection of fillers or neurotoxins;
10. Face lift, forehead lift or neck tightening;
11. Facial bone remodeling;
12. Hair removal;
13. Hair transplantation;
14. Jaw reduction or jaw contouring;
15. Laryngoplasty;
16. Lip augmentation;
17. Lip reduction;
18. Mastopexy;

19. Pectoral implants for chest masculinization;

20. Removal of redundant skin;

21. Rhinoplasty;

22. Skin resurfacing;

23. Thyroid cartilage reduction;

24. Voice modification surgery;

25. Voice lessons and voice therapy.

ARTICLE VIII
GENERAL EXCLUSIONS AND LIMITATIONS

***Except as and to the extent otherwise specifically provided in this booklet*,** Covered Expenses do not include, and no Benefits (whether or not the care was Medically Necessary) will be paid with respect to:

1. **Abdominoplasty** - Charges for abdominoplasty, except if Medically Necessary.
2. **Acupressure and Acupuncture** - Charges for acupuncture, acupressure and related or similar treatments (except for purposes of anesthesia).
3. **Admission Charges** - Charges for Physician or Hospital bed patient services (other than diagnostic x-ray and laboratory tests and charges for Physical Therapy) if admission was primarily for diagnostic reasons or for Physical Therapy, and if such services could have been provided adequately on an outpatient basis without endangering the patient's health.
4. **Artificial Organ** - Charges for services related to obtaining or implanting a non-human, artificial or mechanical organ.
5. **Blood Products** - Charges for blood products storage when not necessary or not in conjunction with a scheduled covered surgery; or blood products when replaced by donation. Charges for procurement and storage of one's own blood, unless incurred within three months prior to the scheduled surgery.
6. **Breast Reduction** - Charges for reduction mammoplasty (breast reduction surgery), unless determined to be Medically Necessary or covered under the Reconstructive Surgery provisions of the Plan.
7. **Comfort Items** - Charges for items or devices primarily used for comfort or convenience, including but not limited to air purifier, humidifier, dehumidifier, whirlpool, air conditioning, water bed, exercise equipment, ultraviolet lighting, or anything useful in the household.
8. **Complications** - Charges for services or supplies received for treatment of complications resulting from services that are not covered except as otherwise stated in this document.
9. **Consultations** - Charges for consults by telephone, e-mail or online Physicians. Charges associated with missed appointments or completion of claim forms.
10. **Controlled Substance, Under the Influence of** - Charges for services, supplies, care or treatment to a Covered Person for Sickness or Injury resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, chemical or drug, unless such controlled substance, chemical or drug was administered on the advice of a Physician. Expenses will be covered for Substance Abuse treatment as specified in this Plan. Expenses will also be covered for Covered Persons other than the person using controlled substances. This exclusion does not apply if the Sickness or Injury resulted from an act of domestic violence or a medical condition (regardless of whether such medical condition is physical or mental, and regardless of whether the medical condition is diagnosed prior to the Sickness or Injury).
11. **Cosmetic Surgery** - Charges for Cosmetic Surgery or procedure and all related services.
12. **Coverage Dates** - Charges for services rendered and or supplies received prior to the Effective Date or after the termination date of a person's coverage.
13. **Craniomandibular Joint Dysfunction** - Charges for treatment of craniomandibular joint dysfunction; myofacial pain syndrome; and all related conditions.
14. **Criminal Act** - Charges for treatment of a Sickness or Injury suffered or incurred:
    a. in connection with any Sickness or Injury of the Covered Person resulting from or occurring during the Covered Person's commission or attempted commission of a criminal battery or felony. Claims shall be denied if the Plan Administrator has reason to believe based on objective evidence, such as, police reports or medical records, that a criminal battery or felony was committed by the Covered Person; or
    b. while taking part in a riot (meaning taking an active part in common with three or more others by using or threatening to use force or violence without authority of law).
15. **Custodial Care** - Charges for Custodial Care to assist in daily living needs not Medically Necessary to recover from a Sickness or Injury; or for Custodial Care or similar services by a member of your Immediate Family or someone who resides with you.
16. **Dental** - Charges for dental treatment resulting from chewing injuries; dental implants; and dental treatment.
17. **Diabetic Supplies** - Charges for insulin; needles, and test strips necessary to treat diagnosed diabetes are covered under your Pharmacy Benefit.
18. **Drugs** - Charges for Drugs and medicines not prescribed by a Physician or that are not required to have a written prescription.
19. **Education** - Charges for testing or training for education or vocation.
20. **Employer Based Clinic** - Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by your Employer.

21. **Exams and Tests for Miscellaneous Purposes** - Charges for physical exams and related x-ray and lab expenses when rendered for purposes of employment, travel, immigration, or to buy insurance; or for pre-marital or family planning tests and exams.
22. **Experimental or Investigational** - Charges for Drugs, devices, supplies, treatments, procedures or services that are considered experimental or investigative by the Plan. The Plan will consider a Drug, device, supply, treatment, procedure or service to be "experimental" or "investigative":
    a. if, in the case of a Drug, device or supply, the Drug, device or supply cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given for the proposed use at the time the Drug, device or supply is furnished; or
    b. if the Drug, device, supply, treatment, procedure or service, or the patient's informed consent document utilized with respect to the Drug, device, supply, treatment, procedure or service was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
    c. if the Plan Sponsor determines in its sole discretion that the Drug, device, supply, treatment, procedure or service is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy.
    d. if the Plan Sponsor determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the Drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.
23. **Family Member, Services Rendered By** - Charges for services or supplies rendered by a member of your Immediate Family or any person residing in your household.
24. **Foot Care** - Charges for routine, palliative or cosmetic foot care, including, but not limited to, treatment of weak, unstable, flat, strained or unbalanced feet, orthopedic shoes, shoe inserts, strapping and other supportive devices; treatment of corns or calluses; non-surgical care of toenails. These services are covered if found to be Medically Necessary for the treatment of metabolic or peripheral-vascular disease (such as diabetes) or other medical diagnoses including plantar fasciitis, bone spurs, bursitis or tendonitis of the foot.
25. **Genetic Testing and Counseling** - Charges for genetic testing and genetic counseling except when Medically Necessary and the intent is to use the results to help determine a course of treatment or care. BRCA testing and Counseling will be covered as preventive services under PPACA guidelines.
26. **Governmental Plan** - Charges for services and supplies that are: furnished by a governmental plan, Hospital or institution, unless you are legally required to pay for the services; paid by an association or foundation; or required by law to be provided by an educational institution to you; nevertheless, such charges shall be considered for payment under the Plan to the extent required by federal law, but only to the extent the Plan would have considered such charges for payment had the services or supplies been provided by other than a governmental Hospital or institution.
27. **Hypnosis** - Charges for hypnosis.
28. **Incurred Expenses** - Charges for any expense that is not incurred at the time a person is a Covered Person, unless a Plan provision specifically provides otherwise. For this purpose, an expense is incurred at the time the service or supply is actually provided.
29. **Infertility** - Charges for in-vitro and in-vivo fertilization testing; treatment or medication for the primary purpose of achieving conception and infertility testing and treatment.
30. **International Services** - Charges incurred outside the U.S. if you traveled to such location for the sole purpose of obtaining medical services, Drugs or supplies.
31. **Maxillofacial Surgery** - Charges for maxillofacial surgeries.
32. **Maximum Allowable Charge** - Charges in excess of the maximum allowable charge; charges for services, supplies or treatment for which the Covered Person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
33. **Medically Necessary** - Charges for services or supplies, which are not Medically Necessary except as specifically stated herein, or to the extent that the charges exceed the Maximum Allowable Amount.
34. **Military Injury, War** - Charges for treatment of a Sickness or Injury suffered or incurred in the course of an act of declared or undeclared war or in the course of, or related to, service in the military forces of any country, including non-military units supporting such forces.
35. **Nerve Stimulators** - Charges for the purchase of TENS nerve stimulators.
36. **No-Fault Auto** - Charges for any treatment or service, which is covered by no-fault (automobile) state provisions or other similar legislation.

37. **Nutritional Support** - Charges for nutritional support that is taken orally. In addition, nutritional support is excluded when administered enterally (feeding tube) or parenterally (intravenous administration) unless determined to be Medically Necessary.
38. **Orthognathic Surgery** - Charges for orthognathic reconstructive surgery.
39. **Osseo-Integrated Implants** - Charges for osseo-integrated implants.
40. **Physician Approval, Scope of License** - Charges for services and supplies that are not recommended and approved by a Physician; or not rendered within the scope of the Physician's license. (If the Physician is not an M.D., then services are only covered if they would otherwise be covered if rendered by an M.D.).
41. **Private Duty Nursing** - Charges for private duty nursing care during a period in which the Covered Person is receiving Home Health Care.
42. **Skin Removal** - Charges for panniculectomy or other surgical removal of excess skin and fat, or other procedure to remove excess skin or fat, unless determined to be Medically Necessary and to not be treatment related to weight loss surgery.
43. **Surrogate Pregnancy** - Charges related to surrogate pregnancies, or charges for the birth expenses of the mother (who is not covered by this Plan) where the covered Employee will adopt the mother's child.
44. **Travel** - Charges for travel, whether or not recommended by a Physician or Nurse, except for charges for Ambulance service to the extent they are otherwise Covered Expenses.
45. **Varicose Veins** - Charges for treatment of varicose veins of extremities, unless determined by the Plan to be Medically Necessary.
46. **Vision** - Charges for vision therapy (orthoptics); eyeglasses or contact lenses; radial keratotomy or any other eye surgery to correct refractive defects of the eye. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.
47. **Weekend Hospital Admission** - Charges for a Hospital admission which occurs between Friday at 8:00 a.m. through Sunday 12:01 p.m. due to a surgery that is to be performed the following Monday or later, unless special circumstances are shown, or because of an Emergency.
48. **Weight Reduction Programs** - Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to, exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and Hospital confinements for weight reduction programs, except as specifically provided herein.
49. **Worker's Compensation -** Charges for treatment of any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, Employer's liability law, or occupational disease law, even though the Covered Person fails to claim rights to such benefits or fails to enroll or purchase such coverage, or if the condition is a result from secondary employment for wage or profit.

Notwithstanding these specific exclusions, if this booklet otherwise specifically provides for payment of a specific Benefit, such other provision shall take precedence over the exclusion. This exception is intended to apply solely to specific Benefits specifically described as covered elsewhere in this booklet, notwithstanding these exclusions. It is not intended to allow general language, such as (but not necessarily limited to) language providing generally that Benefits are paid for "Medically Necessary" care and treatment, to override the terms of an express exclusion described in this Article.

ARTICLE IX
COORDINATION OF BENEFITS, SUBROGATION AND REIMBURSEMENT

This section is intended to prevent the duplicate payment of Benefits, or to prevent reimbursement, with respect to any expense, which exceeds the expense incurred. It applies when a Covered Person is also covered by any other Plan or Plans (as defined in this Section), or is entitled to payments from some other source. When benefits are payable from more than one source, one plan normally pays benefits on a primary basis (as though there were no other source) and the other plan pays a reduced benefit, or pays on a secondary basis. This Plan will always provide coverage either on a primary or secondary basis so that the Benefits it pays, when added to the benefits payable by another source, will not exceed the total allowable expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

DEFINITIONS

This Article contains certain terms, which are defined in a special way. Those definitions follow below. Other defined terms are explained in the Article of this booklet titled, *Definitions*. In the case of ambiguity, terms shall be construed by the Plan Sponsor in a manner consistent with the intention of this Article.

Allowable Expense

An expense which is covered in whole or in part either by this Plan or by the other Plan. It is limited to the Usual, Customary and Reasonable Amount or the "Allowable Amount" for the medical care or treatment provided. Allowable expense is any expense that a provider by law, or in accordance with a contractual agreement, is prohibited from charging a covered person.

Person

Any individual, association, partnership, corporation or any other organization.

Plan

Includes, but is not limited to, any of the following providing payments on account of a Sickness or Injury:

- any group, blanket or franchise health insurance, or coverage similar to same;
- a group contractual prepayment or indemnity plan, or coverage similar to same;
- a Health Maintenance Organization (HMO), whether group practice or individual practice association;
- a labor-management trusted plan or a union welfare plan;
- an employer or multi-employer plan or employee welfare benefit plan;
- a governmental medical benefit program;
- insurance required or provided by statute;
- automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance);
- settlement or judgment proceeds (regardless of the manner in which such proceeds are characterized).

The term "Plan" does not include:

- any individual health insurance policies or contracts;
- public medical assistance programs such as Medicaid; except as otherwise provided herein;
- hospital indemnity or other fixed indemnity;
- accident only;
- specified disease;
- limited benefit health coverage;
- school accident type coverage;
- Medicare Supplemental policies;
- Medicaid policies

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Primary Plan/Secondary Plan

When this Plan is primary, its Benefits are determined before those of the other Plan. The benefits of the other Plan are not considered. When this Plan is secondary, its Benefits are determined after those of the

other Plan. Its Benefits may be reduced because of the other Plan's benefits. When there are more than two Plans, this Plan may be primary as to one and may be secondary as to another.

COORDINATION OF BENEFITS

What this Plan Pays as the Secondary Plan

When this Plan is the Secondary Plan, it considers as the Covered Expense under this Plan the difference (if any) of the total expense minus the amount paid by the Primary Plan. Then, this Plan applies to this remainder any Co-payment and/or Co-insurance amounts and other amounts that would normally apply to a Covered Expense under this Plan.

Secondary Amount Rule

Where this Plan is the Secondary Plan, then notwithstanding any other provision of this Plan to the contrary, the Benefits payable by this Plan are subject to the "secondary amount rule". The "secondary amount rule" applies where the Primary Plan (as determined under applicable coordination of benefits rules) contains a coordination of benefits (or similar type of) provision that reduces the Primary Plan's benefits (either directly or indirectly) on account of the existence of secondary coverage to an amount less than such Primary Plan would have paid had there been no secondary coverage. For example, a Primary Plan might provide that if there is secondary coverage, the Primary Plan's benefits are limited to $1,000. In that event, this Plan will never pay more than the "secondary amount". The "secondary amount" payable by this Plan is the amount this Plan would by its terms pay, as determined by this Plan in its sole discretion, had the Primary Plan paid benefits as though there were no secondary coverage (that is, had the Primary Plan not reduced its benefits on account of the existence of the secondary coverage).

When this Plan is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

Order Of Determination

This Plan determines its order of Benefits using the ***first*** of the following, which applies:

a. **Other Plan Does Not Coordinate**. A Plan that does not coordinate with other Plans is always the Primary Plan.

b. **Non-Dependent/Dependent**. The benefits of the Plan that covers the person as an Employee, laid-off Employee, former Employee, Retired Employee, member or subscriber (other than a Dependent) is the Primary Plan; the Plan which covers the person as a Dependent is the Secondary Plan. However, if that person is a Medicare beneficiary, and if as a result of the provisions of Title XVIII of the Social Security Act and its regulations Medicare is (i) secondary to the plan covering the person as a Dependent, and (ii) primary to the plan covering the person other than as a Dependent (e.g., as a Retired Employee), then the order of benefits is reversed so that the plan covering the person as an Employee, member, subscriber or retiree is secondary and the other plan is primary.

c. **Dependent Child/Parents Not Separated or Divorced**. Except as provided below, in the subsection titled, *Dependent Child/Parents Separated or Divorced*, when this Plan and another Plan cover the same Child as a Dependent of different parents:
   - the Primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The Secondary Plan is the Plan of the parent whose birthday falls later in the year; but
   - if both parents have the same birthday, the benefits of the Plan, which covered the parent the longer, is the Primary Plan; the Plan which covered the parent the shorter time is the Secondary Plan.
   - if the other Plan does not have the birthday rule, but has the gender rule and if, as a result the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

d. **Dependent Child/Separated or Divorced Parents**. If two or more Plans cover a person as a Dependent Child of divorced or separated parents (whether or not the parents were ever married), benefits for the Child are determined in this order:
   - first, the Plan of the parent with custody of the Child;
   - then, the Plan of the spouse of the parent with custody;
   - then the Plan of the parent without custody of the Child;
   - finally, the Plan of the spouse of the parent without custody.

   However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the Child, then that parent's Plan is the Primary Plan. In the case where the parents of a

Dependent Child were never married to each other, these rules shall apply as though such parents were divorced or separated.

e. **Active/Inactive Employee**. The Primary Plan is the Plan that covers the person as an Employee who is neither terminated, laid-off nor retired (or as that Employee's Dependent). The Secondary Plan is the Plan, which covers that person as a former, laid-off or Retired Employee (or as that Employee's Dependent). If the other 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.

f. **Longer/Shorter Length of Coverage**. If none of the above rules determines the order of benefits, the Primary Plan is the Plan, which covered the Employee, member or subscriber longer; the Secondary Plan is the Plan, which covered that person the shorter time.

g. **COBRA or State Continuation**. If a person whose coverage is provided through COBRA or under State Continuation is covered under another plan, the plan covering that person as an Employee (or Dependent) is the primary plan and the COBRA or state continuation plan is secondary. If the other plan does not have this rule and the plans do not agree on order of benefits, this rule is ignored.

h. **If none of these rules determine the order of benefits**. The allowable expenses will be equally shared between the plans meeting the definition of plan. This Plan will not pay more than it would have paid had it been the primary plan.

In order to prevent total payments from exceeding a Covered Person's medical expenses, this Plan may, at its option, defer payment of Benefits until the amount of benefits payable under any other plan has been determined.

Medicare Reduction/Coordination

a. **Active Employees or Dependents of Active Employees Eligible for Medicare Due to Age**. If you are covered under this Plan due to your or someone else's current employment with the Employer, and are also eligible for Medicare due to age, you may:

- continue your coverage under this Plan (to the extent you remain eligible, of course) and defer enrollment in Medicare; or
- continue your coverage under this Plan and also enroll in Medicare; this Plan would be your primary medical coverage and Medicare your secondary medical coverage as long as your coverage under this Plan is attributable to current employment with the Employer; or
- drop your coverage under this Plan and enroll in Medicare, in which case Medicare would be your primary medical coverage.

> ***CAUTION***: If when your coverage ceases due to termination of your or someone else's current employment status with the Employer you (1) are eligible for Medicare, and (2) you elect COBRA coverage under this Plan, you should know three important facts:
>
> - First, your COBRA coverage is not attributable to "current employment status". That means that if you were enrolled in Medicare this Plan would pay *second*, behind Medicare (except in some cases where your Medicare is due to end-stage renal disease).
> - Second, under the Plan, if you're *eligible* for Medicare we'll deem you to be *enrolled* in Medicare, and only pay Benefits after calculating what Medicare *would have paid*. So if you don't enroll in Medicare after losing your coverage attributable to current employment status (that is, if you don't enroll in Medicare when you become eligible for COBRA coverage), ***you may have to pay out-of-pocket the amount Medicare would have paid had you been enrolled***.
> - Third, you have a limited, eight-month special enrollment period for Medicare after your coverage under this Plan ends due to termination of the current employment status. If you wait to enroll in Medicare until after you exhaust COBRA coverage, you may not be able to enroll in Medicare immediately, and you may be required to pay an additional premium for Medicare Parts B and D.
>
> In sum, whether or not you elect COBRA coverage you should consider enrolling in Medicare immediately after your coverage under this Plan ceases to be provided due to your or someone else's current employment status (assuming, of course, you are eligible for Medicare when the current employment status ends).

b. **Covered Persons Eligible for Medicare Due to Disability**. This Plan is primary and Medicare is secondary if you are eligible for Medicare by reason of disability (but not age), and your coverage under this Plan is on account of your (or someone else's) current employment with the Employer. If coverage under this Plan is not on account of current employment status with the Employer and you are eligible for Medicare solely by reason of disability, Medicare is primary and this Plan is secondary. Note that in this

latter case, where this Plan is secondary, this Plan will deem you or the Dependent, as the case may be, to be enrolled in Medicare Parts A and B even if you or the Dependent, as the case may be, is not so enrolled. The rules in this section continue to apply for as long as the Plan has at least 100 participants as described in federal Medicare regulations. ***See the special "Caution" text box above concerning the possible effects of not enrolling in Medicare immediately where Medicare would be your primary payer because of the absence of your or someone else's current employment with the Employer.***

c. **End-Stage Renal Disease (ESRD)**. If you become eligible for Medicare solely on account of end-stage-renal disease (ESRD), then this Plan will be primary to Medicare for up to 30 months (called the "coordination period"); after that, the Plan becomes the secondary payer (assuming you're still eligible for coverage), and Medicare is the primary payer. The coordination period begins on the first day of the month for which you are eligible for Medicare benefits on account of your ESRD, and ends not later than 30 months later (it might end earlier in some cases, such as when your coverage ends under this Plan). If at the time you become eligible for Medicare benefits due to ESRD you are already entitled to Medicare benefits on account of age or disability, and Medicare is the primary payer (and this Plan is secondary), then Medicare remains the primary payer, even after you become eligible for Medicare benefits due to your ESRD. Please note that for purposes of this provision, the coordination period begins in the month you are merely eligible for Medicare benefits due to ESRD, whether or not you actually enroll in Medicare then.

Medicaid and State Children's Health Insurance Program Coordination
This Plan will always be primary, and any Medicaid or State Children's Health Insurance Program will be secondary only.

Coordination With Automobile Insurance Coverage
This Plan's liability for otherwise Covered Expenses arising out of an automobile Accident is based on the type of automobile insurance law enacted by your state. Currently there are three types of state automobile laws (i) No-fault automobile laws; (ii) Financial responsibility laws; and (iii) Other automobile liability insurance laws. It is the Plan's general intent not to pay medical expenses resulting from automobile Accidents, and the Plan will be so interpreted.

a. **Coordination Under Auto No-Fault Coverage**. Except as required by law, the Plan is secondary to any no-fault automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a no-fault automobile insurance policy nor does it intend to be primary in order to reduce the premiums or costs of no-fault automobile coverage. If you incur Covered Expenses as a result of an automobile Accident (either as a driver, passenger or pedestrian), the amount of Covered Expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage; and
- any Co-payment under the automobile coverage; and
- any expense properly excluded by the automobile coverage that is a Covered Expense; and
- any expense that the Plan is required to pay by law.

An individual is considered to be covered under an automobile insurance policy if he or she is either:

- an owner or principal named insured of the policy; or
- a family member of a person insured under the policy; or
- a person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

b. **Coordination Under Financial Responsibility Law**. This Plan is secondary to automobile coverage or to any other party who may be liable for your medical expenses resulting from the automobile Accident. If your state has a "financial responsibility" law which does not allow the Plan to pay Benefits as secondary or which does not allow the Plan to pay advance payments with the intent of subrogating or recovering the payment, the Plan will not pay to you or on your behalf any Benefits related to an automobile Accident.

c. **Coordination Under Other Automobile Liability Insurance**. If your state does not have a no-fault automobile insurance law or a "financial responsibility" law, this Plan is secondary to any applicable automobile insurance coverage or to any other party who may be liable for the automobile Accident.

Coordination With Underinsured/Uninsured Motorist Coverage
If you are involved in an automobile Accident and as a result of the Accident the Plan pays Benefits, and if you receive a settlement or judgment under an uninsured or underinsured motorist policy, the Plan is entitled to receive, from the proceeds of the uninsured or underinsured motorist coverage, an amount equal to the Covered Expenses paid or payable by the Plan whether or not the proceeds are characterized as reimbursement for medical expenses, and whether or not the proceeds are sufficient to make you "whole". The amounts payable to the Plan shall not be reduced on account of your expenses, including attorneys' fees, unless the Plan specifically agrees, in writing, to such a reduction. The Plan may, in the sole discretion of the Plan Sponsor, agree to payment of Benefits prior to the receipt by you of any recovery from the uninsured or underinsured motorist policy, and you agree, as a condition of your and your eligible Dependents' coverage under this Plan, to remit to the Plan the proceeds of any recovery received from an uninsured or underinsured motorist policy up to the amounts paid or payable by the Plan.

Any Covered Expenses paid or payable by the Plan, which are in excess of the proceeds received by the uninsured or underinsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

TRICARE Coordination Rules
Notwithstanding any provision of this Plan to the contrary, the following rules shall apply:

a. This Plan shall not offer any financial or other incentives for a TRICARE-eligible Employee not to enroll (or to terminate enrollment) in this Plan in the situation where this Plan would (in the case of enrollment) be a Primary Plan, in the same manner as the provisions of the Social Security Act apply to prohibit the offering of any financial or other incentives for an individual entitled to Medicare benefits not to enroll (or to terminate enrollment) under a group health plan or large group health plan which would (in the case of enrollment) be a Primary Plan.

b. A TRICARE-eligible Employee shall have the opportunity to elect to participate in this Plan and receive primary coverage for health care services under the Plan in the same manner and to the same extent as similarly situated Employees who are not TRICARE-eligible Employees.

For purposes of this provision, the term "TRICARE-eligible Employee" means a covered beneficiary under 10 U.S.C. Section 1097c(f)(3) who is entitled to health care benefits under the TRICARE program.

These TRICARE coordination rules shall not apply to any employer who has fewer than 20 employees.

RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF
Corrective Payments
Whenever payments which should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any other Plans, this Plan shall have the right to pay to any persons making such other payments any amounts they determine to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts so paid shall be deemed to be Benefits paid under this Plan and, to the extent of such payments; this Plan shall be fully discharged from liability.

Reimbursement
Whenever this Plan makes payments which together with the payments the Covered Person has received or is entitled to receive from any other Plan or Person, exceed the maximum amount necessary to satisfy the intent of this provision; or exceed, under the terms of this Plan, the Benefits properly payable to the Covered Person, Plan, provider or Person to or for or with respect to whom the payments were made, this Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Sponsor in its sole discretion shall determine:

- the Covered Person;
- if the Covered Person is an eligible Dependent or former eligible Dependent, the eligible Employee or former eligible Employee with respect to whom the Covered Person is or was an eligible Dependent;
- any other Plan, provider or Person to or for or with respect to whom such payments were made;
- any insurance company or other Plan or person which should have made the payment; and
- any other organizations.

Alternatively, the Plan Sponsor or its designee may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the future, under this Plan to one or more of the Covered Person, Plans, Persons, providers, insurance companies or other organizations as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Person or by a health care provider who treated the Covered Person, and the Plan Sponsor or its designee later determine that the claim was for an expense not covered under this Plan, the Plan is entitled to recover the payment from the Covered Person or the provider, or to recover part of the payment from the Covered Person and part from the provider, or set-off the amount of the payment from amounts the Plan may owe in the future to the Covered Person or the provider or both. This same rule applies if the Plan makes payment to a Covered Person or a provider of an expense which is a Covered Expense, but the amount so paid exceeds the amount the Plan requires be paid.

These Reimbursement provisions also apply where this Plan makes payments of Covered Expenses incurred for treatment of a Sickness or Injury for which another Plan or Person (as defined in these coordination and reimbursement/subrogation provisions) is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the Sickness or Injury. If the other Plan or Person makes payment to or on behalf of a Covered Person as compensation for the Sickness or Injury, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from the Covered Person (or anyone who received such payment on behalf of the Covered Person) from the payment made by the other Plan or Person, in an amount equal to (i) the lesser of the Benefits paid by this Plan for treatment of the Sickness or Injury, or (ii) the amount of the payment made by the other Plan or Person. This provision shall not apply where the other Plan is a health plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Person's Covered Expenses.

These reimbursement provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Covered Person (or, in the Plan's sole discretion) from any other Person who received payment on behalf of the Covered Person (such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Person and any other Person, such as the Covered Person's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any Person (such as the Covered Person's legal counsel) other than the Covered Person (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Person) where the Plan can be made whole entirely from amounts actually received by the Covered Person (or the Person, such as a parent or legal guardian, who received such amounts on behalf of the Covered Person). This same rule shall apply to the Plan's rights to set-off as described above.

In addition, where another Plan or Person (as defined in this Article) pays compensation to or on behalf of a Covered Person for a Sickness or Injury for which another Plan or Person is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise Covered Expenses for treatment of the Sickness or Injury, a special rule applies. In such a case, such otherwise Covered Expenses which were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, shall be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Person, over the Covered Expenses which the Plan has already paid for treatment of the Sickness or Injury.

This Plan shall not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Covered Person in connection with any recovery from any other Plan or Person unless this Plan agrees, in writing, to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether in a settlement agreement or otherwise, shall not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable Covered Expenses pursuant to these provisions.

Subrogation

The Plan shall be subrogated, to the extent of Benefits paid or payable by this Plan, to any monies (i.e., "first dollar" monies) paid or payable by any other Plan or Person (as defined in this Article) by reason of the Sickness or Injury which occasioned or would occasion the payment of Benefits by this Plan, whether or not those monies are sufficient to make whole the Covered Person to whom or on whose behalf this Plan made its payments or to whom or on whose behalf this Plan's payments are payable. The Plan shall not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Covered Person in connection with any efforts to recover monies from any other plan, unless this Plan agrees, in writing, to pay a portion of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether under a settlement agreement or otherwise, shall not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.

These subrogation provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from the Covered Person (or, in the Plan's sole discretion) any other Person who received payment on behalf of the Covered Person (such as a parent or guardian) by, for example, apportioning

liability for satisfaction of the subrogation lien among the Covered Person and any other Person, such as the Covered Person's legal counsel.

This Plan shall also be subrogated to the extent of Benefits paid under this Plan to any claim a Covered Person may have against any other Plan or Person for the Sickness or Injury which occasioned the payment of Benefits under this Plan. Upon written notification to the Covered Person, this Plan may (but shall not be required to) collect the claim directly from the other Plan or Person in any manner this Plan chooses without the Covered Person's consent. This Plan shall apply any monies collected from the other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining shall be paid to you as soon as administratively practical. The Plan Sponsor may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

Implementation
The Plan Sponsor shall determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue. The Plan Sponsor may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (i) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (ii) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

Where this Plan is entitled to reimbursement or subrogation under the provisions of this section, the Plan shall be permitted to obtain reimbursement or satisfy its subrogation lien by reducing Benefits payable to the Covered Person and/or, in the Plan's discretion, any covered member of the Covered Person's family, for Covered Expenses then incurred but not yet paid, and for Covered Expenses incurred in the future.

Subrogation/Reimbursement Agreement
Except as otherwise provided herein (e.g., the coordination rules regarding automobile insurance), if a Covered Person incurs a Sickness or Injury under circumstances where compensation may be payable to the Covered Person by some other Plan or Person (as defined in this Article), the Plan is not required to pay Benefits for treatment of the Sickness or Injury (notwithstanding any other provision of this Plan to the contrary), but may agree to pay Benefits for that Sickness or Injury to the extent otherwise payable under the Plan. As a condition of paying such Benefits, the Plan may (but is not required to) require the Covered Person or someone legally qualified and authorized to act for the Covered Person, in writing, to:

- consent to the Plan's subrogation of any recovery or right of recovery the Covered Person has with respect to the Sickness or Injury;
- promise not to take any action which would prejudice the Plan's subrogation rights;
- promise to reimburse the Plan for any such Benefits payments to the extent that the Covered Person receives a recovery from another Plan or Person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Covered Person whole. This reimbursement must be made within 30 days after the Covered Person (or anyone on his or her behalf) receives the payment; and
- promise to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose.

In the event the Covered Person fails to, or refuses to execute whatever assignment, form or document requested by the Plan Sponsor or its designee, the Plan shall be relieved of any and all legal, equitable or contractual obligation for any Benefits or Covered Expense incurred by the Covered Person and each member of the Covered Person's family, including claims not yet incurred and claims then incurred but unpaid.

Nothing in this Reimbursement Agreement provision shall be construed to prevent application of the provisions of the Reimbursement provisions of this Plan, regarding the Plan's exclusion of otherwise Covered Expenses which have not been paid at the time the Covered Person receives compensation for the Sickness or Injury which gave rise to the expenses.

Constructive Trust
In the event the Plan, pursuant to these Reimbursement and Subrogation provisions, is entitled under such provisions to be reimbursed for Benefits it has paid for treatment of a Covered Person's Sickness or Injury, and where the Covered Person or someone (including an individual, estate or trust) on behalf of the Covered Person receives or is entitled to receive compensation for such Sickness or Injury from some other source, the Plan shall have a

constructive trust on such compensation to the extent of the Benefits paid by this Plan. Such constructive trust shall be imposed upon the person or entity then in possession of such compensation.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this Plan or any other plan, the Plan Sponsor may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Sponsor deems to be necessary for such purposes, with respect to any person claiming Benefits under this Plan. Any person claiming Benefits under this Plan shall furnish to the Plan Sponsor such information as may be necessary to implement this provision.

ARTICLE X
COBRA CONTINUATION COVERAGE

Eligible Employees and Dependents have the opportunity to continue their coverage in certain instances where coverage would otherwise terminate. Such continuation coverage is as described in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and is therefore sometimes referred to as "COBRA Continuation Coverage". This notice is intended as a summary of a Covered Person's rights and obligations under the provisions of that law.

ENTITLEMENT AND QUALIFYING EVENTS

Qualifying Events

Under COBRA, a covered Employee or covered Dependent may elect to continue health coverage if that coverage would otherwise terminate due to a "qualifying event". Qualifying events are:

a. a covered Employee's termination of employment, for reasons other than gross misconduct, or reduction in work hours;
b. death of the covered Employee;
c. divorce or legal separation of the covered Employee and his spouse or legal termination of a domestic partnership (for those grandfathered prior to 06/01/17);
d. a covered Dependent Child's ceasing to satisfy the Plan's definition of *Dependent Child*; or
e. a covered Employee's entitlement to Medicare.

COBRA Qualified Beneficiaries

A COBRA Qualified Beneficiary is an individual who is entitled to COBRA Continuation Coverage. In addition to those individuals covered under the Plan immediately preceding a qualifying event, a Child born to a Qualified Beneficiary who is a former covered Employee or who is adopted by or placed for adoption with such a former covered Employee, during the Employee's period of COBRA Continuation Coverage, is also a COBRA Qualified Beneficiary.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Douglas County, and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee is a Qualified Beneficiary with respect to the bankruptcy. The Retired Employee's spouse, surviving spouse, and Dependent Children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

NOTIFICATION OF A QUALIFYING EVENT

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Sponsor or its designee has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, your death, commencement of a proceeding in bankruptcy with respect to the Employer, or your enrollment in Medicare (Part A, Part B or both), the Employer must notify the Plan Sponsor or its designee of the qualifying event within 30 days of any of these events (of course, where the Plan Sponsor or its designee is the Employer, there's no need for the Employer to notify itself of these events).

You must notify the Plan Sponsor or its designee (at the address listed below) within 60 days of a divorce or legal separation, or other legal action for terminating a domestic partner relationship (for those grandfathered prior to 06/01/17), of a Child ceasing to meet the Plan's definition of "*Dependent*", or of the Social Security Administration's determination of disability. In addition, if you were a disabled individual who obtained 29 months of COBRA Continuation Coverage, you must notify the Plan Sponsor or its designee of any determination by the Social Security Administration that you are no longer disabled. Notification to the Plan Sponsor or its designee must be made within 30 days of the date such determination is made.

Notice for the qualifying events described above must be sent, ***in writing*** (describing the qualifying event and the date it occurred) to:

Douglas County
Administrative Services
1100 Massachusetts, Unit 204
Lawrence, KS 66044
Phone: (785) 832-5327
Fax: (785) 838-2423

MAXIMUM COVERAGE CONTINUATION PERIODS

General Rules

Coverage under COBRA may continue for up to:

a. eighteen (18) months if you are an Employee or Dependent whose coverage would cease because of a termination of employment or reduction in work hours; or

b. twenty-nine (29) months (i.e. 18 plus 11) if you are a disabled individual who:
   - becomes entitled to the 18 months of continued coverage available after an Employee's termination of employment or reduction in work hours;
   - is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA Continuation Coverage; and
   - notifies the Plan of that disability determination within 60 days after you receive it and while you are still purchasing your first 18 months of COBRA.

   please note that you are eligible for this additional 11 months of coverage, even if you are not disabled, if you are entitled to COBRA Continuation Coverage due to the same qualifying event that entitles a disabled person to the additional 11 months of coverage.

c. thirty-six (36) months, if you are a divorced or widowed spouse or domestic partner (for those grandfathered prior to 06/01/17), or a Child who has ceased to be a "*Dependent*" under the terms of the Plan.

Multiple Qualifying Events

If a Dependent is eligible to choose and chooses to continue coverage under these provisions after an Employee's termination of employment or reduction in work hours, and then another COBRA qualifying event (other than termination of employment or reduction in work hours) occurs during the original COBRA Continuation Coverage period, that Dependent may continue coverage for up to 36 months, measured from the date of the initial qualifying event. However, for an event to operate as a *second* qualifying event, it must be an event that would have triggered a loss of coverage had it been the *initial* qualifying event. *In no case will any period of COBRA Continuation Coverage exceed 36 months*. The Plan Sponsor or its designee must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent, in writing, to the appropriate person described above. Please note that for the Employee's Medicare entitlement to be considered a second qualifying event for eligible Dependents, the Plan must provide that Medicare entitlement causes a loss of coverage for the Dependents.

Special Continuation of Coverage Period for Medicare Entitlement

When an individual becomes entitled to Medicare and then, within 18 months thereafter, experiences a qualifying event that is loss of coverage due to termination of employment or reduction in work hours, the COBRA Continuation Coverage period for the Dependent spouse or Dependent Children may continue for up to 36 months from the date of the Medicare entitlement.

SPECIAL TRADE ACT EXTENSION

Special COBRA rights apply to eligible Employees who lose health coverage as a result of termination or reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These special rules were added to the Trade Act in 2002. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the Employee begins receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begins receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after the Employee's group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 1974, you may contact Douglas County for additional information. You must contact Douglas County promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights.

EARLY TERMINATION OF COBRA COVERAGE

Once you elect to continue your coverage, your coverage may continue for the period described above, unless:

a. you were entitled to 29 months of COBRA Continuation Coverage (due to your or another person's disability), the Social Security Administration determines that you (or such other person) are no longer disabled, in which case your extended COBRA Continuation Coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination;

b. you become entitled to Medicare, after the date you elect COBRA Continuation Coverage;
c. you fail to make a required monthly payment within the 30 day grace period pursuant to this provision;
d. you become covered - after the date you elect COBRA Continuation Coverage - under another employer group health plan (because of employment or otherwise); or
e. the Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

BENEFITS THAT MAY CONTINUE

If you elect COBRA Continuation Coverage, it will be identical to the health coverage then being provided under the Plan to active Employees or, if you are a Dependent, to covered Dependents of active Employees. You do not have to prove insurability to choose Continuation Coverage, but you do have to pay for it.

APPLICATION AND PAYMENT PROCEDURES

After you experience a COBRA qualifying event (and provide any notice required by the preceding, *Notification of a Qualifying Event*, section of this Plan), you will be sent a more detailed notice and an Application for Continued Coverage. To continue coverage under COBRA, you must complete and return the Application to the Plan Sponsor or its designee (the COBRA election notice will show to whom you should send the payment) within 60 days from the later of the date the Application is sent to you or the date your coverage would otherwise terminate.

Your payment for the period from the date your coverage would otherwise terminate through the 45th day after COBRA Continuation Coverage is elected must be made by that 45th day (for example, if you elect COBRA Continuation Coverage on the 30th day after the start of your 60-day election period, you must make your first payment by the 75th day after the start of your election period, and the payment must be for the period of COBRA Continuation Coverage from the date you would otherwise lose coverage to that 75th day). Thereafter, payments must be made within thirty-one (31) days after the monthly premium due date to be considered timely (for practical purposes, a payment due on the first of the month is considered timely if postmarked by the 31st of that month, or in the advent of a shorter month, by the 30th day following the 1st of the month). The Plan will terminate coverage as of the qualifying event, but will reinstate it retroactively to the date of the qualifying event if a timely election for COBRA Continuation Coverage, and timely initial payment, are made.

Although you may receive a monthly bill, payment coupons or any other payment reminder from the Plan Sponsor or its designee, the Plan is not required to send you such payment information. Failure to remit your premium on time even because you did not receive a bill or reminder will not be reason for your coverage to be reinstated once it has ended.

The monthly cost of COBRA Continuation Coverage will be set for 12-month periods by the Plan Sponsor, or its designee, and will not exceed 102% of the cost of coverage under the Plan for similarly situated Covered Persons. However, if you qualify for periods of extended coverage due to a disability (whether yours or another Qualified Beneficiary's), the monthly COBRA premium during the period of extended coverage may be 150% of the cost of coverage under the Plan for similarly situated Covered Persons, depending on whether the disabled person continued coverage during the extended coverage period.

QUESTIONS AND MORE INFORMATION

If you have questions about your COBRA Continuation Coverage, you should contact:

Trustmark Health Benefits, Inc.
C/O COBRA Department
5200 77 Center Drive, Suite 400
Charlotte, NC 28217-0718
1-866-433-0318 ext 44507

or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

In order to protect your family's rights, you should keep your Plan Sponsor or its designee informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Plan Sponsor or its designee.

OTHER METHODS OF CONTINUING COVERAGE

Family and Medical Leave Act

Regardless of the established leave policies of the Employer, the Plan shall at all times comply with the Family and Medical Leave Act of 1993 as outlined in the regulations issued by the Department of Labor, to the extent that Act applies. During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same basis as coverage would have been provided if you had been continuously employed during the entire leave period.

Uniformed Services Employment and Reemployment Rights Act

You may have certain rights to continue or reacquire coverage if you engage in periods of uniformed service, and satisfy certain requirements upon the completion of that service. Your Plan Sponsor has additional information about these special rules.

ARTICLE XI
CLAIM APPEAL PROCEDURES

Written proof of claim for each eligible expense must be given to the Claim Supervisor or the Plan Sponsor within ninety (90) days after the close of the Plan Year in which the expense is incurred. Terminated Employees (and their Dependents) must file all incurred but unfiled claims within ninety (90) days after the close of the Plan Year after the termination of their coverage. In the event of the Plan's termination, you must file all incurred but unfiled claims within ninety (90) days after the close of the Plan Year after the Plan's termination.

Where a claim's submission date is within the appropriate claim-filing deadline, and the claim is later supplemented or resubmitted (either because the initial submission was incomplete, or the Claimant understated the amount due to it, or for any other reason), the initial claim submission date does not apply to the later supplementation or resubmission. The intent of this paragraph is to require the resubmitted claim to be filed within the deadlines described in the preceding paragraph.

Payment of any claim will be made to the Employee unless he/she has previously authorized payment to any entity rendering covered services, treatment or supplies. If the Employee dies before all Benefits have been paid, the remaining Benefits may be paid to any relative of the Employee or to any person appearing to the Plan Sponsor to be entitled to payment. The Plan Sponsor shall fully discharge its liability by such payments.

In the event of a denial or limitation of any Benefit or payment due to or requested by any Claimant, such Claimant shall be given a written Explanation of Benefits (EOB) containing information about the denial or limitation of his Benefit. Upon request, the Plan will inform the Claimant of the specific Plan provisions upon which the denial or limitation was based.

In the event of a denial or limitation of any Benefit, the Claimant or his duly authorized representative shall be permitted to review pertinent documents and to submit issues and comments, in writing, to the Plan Sponsor. In addition, the Claimant or his duly authorized representative may make a written request for a full and fair review of the claim and its denial by the Plan Sponsor (or its delegate to receive such requests) within sixty (60) days after receipt by the Claimant of written notification of the denial or limitation of the claim. The sixty (60) day requirement may be waived by the Plan Sponsor in appropriate cases.

Where an appeal's submission date is within the appropriate deadline, and the appeal is later supplemented or resubmitted (either because the initial submission was incomplete, or for any other reason), the initial appeal submission date does not apply to the later supplementation or resubmission. The intent of this paragraph is to require the resubmitted appeal to be filed within the deadlines described in the preceding paragraph. In the case of an incomplete appeal, however, in no event shall the Plan refuse to accept for processing a resubmission or supplementation of such an appeal that is resubmitted or supplemented within the deadline described in the preceding paragraph.

A decision shall be rendered by the Plan Sponsor within sixty (60) days after the receipt of the request for review, provided that where special circumstances require an extension of time to process the decision, it may be postponed on written notice to the Claimant (prior to the expiration of the initial sixty (60) day period) for an additional sixty (60) days, but in no event shall the decision be rendered more than one hundred and twenty (120) days after the receipt of such request for review.

Any decision by the Claim Supervisor shall be furnished to the Claimant, in writing, and in a manner calculated to be understood by the Claimant and shall set forth the specific reason(s) for the decisions and the specific Plan provision(s) on which the decision is based.

The Claim Supervisor shall have no power to add to, subtract from, or modify any of the terms of the Plan, or to change or add to any Benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a Benefit under the Plan.

External Appeal

The Claimant, or the Claimant's authorized representative, may request a review of a denied claim by making written request to the Claim Supervisor or Plan Administrator, within four (4) months of receipt of notification of the final internal denial of Benefits. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of Benefits. {*Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or*

Federal holiday.} The Claim Supervisor or Plan Administrator may charge a filing fee to the Claimant requesting an external review, subject to applicable laws and regulations.

Right to External Appeal
Within five (5) business days of receipt of the request, the Claim Supervisor will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

1. Medical judgment; or
2. Rescission of coverage under this Plan.

Notice of Right to External Appeal
The Plan Administrator (or its designee) shall provide the Claimant (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. the reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review.

2. if the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the Claimant to perfect the external review request by the later of the following:
   a. the four (4) month filing period; or
   b. within the forty-eight (48) hour time period following the Claimant's receipt of notification.

Independent Review Organization
An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review.

Notice of External Review Determination
The assigned IRO shall provide the Plan Administrator (or its designee) and the Claimant (or authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the Claimant, the Plan and Claim Supervisor, except to the extent that other remedies may be available under State or Federal law.

Expedited External Review
The Plan Administrator (or its designee) shall provide the Claimant (or authorized representative) the right to request an expedited external review upon the Claimant's receipt of either of the following:

1. A denial of Benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the Claimant or the Claimant's ability to regain maximum function and the Claimant has filed an internal appeal request.

2. A final internal denial of Benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the Claimant or the Claimant's ability to regain maximum function or if the final determination involves any of the following:
   a. an admission,
   b. availability of care,
   c. continued stay, or
   d. a health care item or service for which the Claimant received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for *Expedited External Review*, the Plan will do all of the following:

1. perform a preliminary review to determine whether the request meets the requirements in the section, *Right to External Appeal.*
2. send notice of the Plan's decision, as described in the section, *Notice of Right to External Appeal.*

Upon determination that a request is eligible for external review, the Plan will do all of the following:

1. assign an IRO as described in the section, *Independent Review Organization;* and
2. provide all necessary documents or information used to make the denial of Benefits or final denial of Benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, *Notice of External Review Determination*. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the Plan Administrator (or its designee) and the Claimant (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

ARTICLE XII
GENERAL INFORMATION

Employer/Plan Sponsor

Douglas County and other eligible entities

Address and Telephone Number

1100 Massachusetts, Unit 204
Lawrence, KS 66044
(785) 832-5327

Name of Plan

Douglas County Employee Benefit Trust

Plan Effective Date

This restated Plan is effective June 1, 2021.

Identification Numbers

Employer Tax ID No.: 48-6033538

Funding Method

The Plan is self-funded (that is, Benefits are not provided or guaranteed by an insurance company), and is financed by the Employer, which either deposits monies to pay Benefits under the Plan into a trust, or maintains reserves from its own general assets for the purpose of paying Plan Benefits or both; and by contributions from Employees and former Employees and certain Dependents or former Dependents of Employees or former Employees, if such contributions are required. If such contributions are required, you will be notified from time to time by the Employer about the amount of such contributions. These notifications should be considered part of this Plan summary.

The Plan might maintain "reinsurance" or "stop-loss" insurance to protect the Plan in the event claims exceed projections. However, such insurance insures the Plan against liabilities which exceed pre-determined levels, and does not insure covered Employees and Dependents, and no Benefits are payable by the insurer to or on behalf of individual covered Employees or covered Dependents. The existence of "reinsurance" or "stop-loss" insurance does not in any way mean that Benefits are payable or guaranteed by an insurance company.

Type of Administration

The claims under this self-funded Plan are administered by the Claim Supervisor under a contract with the Plan Sponsor.

Name and Address of Agent for Service of Legal Process

Douglas County
1100 Massachusetts, Unit 204
Lawrence, KS 66044
(785) 832-5327

Source of Contributions and Method of Funding

The contributions necessary to finance the self-funded Plan are made by the Employer. You may be required to contribute to the cost of the Plan, either on your own behalf or on behalf of your Dependents or both.

Fiscal Year

This Plan's fiscal year is from June 1 through May 31.

ACTIONS AT LAW
The decision by the ***plan administrator/claims processor*** on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. All claim review procedures provided for in this ***Plan*** Document must be exhausted before any legal or equitable action is brought. Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the ***Plan***, ***plan administrator/claims processor***, any other fiduciary, or their employees, must be filed within one (1) year from the date all claim review procedures provided for in this ***Plan*** Document have been exhausted.

PAYMENT OF BENEFITS
All Benefits are payable when the Plan Sponsor receives written proof of loss. All Benefits are payable to the covered Employee, unless assigned.

WORKER'S COMPENSATION
This Plan and the Benefits provided are not in lieu of, nor shall affect any requirements for coverage under any worker's compensation law or other similar law.

FACILITY OF PAYMENT
If a Claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Plan Sponsor, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until claim is made by a guardian. If a Claimant dies while Benefits remain unpaid, Benefits will be paid, at the Plan Sponsor's option to:

- a person or institution on whose charges claim is based; or
- a surviving relative (spouse, parent or Child)

Such payment will release the Plan Sponsor of all further liability to the extent of payment.

ASSIGNMENT
The Benefits provided under this Plan shall not be assignable without the consent of the Plan Sponsor. The Employee may authorize the Plan Sponsor to pay Benefits directly to the Hospital, Physician or other party providing medical treatment. Any such payment will discharge the Plan Sponsor to the extent of payment made. Unless permitted by law, payments may not be attached, nor be subject to the Employee's debts.

RECORDS
The Plan Sponsor will keep records of the Covered Persons under the Plan. Such records will include the following:

- covered persons by name, age and amount of coverage;
- effective date of coverage and date coverage ends;
- change of status;
- other related data.

EXAMINATION
The Plan Sponsor has the right to have the Claimant examined, as often as reasonably necessary while a claim is pending. Benefits are payable under this Plan only if they are Medically Necessary for the Sickness or Accidental Injury of the participant. This Plan reserves the right to make a utilization review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

NOTICE OF PAYMENT
If the Plan Sponsor cannot locate any person to whom a payment is due, after three (3) months from the date such payment is due, a notice of payment due will be mailed to the last known address of that person. If within three (3) months after that mailing, such person has not made written claim, the Plan Sponsor may direct that such payment and all remaining payments otherwise due to such person be canceled. The Plan shall have no further liability upon such cancellation.

FREE CHOICE OF PHYSICIAN
Generally, the Covered Person shall have free choice of any legally qualified Physician or surgeon and the Physician/patient relationship shall be maintained. The Plan may, however, pay a larger percentage of Covered Expenses if care is received from certain providers.

WAIVER OR ESTOPPEL
No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

RESPONSIBILITY FOR PAYMENT OF CLAIMS
The Plan shall be the sole source of Benefits under the Plan, and to the maximum extent permitted by law, the Plan Sponsor assumes no liability or responsibility for payment of Benefits, and each Employee or other person who shall claim the right to any payment with respect to Benefits under the Plan shall be entitled to look only to the Plan for such payment and shall not have any right, claim or demand thereof against the Plan Sponsor or the medical board or any officer, Employee or director of the Plan Sponsor. The Claim Supervisor shall similarly have no liability or responsibility to fund Benefit payments under the Plan.

CONSTRUCTION
Wherever found in this Plan, a masculine pronoun includes the feminine pronoun.

PLAN INTERPRETATION
The Plan Sponsor has full discretionary authority to interpret and apply all Plan provisions (this includes the power to make factual findings and determinations), including, but not limited to, all issues concerning eligibility for and determination of Benefits. The Plan Sponsor may contract with an independent administrative firm to process claims, maintain Plan data and perform other Plan connected services; however, final authority to construe and apply the provisions of the Plan rests exclusively with the Plan Sponsor. Decisions of the Plan Sponsor shall be final and binding, and subject to the most deferential standard on review.

PROTECTION AGAINST CREDITORS
No Benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Sponsor shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Sponsor in its sole discretion may terminate the interest of such Covered Person or former Covered Person, his spouse, parent, adult, Child, guardian of a minor Child, brother or sister, or other relative or a Dependent of such Covered Person or former Covered Person, as the Plan Sponsor may determine, any such application shall be complete discharge of all liability with respect to such Benefit payment.

PLAN AMENDMENTS
This document contains all the terms of the Plan and may be amended from time to time by the Plan Sponsor in its sole discretion. Any changes so made shall be binding on each Covered Person referred to in this Plan Document.

TERMINATION OF PLAN
The Plan Sponsor reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the Plan Sponsor shall continue to be issued for the purpose of paying Benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar health Benefits to Covered Persons, until all contributions are exhausted. The Plan Sponsor specifically reserves the right to eliminate, reduce or otherwise modify coverage for retired Employees and their Dependents at any time.

PLAN IS NOT A CONTRACT
This Plan document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Employee of the Employer the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Employee.

SUMMARY PLAN DESCRIPTIONS
Each Employee covered under this Plan will be issued an individual Summary Plan Description, which may be satisfied by provision of this booklet, describing the Benefits to which the Covered Persons are entitled, to whom Benefits are payable, and summarizing the provisions of the Plan.

MISSTATEMENT OF AGE
If the age of the Covered Person has been misstated and if the amount of the contribution is based on age, an adjustment of contributions shall be made on the Covered Persons true age. If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverage and amount of Benefits, or both, for which the person is covered shall be adjusted in accordance with the Covered Persons true age. Any such

misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and Benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

FRAUD OR INTENTIONAL MISREPRESENTATION

If you, or anyone acting on your behalf, makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the Covered Person, or from any other person responsible for misleading the Plan, and from the person for whom the Benefits were provided. Any fraud or intentional misrepresentation of a material fact on the part of you or an individual seeking coverage on behalf of the individual in making application for coverage, or any application for reclassifications thereof, or for service there under is prohibited and shall render the coverage under this Plan null and void.

GOVERNING LAW

The Plan is established in and subject to the law of the State of Kansas, to the extent federal law does not apply.

ARTICLE XIII
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 PRIVACY & SECURITY REQUIREMENTS

INTRODUCTION

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to Covered Persons remains confidential, subject to limited exceptions in which PHI may be disclosed. "Protected Health Information" means health information (including oral information) that:

- is created or received by health care providers, health plans or health care clearinghouses;
- relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and
- identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

HIPAA also imposes special requirements upon the Plan and the Employer with respect to *electronic* PHI ("ePHI"). Electronic PHI is PHI, as defined above, that is transmitted by or maintained in "electronic media", as that term is defined in federal regulations, specifically 45 C.F.R. § 160.103.

EFFECTIVE DATE

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy and Security regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan.

DISCLOSURES OF PHI/ePHI BY THE PLAN TO THE EMPLOYER

The Plan (or the Employer on behalf of the Plan) provides to Covered Persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI/ePHI (relating to a Covered Person) to the Employer, as further described below, without the consent or authorization of the Covered Person. In no event may the Plan disclose PHI/ePHI to the Employer, without the consent or authorization of the Covered Person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Employer (although the Plan may disclose summary ePHI or enrollment-related ePHI to the Employer, without authorization, as further described below).

The Plan may disclose PHI/ePHI to the Employer, without the consent or authorization of the Covered Person, subject to the Employer's obligations described below (in the sections titled, *Employer Obligations with Respect to PHI Obtained from the Plan* and *Additional Employer Obligations with Respect to ePHI Obtained from the Plan*) for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, auditing and monitoring. However, only the minimum amount of PHI/ePHI necessary to accomplish a particular Plan administrative function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI/ePHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information, including electronic summary health information, to the Employer, without the consent or authorization of the Covered Person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information, including electronic enrollment and disenrollment information, to the Employer without the consent or authorization of the Covered Person.

EMPLOYER OBLIGATIONS WITH RESPECT TO PHI OBTAINED FROM THE PLAN

As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Person to whom the PHI relates;
- ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;

- not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the Covered Person to whom the PHI relates;
- report to the Plan any improper uses or disclosures of the PHI;
- provide Covered Persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);
- make available to appropriate federal authorities the Employer's internal practices, books and records relating to the use and disclosure of PHI received from the Plan; and
- return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

ADDITIONAL EMPLOYER OBLIGATIONS WITH RESPECT TO ePHI OBTAINED FROM THE PLAN

As a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan;
- ensure that the adequate separation (as required by 45 C.F.R. § 164.504(f)(2)(iii)), between the ePHI and persons who have no legitimate need to access such ePHI, is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- report to the Plan any security incident of which it becomes aware.

USE AND DISCLOSURE OF PHI BY THE EMPLOYER; DISPUTE RESOLUTION

When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to the human resources or employee benefits department of the Employer, and may also be provided to the Employer's payroll department (for purposes of processing payroll deductions for payment of premium) and chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the Covered Person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in the section above titled, *Disclosures of PHI by the Plan to the Employer*. The Employer may also disclose PHI relating to a Covered Person, without the consent or authorization of the Covered Person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the Covered Person, to law enforcement, public health and judicial agencies in certain circumstances. PHI pertaining to a minor Covered Person may, to the extent permitted by local law, be disclosed to the Covered Person's parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the Covered Person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a Covered Person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the human resources or employee benefits department for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which you should have already received (an additional copy is available from the human resources or employee benefits department). If the complaint is filed with the Privacy Official, the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.

APPENDIX A
RETIRED EMPLOYEE COVERAGE

This Retired Employee Coverage Appendix applies only to former Employees who have coverage under the Plan on account of their status as Retired Employees (as defined in this Appendix). The purpose of this Appendix is to describe differences between the coverage provided to Employees and their Dependents, and the coverage provided to Retired Employees and their Dependents.

Where the terms of this Appendix expressly describe a Benefit, right, responsibility or limitation applicable to a Retired Employee, which contradicts a Benefit, right, responsibility or limitation (as described in the preceding pages of this booklet) applicable to an Employee, the provisions of this Appendix override, with respect to anyone covered as a Retired Employee, such provision to the contrary in the preceding pages of this booklet. Similarly, where the terms of this Appendix expressly describe a Benefit, right, responsibility or limitation applicable to a Dependent of a Retired Employee, which contradicts a Benefit, right, responsibility or limitation (as described in the preceding pages of this booklet) applicable to a Dependent of an Employee, the provisions of this Appendix override, with respect to anyone covered as a Dependent of a Retired Employee, such provision to the contrary in the preceding pages of this booklet. *Otherwise, the preceding pages of this booklet describing the Benefits, rights, responsibilities and limitations applicable to covered Employees and their Dependents apply as well to covered Retired Employees and their Dependents, respectively*.

DEFINITIONS. This Appendix includes the following definitions:

Retirement Date. The day immediately following your last date of employment as an Employee, if on such day you are a Retired Employee.

Retired Employee. You are a Retired Employee if you terminate employment with the Employer while covered by this Plan, and at the time you so terminate your employment you meet the following requirements for retiree coverage under the Plan: a retired elected official who has served a minimum of five (5) consecutive years and meets the age requirements as defined in the retirement plan in which they are participating; or a Retired Employee who has served a minimum of five (5) years who meets the age requirements as defined in the retirement plan in which the retiree is participating.

CONTRIBUTIONS TO THE PLAN. As a covered Retired Employee or covered Dependent of a Retired Employee, you may be required to make contributions to the Plan, as a condition of continuing your coverage, that are different from the contributions made by Employees and their Dependents.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE AS A RETIRED EMPLOYEE OR DEPENDENT OF A RETIRED EMPLOYEE

Retired Employee Eligibility. In order to be eligible for coverage under the Plan under the provisions of this Appendix, you must be a Retired Employee. You are eligible to continue coverage as a Retired Employee if you apply for Retired Employee coverage during the 60-day window ending on your Retirement Date, and are a Retired Employee on your Retirement Date. If you apply for coverage as a Retired Employee during this 60-day window and are a Retired Employee on your Retirement Date, your coverage as a Retired Employee will begin on your Retirement Date. If you fail to apply for coverage during this 60-day window or you are not a Retired Employee on your Retirement Date, you will not be enrolled as a Retired Employee upon your Retirement Date and you will be ineligible for coverage under this Plan (except under the Plan's COBRA Continuation Coverage provisions, if applicable) on and after your Retirement Date unless you again become an Employee and again qualify for coverage under the Plan as an Eligible Employee. There is no periodic "open enrollment period" for Retired Employees other than as described in this paragraph, and no "late enrollment" rights.

Eligibility of a Dependent of a Retired Employee. Your Dependents are eligible for coverage under this Appendix on the date you become eligible for Retired Employee coverage, or the date on which the Dependents become your Dependents, whichever occurs last. *However, under no circumstances may you enroll your Dependents under this Appendix if you are not also enrolled under this Appendix*. If both you and your spouse are Retired Employees, and both are eligible for Dependent coverage, either you or your spouse, but not both, may elect Dependent coverage for your other eligible Dependents (e.g., Dependent Children). No person may be covered under this Appendix as both a Retired Employee and as a Dependent.

Special Enrollment Events. As a Retired Employee you are not eligible for special enrollment rights, described in the section of this booklet titled, *Appendix A, Retired Employee Coverage*, *Eligibility and Effective Date of Coverage as a Retired Employee or Dependent of Retired Employee,* attributable to the loss of other coverage or to acquisition of a new Dependent (that is, you are not entitled to a special enrollment right to enroll yourself because you will not be an eligible Retired Employee if you do not enroll as described above, in the paragraph titled, *Retired Employee Eligibility*). If you are covered as a Retired Employee, however, your Dependents are eligible for special enrollment rights as described in the section of this booklet titled, *Effective Date of Coverage*.

TERMINATION OF RETIRED EMPLOYEE COVERAGE AND COVERAGE OF DEPENDENTS OF A RETIRED EMPLOYEE

Retired Employee Coverage Termination. Except as otherwise provided in this Appendix, your coverage, as a Retired Employee will terminate on the earliest of the following dates:

- If you fail to remit required contributions for your coverage when due, the date which is the end of the period for which the last timely contribution was made.
- The date you enter the military, naval or air force of any country or international organization on a full-time basis (after 90 days of military leave) other than scheduled drills or other training not exceeding one month in any calendar year.
- The date you die.
- The date the Plan is terminated or coverage for Retired Employees (or the class of Retired Employees to which you belong) is terminated.
- The last day of the month in which you request your coverage to be terminated.
- The date the Plan Sponsor determines, in its sole discretion, that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.

Termination of Coverage for Dependent of Covered Retired Employee. Except as provided in this Appendix, your coverage as a covered Dependent of a covered Retired Employee will terminate on the earliest of the following dates:

- The date your sponsor's (the eligible Employee's) coverage terminates.
- If required contributions for your coverage are not remitted when due, the date which is the end of the period for which the last timely contribution was made.
- The date you enter the military, naval or air force of any country or international organization on a full-time basis (after 90 days of military leave) other than scheduled drills or other training not exceeding one month in any calendar year.
- The date you cease to meet the definition of *Dependent*, or the date Dependent coverage (for all Dependents or for Dependents of Retired Employees) is discontinued under the Plan.
- The date the Plan is terminated or the date coverage of Retired Employees is terminated.
- The date the Plan Sponsor determines, in its sole discretion, that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.

Note: If the Retired Employee passes away, their surviving spouse is eligible to continue coverage under this Plan indefinitely. If the spouse is eligible for Medicare then Medicare is the primary payer and this Plan pays second, after Medicare.

COORDINATION OF BENEFITS - MEDICARE REDUCTION/COORDINATION

Retired Employee or Dependent of Retired Employee Entitled to or Eligible for Medicare Due to Age or Disability (Other than ESRD). If you are covered under this Plan due to your or someone else's status as a Retired Employee, and are also entitled to Medicare on account of age or disability (other than end-stage renal disease), Medicare is the primary payer and this Plan pays second, after Medicare. If you are eligible for Medicare due to age or disability (other than ESRD) but not enrolled in Medicare, this Plan will deem you to be enrolled in Medicare Parts A and B, and coordinate its Benefit payments as though Medicare had paid first.

Retired Employee or Dependent of Retired Employee Entitled to or Eligible for Medicare Due to End-Stage Renal Disease. If you are covered under this Plan due to your or someone else's status as a Retired Employee, and are also eligible for to Medicare on account of end-stage-renal disease (ESRD), then this Plan will be primary to Medicare for up to 30 months (called the "coordination period"); after that, the Plan becomes the secondary payer (assuming you're still eligible for coverage), and Medicare is the primary payer. The coordination period begins on

the first day of the month for which you are eligible for Medicare benefits on account of your ESRD, and ends not later than 30 months later (it might end earlier in some cases, such as when your coverage ends under this Plan). If at the time you become eligible for Medicare benefits due to ESRD you are already entitled to Medicare benefits on account of age or disability, and Medicare is the primary payer (and this Plan is secondary), then Medicare remains the primary payer, even after you become eligible for Medicare benefits due to your ESRD. Please note that for purposes of this provision, the coordination period begins in the month you are merely eligible for Medicare benefits due to ESRD, whether or not you actually enroll in Medicare then.

APPENDIX B
PRESCRIPTION DRUG BENEFITS

Retail Benefit. The Plan has contracted with a pharmacy network to provide you with covered Drugs. To utilize this Benefit, you must take your Physician's written prescription to a network pharmacy. When the prescription is filled you will be required to pay the Co-pay amount specified in the Schedule of Benefits. The network provider will then bill the Plan for any amount in excess of the Co-pay shown in the Schedule of Benefits. ***Note***: The Co-pay is not eligible for reimbursement under the *Comprehensive Major Medical Benefits* provisions.

Retail 90 Program. This Plan, as reflected in the Schedule of Benefits, enables you to obtain your prescriptions (typically maintenance prescriptions). The Plan Sponsor will provide you with additional information about how to utilize the services of the Retail 90 Program. You may be required to utilize that provider to have certain prescriptions filled. The participating pharmacy will bill the Plan for any amount in excess of the Co-pay shown in the Schedule of Benefits. ***Note***: The Co-pay is not eligible for reimbursement under the *Comprehensive Major Medical Benefits* provisions.

Expenses for Drugs obtained *outside* of the network are not Covered Expenses, except to the extent the Plan specifically provides coverage for Drugs obtained outside of the network (for example, the Plan may specifically provide that Drugs obtained outside of the network are covered if they are obtained outside of the network's area by a Covered Person who resides outside of the network area). Prescriptions filled Out-of-Network, if purchased after hours due to an Emergency or while the Covered Person is on vacation, must be submitted manually to Administrative Services who will send them to the Pharmacy Benefit Manager for reimbursement. The Covered Person will be reimbursed the amount paid, less the Co-pay due, plus a manual claim fee.

A list of specifically covered and specifically excluded Drugs is included below. This list is not necessarily all-inclusive, and will be updated from time to time. For questions regarding this list, please contact the Pharmacy Benefit Manager at the phone number listed on your ID card.

Specialty Drug Program. This Plan utilizes a mandatory Specialty Drug program administered by a Pharmacy Benefit Manager (PBM). All Specialty Drugs require prior authorization by the PBM. If prior authorization is granted, the Specialty Drug must be obtained through the PBM's Specialty Drug program in order for Benefits to be paid.

A Specialty Drug will be excluded from coverage if:

a. prior authorization is not granted by the PBM; or
b. the Specialty Drug is dispensed by a Physician or pharmacy that is not participating in the Specialty Drug program.

Questions about the mandatory Specialty Drug program should be directed to the PBM. Information about the PBM, including the phone number, is listed on your ID card.

Generic Incentive. If a Generic 1/Generic 2 equivalent of a prescription Drug is available and the Covered Person chooses the Formulary Brand Name and Non-Formulary Brand Name over the Generic 1/Generic 2 equivalent, then he or she must pay the cost difference between the Generic 1/Generic 2, and Formulary Brand Name and Non-Formulary Brand Name Drug in addition to the Formulary Brand Name and Non-Formulary Brand Name Co-pay.

If a Generic 1/Generic 2 equivalent of a prescription Drug is available and the Covered Person or doctor chooses the Formulary Brand Name and Non-Formulary Brand Name over the Generic 1/Generic 2 equivalent, then he or she must pay the cost difference between the Generic 1/Generic 2, and Formulary Brand Name and Non-Formulary Brand Name Drug in addition to the Formulary Brand Name and Non-Formulary Brand Name Co-pay.

Generic Plus Program. This Plan utilizes Generic Plus programs administered by the Pharmacy Benefit Manager. Generic Plus programs include ScriptChoice, eScriptChoice, Tablet Splitting Program and First-Fill-Free.

Step Therapy Program. Individuals, who are receiving certain maintenance medications for the first time, will be expected to start with low costing Step 1 Drugs rather than high cost brand name Drugs (Step 2). If the Step 1 Drugs do not seem to achieve the results, they will be then allowed to use Step 2 Drugs. Medications in this category are alpha 1 blockers for BPH, anti-depressants, anti-hypertensive agents, anti-inflammatory, biophosphonates, lipid-lowering agents, muscle relaxants, nasal steroids, proton pump inhibitors, sedatives & hypnotics, triptans for migraines, non-selective Beta Blockers, Nuvigil/Provigil, and oral acne agents.

Individuals who are Non-Grandfathered and in the Step Therapy Program will not be required to start with low costing Step 1 Drugs during the first six (6) months for certain maintenance medications.

Starter Dose Program. Individuals presenting new prescriptions to a network pharmacy will only be able to obtain a 30-day supply for the first prescription. This is to save the Plan and the individual money in the event that the medication doesn't work out. From that point on, the individual will be able to obtain a 90-day supply at a time. The PBM will determine new prescriptions by looking at the individual's history in the past 180 days.

Tria Health. This is a chronic Drug therapy management program designed to put selected individuals in touch with a clinical pharmacist to ensure they are getting the most out of their medications. Individuals taking several medications will be targeted. If individuals sign up for this program, the clinical pharmacists will review current medications with them, answer any questions or concerns they may have with their medications, and possibly make recommendations for changes. These phone calls will occur approximately 4 times per year. Employees who are eligible and choose to participate (and continue to participate) will then receive their Generic 1 medication at no cost and Generic 2 medication at half the Co-pay ($20), one-half (1/2) the Co-pay of Formulary Brand Name ($25) and one-half (1/2) the Co-pay of Non-Formulary Brand Name ($35); for a 90-day supply, eligible Employees will receive Generic 1 medication at no cost and Generic 2 medication at half the Co-pay ($60), one-half (1/2) the Co-pay of Formulary Brand Name ($75) and one-half (1/2) the Co-pay of Non-Formulary Brand Name ($105)

Co-pay Waiver Program. The Pharmacy Benefit Manager will identify Covered Persons who are taking a high-cost, single-source branded product. Examples include medications in the cholesterol lowering, anti-depressant, sleep aid and ulcer classifications. Covered Persons taking such medications may be eligible to participate in the Co-pay Waiver Program.

The Covered Persons who are eligible for this program will receive a letter from the Pharmacy Benefit Manager explaining that the Plan will waive the Co-pay for up to six (6) months should the member choose to switch to one of the generics alternatives available in the program. Covered Persons are encouraged to speak with their Attending Physician before making the switch to a generic alternative Drug.

Any Covered Person who has received a letter and obtained a prescription for one of the generic alternatives must call the Pharmacy Benefit Manager to receive a Co-pay waiver on that Drug.

- The Pharmacy Benefit Manager will authorize the generic Drug for up to six (6) months for $0 Co-pay at participating retail pharmacies.
- The Pharmacy Benefit Manager will send letters every six (6) months, and the list of Drugs is subject to change.

Please note, that the Co-pay Waiver Program is optional. Letters are sent out to Covered Persons twice a year.

Questions and More Information. Questions about any of the above referenced programs, including requests for more information on these programs, should be directed to the PBM. Information about the PBM, including the phone number, is listed on your ID card.

SCHEDULE OF BENEFITS

Plan Sponsor: **Douglas County**
Benefit Period: **June 1 - May 31**

Primary Plan Covered Services	**In-Network** (% of Negotiated Rate, if applicable otherwise % of Maximum Allowable Amount)	**Out-of-Network** (% of the Maximum Allowable Amount)
Benefit Period Maximum	Unlimited	
Deductible (per Benefit Period)		
Individual *Other special deductibles may apply to specific services*	$1,000	$1,300
Family	$1,500	$1,950
Deductible Shares between In-Network & Out-of-Network		
Medical Out-of-Pocket Maximum (includes deductible, coinsurance and copayments**)**. The Prescription Drug Out-of-Pocket Maximum is not included in your Medical Out-of-Pocket Maximum.		
Individual	$3,200	$4,300
Family	$5,500	$11,600
Out-of-Pocket Maximum Shares between In-Network & Out-of-Network		
The Plan will pay the designated percentage of Covered Expenses until the Out-of-Pocket Maximum Amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Expenses for the rest of the Benefit Period unless stated otherwise. The following charges do not apply to the Out-of-Pocket Maximum and are never paid at 100%: • expenses not covered by the Plan • expenses in excess of amounts covered by the Plan • expenses in excess of Maximum Allowable Amounts • prescription drugs		
Standard Benefit Percentage	80%	50% of the Maximum Allowable Amount
Services at an In-Network facility rendered by an Out-of-Network Provider for Ancillary Radiology, Anesthesia, Pathology		In-Network Rate
Services provided at an Out-of-Network facility or by an Out-of-Network Provider when there is no In-Network facility or Provider available		In-Network Rate
Services received Out-of-Network while traveling		Out-of-Network Rate, Deductible waived

Primary Plan Covered Services	**In-Network** (% of Negotiated Rate, if applicable otherwise % of Maximum Allowable Amount)	**Out-of-Network** (% of the Maximum Allowable Amount)
	Deductible and Co-insurance Apply Except as Provided:	
Physician Services Primary Care Office Visit Specialist Office Visit Lab/X-Ray *Services rendered at time of visit*	 100% after $25 Co-pay 100% after $50 Co-pay 80%	 50% 50% 50%
Preventive Services	100% Deductible waived	100% Deductible waived
• Includes all Evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), including 3-D imaging for mammograms. • For additional information see: http://www.uspreventiveservicestaskforce.org		
Preventive Services for Women as required by the Patient Protection and Affordable Care Act. For additional information and limitations www.hrsa.gov/womensguidelines: • Screening for gestational diabetes in a pregnant woman; • Human papillomavirus DNA testing every three (3) years for women age thirty (30) and above; • Annual counseling for sexually transmitted infections for a sexually active woman; • Annual counseling and screening for human immune-deficiency virus for a sexually active woman; • FDA approved contraceptive methods. • Sterilization procedures, patient education and counseling for women with reproductive capacity; • Breastfeeding support, supplies and counseling in conjunction with each birth, including the cost of purchasing or renting breastfeeding equipment; and • Annual screening and counseling for interpersonal and domestic violence.		
Well Child/Well Baby Care (under age 2 includes immunizations and office visit)	100% Deductible waived	100% after $25 Co-pay Deductible waived
Vision Exam (*1 exam per year*) *$50 Max. for purchase of eyewear*	100% Deductible waived	100% Deductible waived
Preventive Colonoscopy **Initial Colonoscopy** **Subsequent Preventive Colonoscopies**	 100% Deductible waived 100% Deductible waived	 100% Deductible applies 50%
Urgent Care Services	100% after $25 Co-pay	50%
Hospital Care	80%	50%
Outpatient Surgery	80%	50%

Primary Plan Covered Services	In-Network (% of Negotiated Rate, if applicable otherwise % of Maximum Allowable Amount)	Out-of-Network (% of the Maximum Allowable Amount)
Emergency Room *Co-pay waived if admitted*	$200 Co-pay, then 80%, Deductible waived	
Private Duty Nursing *$2,000 Max. per Benefit Period*	80%	50%
Ambulance	80% after In-Network Deductible	
Organ Transplant	80%	50%
Skilled Nursing Facility *60 Days Max. per Benefit Period*	70%	50%
Home Health Care *120 visits per disability Max. per Benefit Period*	80%	50%
Hospice Care	80%	50%
Rehabilitation Facility	80%	50%
Physical, Occupational, and Speech Therapy *90 visits combined Max. per Benefit Period*	80%	50%
Chiropractic Care *$25 Max. per visit* *$500 Max. per Benefit Period*	70% Deductible waived	50% Deductible waived
Mental and Nervous/Substance Abuse		
Inpatient	80%	50%
Outpatient	80%	50%
Office/Clinic ***(includes Hospital or other Clinic)***	100% after $25 Co-pay	50%
Preadmission Testing (within 7 days of admission)	100% Deductible waived	100% Deductible waived
Second Surgical Opinion	100% Deductible waived	100% Deductible waived
Durable Medical Equipment	80%	50%
Allergy Shots and Testing	80%	50%
TMJ Treatment	80% Deductible waived	80% Deductible waived
Impacted Teeth	80% Deductible waived	80% of the Maximum Allowable Amount plus Balance Billing (Deductible waived)

Primary Plan **Covered Services**	**In-Network** (% of Negotiated Rate, if applicable otherwise % of Maximum Allowable Amount)	**Out-of-Network** (% of the Maximum Allowable Amount)
Weight Loss Services		
Non-surgical treatment and programs		
Primary Care Office Visit	100% after $25 Co-pay	Not Covered
Specialist Office Visit	100% after $50 Co-pay	Not Covered
Lab/X-Ray	80%	Not Covered
Surgical treatment	80%	Not Covered
A1C testing	100% of Allowable	50%
Hearing Aids	80%	50%
	Maximum: $2,000 per Covered Person every three (3) years	

PRESCRIPTION DRUG BENEFITS	
Out-of-Pocket Prescription Maximum (Includes Co-pays and Co-insurance) The Prescription Drug Out-of-Pocket Maximum is not included in your Medical Out-of-Pocket Maximum.	
Individual	$5,350
Family	$11,600
Retail Pharmacy (30-day supply) Generics<$100 Generics >$100 Formulary Brand Name Non-Formulary Brand Name *One Co-payment applies per 30 days of medication*	 $25 Co-pay $50 Co-pay $60 Co-pay $80 Co-pay
Retail 90-Day Tier 1 Generics <$300 Tier 2 Generics >$300 Formulary Brand Name Non-Formulary Brand Name	 $75 Co-pay $150 Co-pay $180 Co-pay $240 Co-pay
Specialty Injectables (30-day supply)	20% Co-insurance up to a minimum of $35 or a maximum of $200 per Fill
Compound Drugs	$40 Co-pay or 50% of the cost of the compound, whichever is higher
If a Generic 1/Generic 2 equivalent of a prescription Drug is available and the Covered Person chooses the Formulary Brand Name and Non-Formulary Brand Name over the Generic 1/Generic 2 equivalent, then he or she must pay the cost difference between the Generic 1/Generic 2, and Formulary Brand Name and Non-Formulary Brand Name Drug in addition to the Formulary Brand Name and Non-Formulary Brand Name Co-pay. If a Generic 1/Generic 2 equivalent of a prescription Drug is available and the Covered Person or doctor chooses the Formulary Brand Name and Non-Formulary Brand Name over the Generic 1/Generic 2 equivalent, then he or she must pay the cost difference between the Generic 1/Generic 2, and Formulary Brand Name and Non-Formulary Brand Name Drug in addition to the Formulary Brand Name and Non-Formulary Brand Name Co-pay.	
Prescriptions filled Out-of-Network, if purchased after hours due to an Emergency or while the Covered Person is on vacation, must be submitted manually to Administrative Services who will send them to the Pharmacy Benefit Manager for reimbursement. The Covered Person will be reimbursed the amount paid, less the Co-pay due, plus a manual claim fee.	
A formulary of carefully selected medications are used that can assist in maintaining quality care while providing opportunities for cost savings to the member and the Plan. Under this program, your Plan requires you to pay a lower co-payment for medications that are preferred and a higher co-payment for medications that are considered non-preferred. By asking your doctor to prescribe a preferred medication, you can maintain high quality care while you help to control rising health care costs. Copayment Structure: Generics 1 <$100 Generics 2 >$100 Formulary Brand Name: Higher costing brand name drugs; new brand name drug products are placed in Tier 3 until reviewed Non-Formulary Brand Name: Higher costing non-preferred brand drugs.	
Specialty Drugs are only available in 30-day supplies and <u>must</u> be obtained through the pharmacy benefit manager's Specialty Drug program in order to be a covered Benefit, see the section titled, *Appendix B, Prescription Drug Benefits*, for further details.	

AMENDMENT AND RESTATEMENT

DOUGLAS COUNTY EMPLOYEE BENEFIT TRUST

The terms of the Douglas County Employee Benefit Trust provide that Douglas County ("the Plan Sponsor") may amend the Plan at any time and from time to time. In accordance with the authority granted by that provision, the Plan Sponsor hereby amends and restates the Plan in its entirety, in the form attached hereto.

This amendment and restatement shall be effective June 1, 2021, except that certain provisions of this amended and restated Plan may be effective earlier, to the extent changes in the law so require.

DOUGLAS COUNTY

By Michelle Spreer

Title Human Resources Manager

Date 06-22-2021

ATTEST:

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