ALLEN COUNTY EMPLOYEES
EMPLOYEE HEALTH CARE PLAN

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

BMI 238

Claims Administered by:

Benefit Management, Inc.
PO Box 1090
Great Bend, KS 67530
(620) 792-1779 phone
(800) 290-1368 toll free
(620) 792-7053 fax
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WOMEN'S HEALTH AND CANCER RIGHTS ACT

Do you know that your group health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? In the case of a Plan Participant who is receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to the annual deductible and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

Contact the Claims Administrator for more information: Benefit Management, Inc., PO Box 1090, Great Bend, Kansas 67530, (800) 290-1368.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Claims Administrator.

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INTRODUCTION

This document is a description of Allen County Employees Employee Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Claim Provisions. Explains the rules for filing claims.

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

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

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

SCHEDULE OF BENEFITS

Verification of Eligibility (800) 290-1368

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

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

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

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

Hospitalization
Skilled Nursing Facility stays
Inpatient Mental Disorder and Substance Abuse Treatments

Please see the Cost Management section in this booklet for details.

The Plan is a plan, which contains a Network Provider Organization. The PPO is identified on the Plan Participant's identification card. Included on the card are the PPO logo, phone number, physical claim address, EDI filing number and web address. To obtain information about Network Providers, contact the PPO or visit the PPO's website.

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

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use. Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person receives services at a Municipal Health Department.

If a Covered Person has a Medical Emergency or is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Network Physician or Medical Care Facility refers x-ray and laboratory services to a Non-Network provider.

If a Non-Network assistant surgeon performs services in a Network Facility.

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at a Network facility.

If a Covered Person has no choice for purchasing Medical/ Surgical Supplies and Durable Medical Equipment through a Network Provider.

Usual and Reasonable Charges apply to the Non-Network expenses. Charges in excess of the Usual and Reasonable Charge are not eligible for payment.

Deductibles, coinsurance, and copayments payable by Plan Participants

A deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each April 1st, a new deductible amount is required. However, Covered Charges incurred in, and applied toward the deductible in January, February and March will be applied to the deductible in the next Plan Year as well as the current Plan Year. Deductibles do not accrue toward the coinsurance maximum out-of-pocket amount.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the deductible or coinsurance maximum out-of-pocket amount.

Coinsurance is the percentage of the Usual and Reasonable charge at which payment is made after any applicable deductible or copayment amount has been satisfied.

Order of Claims Determination

Many times claims for covered services are not submitted in the same order the covered services are provided. Regardless of the order claims are incurred, the deductible and percentage payable will be applied to covered services in the sequence that claims are submitted and ready for payment.

MEDICAL BENEFITS SCHEDULE

BENEFIT CATEGORY	NETWORK PROVIDER	NON-NETWORK PROVIDER
Maximum Benefit Amount: Annual Aggregate Limit	$2,000,000	
DEDUCTIBLE PER PLAN YEAR		
Per Covered Person	$1,200	$1,500
Per Family Unit	$2,400	$3,000
COINSURANCE PERCENTAGE PAYABLE		
Percentage payable by the Plan	80%	50%
COINSURANCE OUT-OF-POCKET MAXIMUM PER PLAN YEAR (Excludes deductible)		
Per Covered Person	$1,000	$1,500
Per Family Unity	$2,000	$3,000

IMPORTANT NOTES ABOUT DEDUCTIBLES AND COINSURANCE OUT OF POCKET MAXIMUMS

- Network and Non-Network Deductibles are independent of each other.
- Network and Non-Network Coinsurance Maximums are independent of each other.
- The following charges DO NOT apply toward the Deductible or Coinsurance Maximum Out Of Pocket amounts
  - Copays
  - Cost Containment Penalties
  - Amounts over Usual and Reasonable Charge
- After satisfaction of the Deductible, the Plan will pay the designated Coinsurance percentage of Covered Charges until the Coinsurance Maximums are reached, then the Plan will pay 100% of the Covered Charges for the remainder of the Plan Year unless stated otherwise.

COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a aximum of 60 days is listed under a service, the Plan Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Hospital Services		
Room and Board Payment rate is the semi-private room rate	80% after deductible	50% after deductible
Intensive Care Unit Payment rate is the Hospital's ICU Charge	80% after deductible	50% after deductible
Emergency Room Visit (Copayment waived if admitted)	$100 copay, then 80% after deductible	$100 copay, then 50% after deductible
Ambulatory Surgical Center/Birthing Center	80% after deductible	50% after deductible
Skilled Nursing Facility Payment rate is the semi-private room rate Plan Year maximum limit: 90 days.	80% after deductible	50% after deductible
Physician Services		
Inpatient visits	80% after deductible	50% after deductible
Office visits Copayment covers the office visit; all other Covered Charges for services received during the office visit are subject to the applicable Plan benefit.	$25 copayment, then paid 100%, deductible waived	50% after deductible

BENEFIT CATEGORY	NETWORK PROVIDER	NON-NETWORK PROVIDER
Physician Services, continued		
Allergy office visits and injections	$25 copayment, then paid 100%, deductible waived	50% after deductible
Allergy testing, serums/ antigens	80% after deductible	50% after deductible
Surgery	80% after deductible	50% after deductible
Spinal Manipulation/ Chiropractic Care Plan Year maximum limit: 20 visits	$25 copayment, then paid 100%, deductible waived	50% after deductible
Outpatient Diagnostic Testing (x-ray and lab)	First $300 per Plan Year paid 100%; thereafter, 80% after deductible	50% after deductible
Home Health	80% after deductible	50% after deductible
Hospice Care (Includes Bereavement Counseling)	80% after deductible	50% after deductible
Ambulance Service	80% after Network deductible	
Jaw Joint/ TMJ	80% after deductible	50% after deductible
Rehabilitation Services		
Cardiac Rehabilitation	80% after deductible	50% after deductible
Neuropsychological Testing	80% after deductible	50% after deductible
Occupational Therapy	80% after deductible	50% after deductible
Physical Therapy	80% after deductible	50% after deductible
Pulmonary Rehabilitation	80% after deductible	50% after deductible
Respiratory Therapy	80% after deductible	50% after deductible
Speech Therapy Plan Year maximum limit: one (1) service per day up to 90 daily services	80% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible
Prosthetics	80% after deductible	50% after deductible
Orthotics	80% after deductible	50% after deductible
Mental Disorders and Substance Abuse Treatments		
Inpatient	80% after deductible	50% after deductible
Outpatient Visits	$25 copayment, then paid 100%, deductible waived	50% after deductible

BENEFIT CATEGORY	NETWORK PROVIDER	NON-NETWORK PROVIDER
Preventive Care Services		
Routine Physical Exam (All ages) Copayment covers only the exam	$25 copayment, then paid 100%, deductible waived	50% after deductible
All other Preventive Care Services Preventive Care Services include – but are not limited to – pap smear, mammogram, prostate exam, bone density screening, immunizations and preventive laboratory and x-ray. See also *"Childhood Immunizations".*	First $300 per Plan Year paid 100%; charges in excess of $300 paid 80% after deductible	50% after deductible
Childhood Immunizations (Dependent Children birth to age 72 months)	100%, deductible waived	
Routine Vision Exam (Includes refractions) Plan Year maximimum limit: one (1) exam	100% deductible waived	50% after deductible
Routine Well Newborn Care Routine care while the newborn is Hospital confined after birth. Charged to the Plan of the newborn.	80% after deductible	50% after deductible
Organ Transplants Precertification required	80% after deductible	50% after deductible
Second or Third Surgical Opinion (A third opinion is covered only if the first and second opinions are contradictory)	$25 copayment, then paid 100%, deductible waived	50% after deductible
Pregnancy	80% after deductible	50% after deductible
Sterilization (Reversals excluded)	80% after deductible	50% after deductible
Infertility Benefits	80% after deductible	50% after deductible
Includes care, supplies and services to diagnose the cause of infertlity and charges for surgical correction of physiological abnormalities causing the infertility problem. Assisted Reproductive Technology is excluded by the Plan.		

OUTPATIENT PRESCRIPTION DRUG CARD BENEFITS SCHEDULE

BENEFIT CATEGORY	Participating Pharmacy	Non-Participating Pharmacy
Acute Medications (34 day supply or 100 units whichever is less)		
Generic Prescription	$15 copayment	Reimbursement is at the Network allowable cost for the drug. You may have higher out of pocket expenses if you use a Non-Participating Pharmacy
Brand Name Prescription	$30 copayment	
Mail Order Maintenance Medication (Up to a 90 day supply)		
Generic Prescription	$30 copay	Reimbursement is at the Network allowable cost for the drug. You may have higher out of pocket expenses if you use a Non-Participating Pharmacy
Brand Name Prescription	$60 copay	

Refer to to the Outpatient Prescription Drug Card Benefits section for details on the Prescription Drug Benefit.

Certain eligible injectables are covered under the Prescription Drug Card Program and can be ordered through Medtrak specialty pharmacies. For those eligible injectables found not to be covered under the Prescription Drug Card Program, Medical Necessity will need to be determined. If the eligible injectable is found to be Medically Necessary for the treatment of a covered Illness or Injury, it will be payable under this Plan subject to any medical Network Deductible and Coinsurance. For further information about the coverage available for eligible injectables, please contact Benefit Management, Inc. (BMI).

DENTAL CARE BENEFITS SCHEDULE

BENEFIT CATEGORY	PERCENTAGE PAYABLE
Class I - Preventive Services	100%
Class II – Basic Services	80%
Class III – Major Services	50%
Orthodontia Services	Not Covered
Plan Year maximum payable for Class I, II, and III Services combined:	$2,000 per Covered Person

Refer to to the Dental Care Benefits section for details on the dental benefits.

Dental benefits are optional. In order to receive benefits under this Dental Care Benefit Section, Dental coverage must be elected on the enrollment application, and the Employee and Dependent(s), if applicable, must remain eligible for coverage under the Plan. If the Employee and Dependent(s) are not enrolled for Dental coverage, then no benefits are available under the Dental Care Benefit Schedule.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees. All Full-time Active Employees and qualifying Retired Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work,

(2) is in a class eligible for coverage,

(3) completes a 90 day employment Waiting Period. A “Waiting Period” is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

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

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married. The Plan Administrator may require documentation proving a legal marital relationship.

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

An Employee's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the Child reaches the applicable limiting age, coverage will end on the last day of month in which the Child reaches the limiting age.

(3) A covered Employee's Qualified Dependents.

The term "Children" shall include children for whom the Employee or Spouse is a Legal Guardian. The Legal Guardianship must be established through a court of law, and the Child must be under the age of 18 when the court decree is final.

(4) An Alternate Recipient

Regardless of this Plan’s non-ERISA status, any child of an Employee who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. The Employee must otherwise be eligible for coverage under the Plan and if not covered, the Plan must enroll the Employee. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator. Coverage shall be effective on the first day immediately following the date the Plan Administrator qualifies the medical child support order.

(5) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap,

primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

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

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

If both mother and father are Employees, their Children will be covered as Dependents of the mother or father, but not of both.

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

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

FUNDING

Cost of the Plan. Allen County shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

PRE-EXISTING CONDITIONS

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan even if that coverage is still in effect. The Plan will reduce the length of the Pre-Existing Condition Limitation period by each day of Creditable Coverage under this or a prior plan; however, if there was a significant break in the Creditable Coverage of 63 days or more, then only the coverage in effect after the break will be counted.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage from this Plan if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

All questions about the Pre-Existing Condition Limitation and Creditable Coverage should be directed to the Claim Claims Administrator: Benefit Management, Inc., PO Box 1090, Great Bend, KS 67530 (800) 290-1368 or locally at (620) 792-1779.

Covered Charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 90 consecutive days after a person's Enrollment Date. This time, known as the Pre-Existing Conditions Limitation period, may be offset if the person has Creditable Coverage from his or her previous plan.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within 90 days prior to the person's Enrollment Date under this Plan. Genetic Information is not, by itself, a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy or to a Covered Person under the age of 19.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing and appropriately submitting an enrollment application or change form, whichever is applicable, to the Plan Administrator. Dependent benefits are not automatic. If Dependent coverage is desired, then the covered Employee is required to enroll for Dependent coverage also, including newborn Children, by completing and appropriately submitting an enrollment application or change form, whichever is applicable, to the Plan Administrator.

Enrollment Requirements for Newborn Children.

An Employee must enroll the newborn for Plan coverage by completing and appropriately submitting an enrollment application or change form, whichever is applicable, to the Plan Administrator. If the newborn is not enrolled for the Plan within 63 days of birth, the newborn's enrollment is considered a Late Enrollment. The parents will be responsible for any costs incurred by the newborn. Submission of a medical claim is not considered notification for continued coverage.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 63 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

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

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

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

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on April 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his Dependents (including their Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 63 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption, placement for adoption, or legal guardianship, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 63 days after the birth, marriage, adoption, placement for adoption, or the date legal guardianship is established through a court of law.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator: Allen County, 1 N. Washington, Iola, KS 66749, (620) 365-1407.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. This means that any Pre-Existing Condition will be determined on the basis of the look back period prior to the Enrollment Date, and the period of the Pre-Existing Conditions Limitation will start on the Enrollment Date.

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

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

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

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 63 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above.

Coverage will begin on the day immediately following the loss of coverage event.

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

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

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

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

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

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

(3) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption, placement for adoption, or legal guardianship.

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth, adoption of a child, placement of adoption, or legal guardianship, the Spouse of the covered Employee and any other Dependent of the Employee may be enrolled as a Dependent of the covered Employee if the Spouse and other Dependent are otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 63 days and begins on the date of the marriage, birth, adoption, placement for adoption, or the date legal guardianship is established through a court of law. To be eligible for this Special Enrollment, the Dependent and/ or Employee must request enrollment during this 63-day period.

The coverage of the Dependent and/ or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the date of marriage;

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

(c) in the case of a Dependent's adoption, placement for adoption or legal guardianship, the date of the adoption, placement for adoption, or the date legal guardianship is established through a court of law.

(d) in the case of discharge from the military, the first day immediately following the date coverage is lost.

(4) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 63 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 63 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day following the loss of coverage, the date eligibility assistance is established, or the date established by regulation.

EFFECTIVE DATE

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

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

(4) The next open enrollment period when the Employee is a Late Enrollee.

Active Employee Requirement.

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

Effective Date of Retiree Coverage. When an Employee changes status from an Active Employee to a Retired Employee, coverage under the retiree class shall be effective on the first day of the month immediately following the retirement event.

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

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/ or Retiree and/ or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/ or covered Retirees and/ or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/ or Retiree's and/ or Dependent's paid contributions.

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

(1) The date the Plan is terminated.

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

(3) The date the Employee enters the full-time, active armed forces of any country.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) The last day of the calendar month in which the covered Employee voluntarily terminates coverage under the Plan by submitting written notification to the Plan Administrator.

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

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor. FMLA runs concurrently with any employer-certified disability or leave of absence.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/ or his or her Dependents when Plan coverage terminated. Coverage under FMLA ends on the earliest of these events:

(1) the date the Plan is terminated.
(2) The last day of the calendar month after the Plan Administrator receives a request to voluntarily terminate coverage.
(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
(4) The last day of the calendar month in which FMLA leave ends and the Employee does not return to Active full-time work.

Continuation of Insurance as a Retired Employee. An Active Employee that qualifies under the early retirement system may elect to continue benefits as a Retired Employee. Continuation of coverage is extended to the Dependents of the Retired Employee for such time that the Retired Employee qualifies for the Plan. Coverage must be elected within 63 days of retirement, and if waived, coverage cannot be elected at a later date. Retired Employee coverage cannot be reinstated after the coverage has lapsed.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if an Employee returns to work and continues COBRA coverage under this Plan until their Enrollment Date, the Employee will not have to satisfy a Waiting Period. The Pre-Existing Conditions Limitations provision will apply only to the extent it was in effect on the last day of COBRA coverage.

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

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator: Allen County, 1 N. Washington, Iola, KS 66749, (620) 365-1407. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

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

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The last day of the calendar month in which a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

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

(5) The date the Dependent enters the full-time, active armed forces of any country.

(6) The last day of the calendar month after the Plan Administrator receives a written request to voluntarily terminate coverage.

(7) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

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

OPEN ENROLLMENT

Every March, the annual open enrollment period, Employees will be able to change some of their benefit decisions based on which benefits and coverages are right for them. During open enrollment, Late Enrollees will also be able to enroll in the Plan. Benefit choices made during the open enrollment period will become effective April 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Enrolling during an open enrollment Period does not waive a Pre-Existing Condition Exclusion period; however, the amount of exclusion period may be reduced by the same number of Creditable Coverage days. A Late Enrollee on the Plan may have a period of 90 days of Pre-Existing Condition Exclusion.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

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

DEDUCTIBLE

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

This amount will not accrue toward the coinsurance maximum out-of-pocket amount.

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in January, February and March will be applied toward the deductible in the next Plan Year.

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

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Plan Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Plan Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Plan Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Plan Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for Essential Health Benefits during the Plan Year. The Maximum Benefit applies to all plans and benefit options offered under the Allen County Employees Employee Health Care Plan, including the ones described in this document.

COVERED CHARGES

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

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at the private room rate.

If a private room is assigned at the Covered Person's request, then the reimbursement is at the semi-private room rate.

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

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee, Spouse or Dependent daughter. The Plan covers the obstetrical and delivery expenses of the birth mother of a child adopted or placed for adoption within 90 days of birth of such child. The Covered Expenses will be charged to the Plan of the newborn child.

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

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

(b) the confinement starts within 14 days of a Hospital confinement of at least three (3) days; and

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

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

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

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

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

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

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 25% of the surgeon's Usual and Reasonable allowance.

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

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

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those

shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

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

Benefit payment for nursing and home health aide services is subject to the Home Health Care limit shown in the Schedule of Benefits.

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

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

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

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

Charges for Bereavement counseling are subject to the limits as shown in the Schedule of Benefits.

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

(a) Services, supplies, care or treatment in connection with an **abortion** when the life of the mother is endangered by the continued Pregnancy, the Pregnancy is the result of rape or incest, or a fetal or chromosomal abnormality exists which was diagnosed prior to the abortion.

If complications arise after the performance of any abortion, any expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.

(b) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

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

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

(e) **Chemotherapy** or radiation and treatment with radioactive substances. The materials and services of technicians are included.

(f) Initial **contact lenses,** glasses, or intraocular lens following a Medically Necessary surgical procedure to the eye or for aphakic patients. Also covered are soft lenses or sclera shells intended for use as corneal bandages.

(g) **Contraceptive devices and injections** and the related office visit. The device or injection is subject to the applicable deductible and out-of-pocket maximum and the office visit is subject to the Physician Services shown in the Schedule of Benefits. Oral contraceptives are covered under the Prescription Drug Card Program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or provided over-the-counter.

(h) **Diabetic Supplies, Equipment and Self-Management Programs** as described:

All Physician prescribed Medically Necessary and appropriate equipment and supplies used in the management and treatment of diabetes; and

Diabetes Outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with gestational, Type I and Type II diabetes.

For Covered Persons with diabetes who have documented peripheral vascular disease and/ or peripheral neuropathy, the Plan will cover one (1) pair of orthopedic shoes and two (2) pair of associated shoe inserts per Covered Person, per Plan Year, as deemed Medically Necessary and ordered by a Physician.

(i) Hemodialysis/ Peritoneal **Dialysis** treatment of a kidney disorder as an Inpatient in a Hospital or other facility, or for expenses in an Outpatient Dialysis Facility, or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or Outpatient dialysis treatments, the Plan will consider rental (or purchase as the case may be) of dialysis equipment and expendable Medical Supplies for use in the Covered Person's home. The dialysis equipment is subject to the Durable Medical Equipment benefit and the expendable Medical Supplies are subject to the Medical/ Surgical Supplies of the Plan.

(j) Rental of **Durable Medical Equipment** if deemed Medically Necessary subject to the following:

The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury; and

These items may be bought rather than rented. Prior approval is required before the purchase of any Durable Medical Equipment. But in no case will the Plan pay rental past the purchase price (oxygen equipment is not limited to the purchase price). Any amount paid to rent the equipment will be applied towards the purchase price; and

Benefits will be limited to standard models, as determined by the Plan; and

The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medically Necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan; and

If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered.

Exclusions:

(i) Home traction units.

(ii) Equipment used to provide exercise to functioning and non-functioning portions of the body when leased, purchased, or rented for use outside a recognized institutional facility.

(iii) Equipment designed to provide the walking capability for individuals with non-functioning legs.

Expenses for the rental or purchase of any type of air conditioner, air purifier, or any other device or appliance will not be considered a Covered Charge.

(k) **Infertility.** Care, supplies and services to diagnose the cause of infertlity and charges for surgical correction of physiological abnormalities causing the infertility problem. Assisted Reproductive Technology (ART) whether by chemical or mechanical means is not covered. Additionally, travel costs, donor eggs or semen and related costs including collection, preparation and storage, non-Medically Necessary amniocentesis, other forms of assisted reproductive technology and any infertility treatment deemed Experimental or Investigational including pharmaceutical agents are not Covered Charges.

(l) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

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

(n) **Medical/ Surgical Supplies.** Covered Charges for Medically Necessary Medical and Surgical Supplies.

(o) Treatment of **Mental Disorders and Substance Abuse**. For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

All treatment is subject to the benefit payment shown in the Schedule of Benefits.

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

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

(i) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(ii) Emergency repair due to Injury to sound natural teeth (not from biting or chewing). This includes replacement of natural teeth lost due to an Injury.

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

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

(v) External incision and drainage of cellulitis.

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

(vii) Removal of impacted teeth.

(viii) X-rays related to above services.

(ix) General anesthesia for covered oral surgery.

(x) Facility Charges determined to be Medically Necessary for dental care, and provided to the following persons:
- **(a)** Covered Children five years of age or under; or
- **(b)** A Covered Person who is severely disabled; or
- **(c)** A Covered Person who has a medical or behavioral condition, which requires Hospitalization or general anesthesia when dental care is provided.

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

(q) **Nutritional Supplements** which are Physician prescribed or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician. Enteral products that can be administered orally are not considered eligible. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician. Rental or purchase of equipment is subject to the Durable Medical Equipment benefit and the supplements are subject to the Medical/ Surgical Supplies of the Plan.

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

(s) **Organ transplant limits**. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ, bone marrow or tissue transplant are subject to these limits:

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

The transplant must be a human-to-human organ, bone marrow, or tissue transplant.

All other conventional means of treatment have been unsuccessful in treating the condition.

The condition is covered by the Plan.

The Covered Person is obligated to pay for the transplant; it is not covered by a government agency or transplant program.

The transplant is not considered Experimental and/ or Investigational.

The following charges for obtaining donor organs, marrow or tissue are Covered Charges under the Plan: **(i)** evaluating the organ, marrow or tissue; **(ii)** removing the organ, marrow or tissue from the donor; and **(iii)** transportation of the organ, marrow or tissue from within the United States and Canada to the place where the transplant is to take place.

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

If both the donor and the recipient are Covered Persons under this Plan, eligible expenses incurred by each person will be treated separately for each person.

If the recipient is not a Covered Person under this Plan, then the donor's charges are not covered under this Plan.

If a contracted Transplant Network is utilized, covered medical expenses relating to the transplant will be payable at the Transplant Network contracted rate. The Transplant Network contracted rate supersedes any negotiated PPO Network discount.

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

(t) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

Exclusions:
(i) Benefits are not payable for special or extra-cost convenience features.
(ii) Foot only Orthotics, except as described under Diabetic Supplies, Equipment and Self-Management Programs.
(iii) Over the counter shoe inserts or orthotic devices.

In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered. Orthopedic shoes for diabetes are covered as described in Diabetic Supplies, Equipment and Self-Management.

(u) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Covered Charges do not include Maintenance Therapy.

(v) **Podiatry.** Treatment for the following foot conditions: **(i)** bunions, when an open cutting operation is performed; **(ii)** toenails, when at least part of the nail root is removed; **(iii)** any Medically Necessary surgical procedure required for a foot condition.

(w) **Prescription Drugs** (as defined).

(x) **Preventive Care Services.** Covered Charges under Medical Benefits are payable for Preventive Care Services as shown in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law. A current listing of required preventive care can be accessed at www.HealthCare.gov/ center/ regulations/ prevention.html. If a diagnosis is indicated after a routine exam, the exam will still be payable under the Preventive Care Services; however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Benefits for Mammograms

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

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

If the Covered Person is at high risk of developing breast cancer or has a family history of breast cancer and the provider properly files the claim with this information, the claim

will be processed as a routine procedure according to the benefit provisions of the Plan's Preventive Care.

In all other cases the claim will be subject to the routine mammogram provisions shown in the Schedule of Benefits, see "Preventive Care".

Colorectal Cancer Screenings

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

If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition, and the provider properly files the claim with this information, the claim will be processed as a diagnostic procedure according to the benefit provisions of the Plan dealing with surgical procedures.

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

In all other cases the claim will be subject to the routine colorectal cancer screening benefit provisions shown in the Schedule of Benefits, see "Preventive Care".

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

(y) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts as shown in the Schedule of Benefits.

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

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

Coverage is available for two post-mastectomy bras per Plan Year. A post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses.

(z) **Reconstructive Surgery.** Correction of a Congenital Abnormality, repair of damage from an Injury or Illness, and reconstructive mammoplasties will be considered Covered Charges. This mammoplasty coverage will include reimbursement for:

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

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

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient. Coverage is available for two post-mastectomy bras per Covered Person per Plan Year. A

post-mastectomy bra is a bra that is specifically designed and intended to support single or bilateral breast prostheses.

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

(bb) **Spinal Manipulation/ Chiropractic services** by a licensed M.D., D.O. or D.C. Physical medicine modalities - including but not limited to - correction or adjustment by manual; mechanical; electrical or physical means (including the use of light, heat, water or exercise) of structural imbalance; distortion; subluxation or misplaced tissue of any kind or nature of the human body. Coverage does not include nutritional supplements or Maintenance Therapy.

(cc) **Surgical Sterilization**. Reversal of sterilization is excluded.

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

(ee) **Telehealth services** will be covered when interactive audio and video telecommunication is used instead of the Physician performing such service in a face to face setting with the Covered Person. Telehealth services will only be covered when the following criteria are met:

i. The Covered Person must be present for services at an originating site located in a rural health professional shortage area or non-metropolitan statistical area. Originating sites include rural hospitals, critical access hospitals, rural health clinics, federally qualified health centers, or the office of a licensed Physician or health care practitioner; and

ii. The Covered Person must be attended by a Health Professional.

iii. The only Physicians at the distant site who may furnish and receive payment for telehealth services are Physicians, ARNPs, physician assistants, psychologists, clinical social workers and registered dieticians.

Limitation:

The only services eligible to be offered through telehealth services are consultations, office visits, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end stage renal disease related services, and individual medical nutrition therapy.

Exclusions:

(i) Consultations performed through the use of telephone, fax, or e-mail communications.

(ii) Consultations utilizing asynchronous “store and forward” technology.

(iii) Origination site fees and technical component fees.

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

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

This coverage is only provided if the newborn Child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2)

enrolls himself or herself (as well as the newborn Child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn Child while Hospital confined as a result of the Child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn Child.

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

Charges for covered routine Physician care will be applied toward the Plan of the newborn Child.

(gg) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Plan Participant's ID card for the name of Cost Management Services and their phone number.

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

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the coinsurance maximum out-of-pocket amount.

UTILIZATION REVIEW

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

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/ or Surgical services are provided:

Hospitalization
Inpatient Substance Abuse or Mental Disorder treatments
Skilled Nursing Facility stays

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

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

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

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

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

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

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

Here's how the program works.

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

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

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

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

The utilization review administrator will determine the Medically Necessary number of days of Medical Care Facility confinement or use of other listed medical services. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive precertification for inpatient admissions as explained in this section, the benefit payment will be reduced by $250 per confinement.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/ OR THIRD OPINION PROGRAM

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

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

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

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

PREADMISSION TESTING SERVICE

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

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable at the applicable deductible, copayment and coinsurance even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

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

-- personal support to the patient;
-- contacting the family to offer assistance and support;
-- monitoring Hospital or Skilled Nursing Facility;
-- determining alternative care options; and
-- assisting in obtaining any necessary equipment and services.

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

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

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

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

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

DEFINED TERMS

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

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

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

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

Assisted Reproductive Technology (ART) means any combination of chemical and/ or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.

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

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

Brand Name means a trade name medication.

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

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

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

Cosmetic Dentistry means dentally unnecessary procedures.

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

Covered Person is an Employee, Elected Official, Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits, liability, or specified disease and/ or other supplemental-type benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

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

could normally be self-administered.

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

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

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/ Employer relationship.

Employer is Allen County.

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

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

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

(1) The drugs or dosages, devices, equipment, services, supplies, tests or medical treatment or procedures (generally, individually or collectively called ("Regimens")) have not received final approval from the U.S. Food and Drug Administration for the lawful marketing of the Regimens for the specific Injury or Illness to be treated.

(2) The Regimens have not received the approval or endorsement of the American Medical Association (AMA) for the specific Injury or Illness to be treated.

(3) The Regimens have not received the approval or endorsement of the National Institutes of Health (NIH) or its affiliated institutes for the specific Injury or Illness to be treated.

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

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

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

Except,

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

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

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

(i) American Hospital Formulary Service Drug Information;

(ii) National Comprehensive Cancer Network's (NCCN) Drugs & Biologics Compendium;

(iii) Thomson Micromedex DrugDex;

(iv) Elsevier Gold Standard Clinical Pharmacology.

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

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

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

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

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

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

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

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

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

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

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

Hospital is a legally operated institution which meets at least one of these tests:

(1) Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or
(2) Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments in accordance with the provisions of Medicare, or
(3) Is supervised by a staff of Physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:
(a) General Inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control, or
(b) Specialized Inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.
(c) A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.
(d) A free-standing treatment facility, other than a Hospital, whose primary function is the treatment of Alcoholism or Substance Abuse provided the facility is duly licensed by the appropriate governmental authority to provide such service, and is accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Hospital Association.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:
(1) Is primarily a facility for convalescence, nursing, rest, or the aged, or
(2) Furnishes primarily domiciliary or custodial care, including training in daily living routines, or
(3) Is operated primarily as a school.

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

Infertility means incapable of producing offspring.

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

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 63-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

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

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of

an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

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

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

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

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

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

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

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

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

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

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

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

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

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

federal agency and is acting within the scope of his or her license.

Plan means Allen County Employees Employee Health Care Plan, which is a benefits plan for certain Employees of Allen County and is described in this document.

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

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

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

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

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

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

(1) Employed by the Employer for not less than 10 years.
(2) Under age 65.
(3) Provided written application to the Employer within 63 days following retirement to continue Plan coverage as a qualified Retiree.
(4) Not covered or eligible to be covered under a plan of another employer.

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

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

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

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

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

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

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

(5) It has an effective utilization review plan.

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

(7) It is approved and licensed by Medicare.

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

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

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

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

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means that due to Sickness or Injury an Employee is not able to work at any job for pay or profit and is not able to engage in the normal activities of a person of like age and gender in good health; for a Child, Total Disability means the complete inability as a result of an Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. The Plan will consider the actual charge billed if it is less than the Usual and Reasonable Charge. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Outpatient Prescription Drug Benefits section.

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

(1) **Alternative medicine -** including but not limited to - biofeedback, aromatherapy, naturopathy, and homeopathic and holistic treatment or acupuncture and hypnosis.

(2) **Autopsies.**

(3) **Chelation therapy**, except for acute arsenic, gold, mercury or lead poisoning.

(4) **Communication devices.**

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

(6) **Counseling Services** and treatment related to relational problems, anti-social behavior, academic or phase-of-life problems, religious counseling, marital/ relationship counseling, vocational or employment counseling and sex therapy, except as may be required by applicable law.

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

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

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

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

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

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

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

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

(15) **External Defibrillators.**

(16) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders.

(17) **Foot orthotics.** Except as stated, foot orthotics including any casting or fitting charges.

(18) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law. This does

not apply to Covered Charges rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

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

(20) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting. The initial purchase of a hearing aid is covered if the loss of hearing is a result of a surgical procedure. Surgical procedures for the implantation of Bone Anchored Hearing Aids (BAHA) are covered; the device itself is not a Covered Charge.

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

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

(23) **Infertility.** Except as stated, care, supplies and services for infertility.

(24) **Maintenance Therapy.**

(25) **Massage Therapy.** Charges for or related to massage therapy sessions.

(26) **Milieu therapy.** Charges for milieu therapy or any confinement in an institution primarily to change or control one's environment.

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

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

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

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

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

(32) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan. These services include, but are not limited to, missed appointments, completion of claim forms, professional charges for travel expenses, mileage, traveling time, telephone calls, or for services provided over the telephone. Excluded also are Physician's fees for any treatment, which is not rendered by or in the physical presence of a Physician, except as stated under Telehealth services.

(33) **Obesity/ Morbid Obesity.** Except as specifically stated under "Preventive Care Services", care and treatment of obesity, weight loss or dietary control. Specifically excluded are charges for bariatric

surgery - including but not limited to - gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.

(34) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

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

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

(37) **Radioactive contamination.**

(38) **Relative giving services.** Professional services performed by a person who is related to the Covered Person as a Spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

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

(40) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

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

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

(43) **Sexual dysfunction.** Charges for treatment of sexual dysfunction, except as stated.

(44) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

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

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

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

(48) **War.** Any loss that is due to a declared or undeclared act of war.

OUTPATIENT PRESCRIPTION DRUG CARD BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs through a Pharmacy Benefit Manager. Refer to the Plan Participant's identification card for the name of the Pharmacy Benefit Manager, telephone number and website address.

Copayments

The copayment is applied to each covered Pharmacy drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one Pharmacy prescription for Acute medications is limited to a 34-day supply.

Maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.) are limited to a 90 day supply.

If a drug is purchased from a non-participating Pharmacy, or a participating Pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Covered Prescription Drugs

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

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

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

(4) Injectable drugs and drugs any prescription directing administration by injection. Except, Growth Hormones are not covered.

Limits To This Benefit

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

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

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

Expenses Not Covered

The Plan Administrator reserves the right to review medications for coverage or exclusion by the Plan. Contact the Prescription Network listed on the Plan Participant's identification card for more information about prescription drug coverage by the Plan.

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

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

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription and vitamins D and K that require a prescription.

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

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

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines as defined by the Plan, even though a charge is made to the Covered Person.

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

(8) **Growth Hormones.**

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

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

(11) **Investigational as defined by the Plan.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

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

(13) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

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

(15) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent products, for smoking cessation.

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

DENTAL CARE BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

BENEFIT PAYMENT

Each Plan Year, payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. A charge will be considered to be incurred:

(1) For Dentures or partials – on the date the impression is taken;
(2) For fixed Bridgework, Crowns, Inlays or onlays – on the date the tooth or teeth are prepared and final impressions are made;
(3) For root canal therapy – on the date the pulp chamber is opened and explored; and
(4) For all other services – on the date the service is performed.

COVERED DENTAL SERVICES

Class I Services:
If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown in the routine services.

(1) Routine oral exams. This includes the cleaning, polishing, and scaling of teeth. Limit of two exams per Covered Person each Plan Year.

(2) One bitewing x-ray series limited to two (2) per Plan Year.

(3) One full mouth x-ray every three Plan Years.

(4) One fluoride treatment each Plan Year limited to Covered Persons under the age of 23 years.

(5) Sealants on the occlusal surface of a permanent posterior tooth for Dependent Children from age 5 through age 17 years, once per tooth in any four years.

(6) Space maintainers for covered Dependent Children under age 19 to replace primary teeth.

Class II Services:

(1) Problem focused exam.

(2) Periodontics (gum treatments).

(3) Endodontics (root canals).

(4) Simple Extractions. This service includes local anesthesia and routine post-operative care.

(5) Fillings, other than gold.

(6) Emergency palliative treatment for pain.

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

(8) Inlays, other than gold.

(9) Repair of Crowns, Bridgework and removable Dentures.

(10) All other x-rays.

(11) Antibiotic drugs.

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

(13) Biopsy and examination of oral tissue.

(14) Surgery of the bony structure supporting the teeth.

Class III Services:

(1) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for Dentures and removal of tooth-generated cysts of less than 1/ 4 inch.

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

(3) Installation of Crowns.

(4) Onlays.

(5) Installing precision attachments for removable Dentures.

(6) Installing partial, full or removable Dentures to replace one or more natural teeth. This service also includes all adjustments made during a six-month period following the installation.

(7) Addition of clasp or rest to existing partial removable Dentures.

(8) Initial installation of fixed Bridgework to replace one or more natural teeth.

(9) Recementing Bridges, Crowns or Inlays.

(10) Repair of Crowns and Bridgework.

(11) Rebasing or relining of removable Dentures.

(12) Replacing an existing removable partial or full Denture or fixed Bridgework); adding teeth to an existing removable partial Denture; or adding teeth to existing Bridgework to replace extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The replacement or addition of teeth is required because of one or more natural teeth being extracted.
(b) The existing Denture or Bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
(c) The existing Denture is of an immediate temporary nature.

(13) Dental implants

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause, which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment, which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

(1) **Bone grafts** for alveolar ridge augmentation.

(2) **Chemotherapeutic agents(s)** inserted into a periodontal pocket.

(3) **Completion of claim forms**.

(4) Treatment which is for **cosmetic** purposes, or to correct congenital malformations. Facings on Crowns or pontics beyond the second bicuspid are considered cosmetic, except for medically necessary care and treatment of cleft lip and palate.

(5) **Crowns for teeth that are restorable** by other means or for the purpose of Periodontal Splinting.

(6) **Crowns, fillings or appliances that are used to connect** (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are Cosmetic.

(7) Services related to: **equilibration, bite registration or bite analysis**.

(8) **Home Sealant Kits.**

(9) **Hospital calls and/or consultations.**

(10) **Oral hygiene**, plaque control programs or dietary instructions.

(11) **Orthodontic services.**

(12) **Orthognathic surgery**. Surgery to correct malpositions in the bones of the jaw.

(13) **Patient education** services.

(14) **Personalization of Dentures.**

(13) **Recall visits** for checking sealant application.

(14) **Replacement of lost** or stolen appliances.

(15) **Replacement of any prosthetic appliance**, crown, Inlays or only restoration, or fixed bridge within five years of the date of the last placement of these items. If a replacement is required because of an accidental bodily injury, it will be a Covered Charge.

(16) **Services that are excluded** under Medical Plan Exclusions.

(17) **Services** that, to any extent, are **payable under any medical** expense benefits of the Plan.

(18) **Services** which are **not included** in the list of covered dental services.

(19) Charges for the treatment of **Temporal Mandibular Joint dysfunction (TMJ).**

(20) **Temporary or Provisional dental services** and procedures including – but not limited to – Provisional Crowns, Provisional splinting, interim complete or partial Dentures.

DENTAL DEFINITIONS

Bridge means a fixed, artificial replacement for one or more natural teeth.

Crown means a complete or partial veneer Restorations covering the crown (exposed portion) of a tooth.

Denture means a removable artificial (full or partial) replacement for natural teeth.

Endodontics means treatments of root canals and tooth pulp (composed of nerves, blood vessels, and connective tissue).

Impaction/Impacted means a tooth that has not or only partially erupted through the gum.

Inlay (usually gold) means a repair formed to fit a cavity and then cemented.

Malocclusion means abnormally crooked teeth that prevent the natural fitting together of upper and lower teeth, which if untreated may interfere with normal speech, chewing, or breathing.

Orthodontic means correction of abnormally crooked or poorly positioned teeth.

Periodontic means treatment of tissue and structures surrounding and supporting the teeth.

Provisional means a service or procedure that is provided for temporary purposes or is used over a limited period of time; a temporary or interim solution; usually refers to a prosthesis or individual tooth Restorations.

Restoration means rebuilding a natural tooth to its original condition by means of fillings, Inlays or Crowns (caps).

Simple Extraction means to remove erupted natural teeth which are not Impacted in tissue or bone, and which do not require surgery.

HOW TO SUBMIT A CLAIM

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

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

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

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/ or procedure codes
- Date of services
- Charges

(2) Send the above to the claim address on the Plan Participant's identification card. If you have questions about how to submit a claim or need assistance, contact the Claims Administrator at this address:

Benefit Management, Inc.
PO Box 1090
Great Bend, KS 67530, Kansas 67530
(800) 290-1368 or locally (620) 792-1779

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

PROCESSING CLAIMS AND APPEALS

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

I. Terminology

Adverse Benefit Determination. If a Claim is denied, in whole or in part, the denial is known as an "Adverse Benefit Determination."

Appeal. A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." An Appeal will be recognized as valid only if it is submitted by a claimant or his/ her representative in accordance with the Plan's procedures for filing an Appeal of an Adverse Benefit Determination.

Claim. A "Claim" is defined as a formal request for a Plan benefit, made by a claimant or his/ her representative, which complies with the Plan's procedures for filing claims. A Claim does not include a request for a determination of an individual's eligibility to participate in the Plan, nor does it include a casual inquiry regarding the scope of coverage under the Plan. A communication regarding benefits that is not made in accordance with these procedures for filing a Claim will not be treated as a Claim.

Claims Administrator. The "Claims Administrator" is Benefit Management, Inc.

Final Adverse Benefit Determination. If a Claim is denied at the end of the internal Appeal process, the Plan's final decision is known as a "Final Adverse Benefit Determination."

Receipt. The Plan Administrator (or its designee) will be deemed to be in "Receipt" of a claimant's Claim, Appeal, or other information submission only after the Claim, Appeal, or other information submission is received – through electronic means or otherwise – in the physical offices of the Plan Administrator (or its designee). A claimant will be deemed to be in Receipt of a request for additional information or other notification from the Plan when such request/ notification is delivered to the Claimant's mailing address or communicated to him/ her electronically, whichever is earlier.

II. Claims Process

Full and Fair Independent Review. Both the Claims and the Appeal procedures (set forth in Sections III and IV below) are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions, and that the compensation of the decision maker(s) will not be based on whether a Claim or Appeal is granted or denied.

Delegation of Plan Administrator Responsibilities to Third Parties. Any of the authorities and responsibilities of the Plan Administrator under the Claims and Appeal Procedures, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. Regardless of any such delegation, however, the timelines set forth in these procedures and the requirements applicable to the claimant will remain unchanged. If you have any questions regarding these procedures, please contact the Claims Administrator.

Submission and Decision Deadlines. There are different kinds of Claims and each one has a specific timetable for each step in the submission and review process. Upon Receipt of a Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision generally must be made within the time frame set forth in Section III below.

However, if a Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may – under certain circumstances – be notified that the period for reviewing and issuing a decision on the Claim will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in Section III.

If a Claim is denied, in whole or in part, the claimant has the right to file an Appeal. If the claimant does so, the Plan Administrator must then decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the required time periods set forth in Section IV below.

Decisions will be made within a reasonable period of time appropriate to the circumstances, but no later than the maximum time period set forth below. Unless otherwise noted, "days" means calendar days.

Mandatory Exhaustion of Administrative Remedies. A claimant must follow all Claims and Appeal procedures before he/ she can file a lawsuit. If a lawsuit is brought, it must be filed no later than 180 days after the Plan issues a Final Adverse Benefit Determination.

III. Specific Types of Claims and Applicable Initial Submission/ Decision Deadlines

The Claims that may be filed under the Plan fall into five different categories:

- Urgent Care Claims;
- Concurrent Care Decisions;
- Pre-Service Claims;
- Post-Service Claims; and
- Rescission of Coverage Claims.

Each is described below, along with the applicable deadlines for claimants to submit, and the Plan Administrator to decide, Claims arising under each category.

A. Urgent Care Claims

Definition of Urgent Care Claim. An "Urgent Care" Claim is any Claim for medical care or treatment in which:

(1) The Plan conditions receipt of benefits, in whole or in part, on advance approval of the particular care or treatment; and

(2) Using the timetable for non-Urgent Care determinations (e.g., Pre-Service Claims, Post-Service Claims, etc.):

(a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) In the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

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

Timetable for Submission / Initial Decision Deadlines. In the case of a Claim involving Urgent Care, the following timetable applies:

• Notification to claimant of Claim determination / Adverse Benefit Determination	72 hours (after Receipt of Claim)
• Insufficient information on the Claim, or failure by claimant to follow Plan's procedure for filing a Claim:	
o Notification to claimant, orally or in writing	24 hours (after Receipt of Claim)
o Response by claimant, orally or in writing	48 hours (after Receipt of request for information)
o Benefit determination, orally or in writing	48 hours (after Receipt of additional information or end of 48-hour period for submitting additional information, whichever is earlier)

B. Concurrent Care Decisions

Definition of Concurrent Care Decision. When the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments, this is known as a "Concurrent Care Decision." Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or specified number of treatments will be treated as an Adverse Benefit Determination, which is subject to Appeal by the claimant within the time frames set forth below.

(Note: If a participant requests to extend a course of treatment beyond the period of time or number of treatments previously approved, the request will be treated as a new benefit Claim and decided within the time frame appropriate to the type of claim, i.e., as an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim, as applicable.)

Timetable for Submission / Initial Decision Deadlines. In the case of a Concurrent Care Claim, the following timetable applies:

• Notification to claimant of reduction or termination of previously approved course of treatment	Sufficiently prior to the scheduled termination of course of treatment to allow claimant to appeal and obtain a decision on review before benefit is reduced or terminated
Notification to claimant of denial of request for extension of Concurrent Care course of treatment that involves Urgent Care	72 hours (after Receipt of Claim)

C. Pre-Service Claims

Definition of Pre-Service Claim. A "Pre-Service" Claim means any Claim for a benefit *not involving Urgent Care* where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. Examples include Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims. (Please note that a total rescission of Plan coverage as a result of alleged fraud or misrepresentation is treated separately under Section III.E. and Section IV below.)

Timetable for Submission / Initial Decision Deadlines. In the case of a Pre-Service Claim, the following timetable applies:

• Notification to claimant of Adverse Benefit Determination	15 days (after Receipt of Claim)
• Insufficient information provided by claimant on the Claim:	
o Notification to claimant	15 days (after Receipt of Claim)
o Response by claimant	45 days (after Receipt of request for information)
o Benefit determination	15 days (after Receipt of additional information from claimant)
• Need for extension due to matters beyond the control of the Plan:	
o Notification to claimant	15 days (after Receipt of Claim)
o Benefit determination (after extension)	30 days (after Receipt of Claim)

- Claimant's failure to follow Plan's procedures for filing a claim:

  - o Notification to claimant — 5 days (after Receipt of claim)
  - o Response by claimant — 45 days (after Receipt of notice of proper claim procedures)
  - o Benefit determination — 15 days (after Receipt of proper claim submission)

D. Post-Service Claims

Definition of Post-Service Claim. A "Post-Service" Claim means any Claim that involves a request for payment under the Plan for medical services already received by the claimant.

Timetable for Submission / Initial Decision Deadlines. In the case of a Post-Service Claim, the following timetable applies:

- Notification to claimant of Adverse Benefit Determination — 30 days (after Receipt of Claim)
- Need for extension due to matters beyond the control of the Plan
  - o Notification to claimant — 15 days (after Receipt of Claim)
  - o Benefit determination (after extension) — 45 days (after Receipt of Claim)
- Insufficient information provided by claimant on the Claim:
  - o Notification to claimant — 30 days (after Receipt of Claim)
  - o Response by claimant — 45 days (after Receipt of request for information)
  - o Benefit determination — 15 days (after Receipt of additional information from claimant)

E. Notice to Claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. The Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. (With Urgent Care Claims, the notification may be oral, followed by written or electronic notification within three days of the oral notification.) The Adverse Benefit Determination notice will be provided in a format that is calculated to be understood by the claimant. The notice will include the following:

(1) Information sufficient to allow the claimant to identify the Claim involved;

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim;

(3) Reference to the specific Plan provisions on which the determination was based;

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary;

(5) A description of the Plan's Appeal procedures. This description will include information on how to

initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action following a Final Adverse Benefit Determination;

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request; and

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

IV. Appeals

When a claimant receives notification of an Adverse Benefit Determination, he/ she may appeal that Adverse Benefit Determination to the Plan Administrator under the Plan's Appeal procedures. The procedures and timetables for submitting an Appeal are summarized below.

A. Procedures for Appealing Adverse Benefit Determinations

Except in the case of Urgent Care Claims or Concurrent Care Claims where expedited processing is requested (and necessary), a claimant's request for an Appeal of an Adverse Benefit Determination must be submitted in writing to the Plan Administrator (or its designated representative). The claimant may submit written comments, documents, records, and any other information relevant to the Claim.

If the claimant so requests, he/ she will be provided, free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator will also provide to the claimant, free of charge, any new or additional evidence that is relied upon, considered by, or generated at the direction of the Plan, as well as any new or additional rationale for denying the Claim. The relevant documents, records, information, and/ or new rationale will be provided to the claimant sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

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

(1) Was relied upon in making the benefit determination;

(2) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

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

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

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator will provide written notification of the Final Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(2) The specific reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim;

(3) Reference to the specific Plan provisions on which the determination was based;

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary;

(5) A description of the Plan's Appeal procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action following a Final Adverse Benefit Determination;

(6) The claimant's entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim;

(7) If the Final Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Final Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request; and

(8) If the Final Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

B. Timetable for Appealing and Ruling on Adverse Benefit Determinations Appeals

The timetable for claimants to submit an Appeal of an Adverse Benefit Determination, and the deadline for the Plan to rule on such an Appeal, depend on the nature of the Claim, as summarized below. The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

1. Urgent Care Claims

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

• Claimant's Appeal Deadline	180 days (after Receipt of Adverse Benefit Determination) (but claimant is strongly encouraged to request expedited review)
• Notification to claimant of decision on Adverse Benefit Determination Appeal	72 hours (after Receipt of Appeal)

2. Concurrent Care Claims

If there is an Adverse Benefit Determination on a Concurrent Care Decision, a request for an expedited Appeal may be submitted by the claimant in writing or, if circumstances require expedited processing because of the short period of time between the Adverse Benefit Determination and the date in which benefits are scheduled to be reduced or terminated, orally. If expedited processing is necessary, all necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. The timetable for appealing a Concurrent Care Claim is as follows:

• Claimant's Appeal deadline involving Claim regarding reduction or termination of previously approved course of treatment	Sufficiently in advance of reduction or termination of benefits to allow plan to resolve Appeal prior to the reduction or termination of benefits
• Notification to claimant of decision on Adverse Benefit Determination Appeal involving Claim regarding reduction or termination of previously approved course of treatment	Before treatment ends or is reduced

3. Pre-Service Claims

The timetable for appealing a Pre-Service Claim is as follows:

• Claimant's Appeal Deadline	180 days (after Receipt of Adverse Benefit Determination)
• Notification to claimant of decision on Adverse Benefit Determination Appeal	30 days (after Receipt of Appeal)

4. Post-Service Claims

The timetable for appealing a Post-Service Claim is as follows:

• Claimant's Appeal Deadline	180 days (after Receipt of Adverse Benefit Determination)
• Notification to claimant of decision on Adverse Benefit Determination Appeal	60 days (after Receipt of Appeal)

COORDINATION OF BENEFITS

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

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

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

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

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

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

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

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

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

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

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

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

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

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

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

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the

other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

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

(d) When a Child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

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

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

(e) When a Child's parents are divorced or legally separated, these rules will apply:

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

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

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

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

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

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

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

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

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

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

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

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

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all

Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Allen County Employee Health Care Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Allen County, 1 N. Washington, Iola, KS 66749, (620) 365-1407. COBRA continuation coverage for the Plan is administered by Benefit Management, Inc., PO Box 1090, Great Bend, Kansas 67530, (800) 290-1368 or locally at (620) 792-1779. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent Child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent Child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent Child of the individual will also not be

considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/ or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Recent changes in the law increased this assistance temporarily to 80%, and temporarily extended the period of COBRA continuation coverage for eligible individuals. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/ TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/ tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Attn: Human Resources
Allen County
1 N. Washington
Iola, KS 66749

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent Child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the

maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S.

Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Allen County Employee Health Care Plan is the benefit plan of Allen County, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Allen County to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Allen County shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

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

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

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

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care

operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Allen County's workforce are designated as authorized to receive Protected Health Information from Allen County Employees Employee Health Care Plan ("the Plan") in order to perform their duties with respect to the Plan: Human Resources and Benefits Administrator.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Allen County Employees Employee Health Care Plan

PLAN NUMBER: 501

TAX ID NUMBER: 48-6039815

PLAN EFFECTIVE DATE: April 1, 2009

RESTATEMENT DATE: April 1, 2012

PLAN YEAR ENDS: March 31

EMPLOYER INFORMATION

Allen County
1 N. Washington
Iola, KS 66749
(620) 365-1407

PLAN ADMINISTRATOR

Allen County
1 N. Washington
Iola, KS 66749
(620) 365-1407

CLAIMS ADMINISTRATOR

Benefit Management, Inc.
PO Box 1090
Great Bend, KS 67530
(800) 290-1368

BY THIS AGREEMENT, Allen County Employees Employee Health Care Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Allen County on or as of the day and year first below written.

By _____
Allen County

Date _____

Witness _____

Date _____