



MIDWEST PUBLIC RISK OF MISSOURI
HEALTH CARE PLAN

Effective July 1, 2011

MPR
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WOMEN'S HEALTH AND CANCER RIGHTS ACT

This 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 Covered Person 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 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 pre-certification. For information on pre-certification, contact your Claims Administrator.

I. INTRODUCTION

This document is a description of the Midwest Public Risk of Missouri Health Care Plan. No oral interpretations can change this Plan. The Plan described is designed to protect Covered Persons against certain catastrophic health expenses. Coverage under this Plan will take effect for an Employee, Elected Official or Eligible Retiree only if they are eligible for coverage and become and remain covered by the terms of the Plan. This document and the Schedule of Benefits make up Your entire contract of coverage by the Midwest Public Risk of Missouri Health Care Plan. This document summarizes the Plan rights and benefits for covered Employees and their Dependents. This Plan Document is the final determining factor in the payment of benefits to be covered by this Plan. It may be amended from time to time.

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

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

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, 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 charges incurred while this coverage is in force. No benefits are payable for charges 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.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

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

In this document, We have avoided the use of gender specific pronouns whenever possible. However, where such avoidance would have led to very awkward sentences, We have used the masculine pronoun. This use should be considered to refer to both genders.

The terms "We, "Our, or Us" means Plan Administrator and "You, Your, Yours" means a Covered Person who is receiving Plan benefits.

II. YOUR RESPONSIBILITIES

It is Your responsibility to confirm benefit coverage prior to seeking treatment. Certain Plan procedures are subject to pre-certification. Even though pre-certification was obtained, the Covered Person is still subject to all Plan limitations, conditions and exclusions.

Prior Authorization is required for all Specialty Drugs. Even though Prior Authorization was obtained, the Covered Person is still subject to all Plan limitations, conditions and exclusions. See Your Schedule of Benefits and this document's "Outpatient Prescription Drug Card Benefits" for more information about Specialty Drugs.

Benefits are paid by the Plan Year, July 1 through June 30. Premium amounts may change on any July 1, or at any time as deemed appropriate by the MPR Board of Directors.

III. AUTHORITY TO INTERPRET THE PLAN

The Plan Administrator and the delegates, where responsibility has been delegated to others, shall have complete authority to determine the standard of proof required in any case and to apply and interpret the Plan Document. The decisions of the Plan Administrator or its delegates shall be final and binding.

All questions or controversies, of whatsoever character arising in any manner or between any parties or persons in connection with this Plan or its operation, whether as to any claim for benefits, or as to the construction of language or meaning of the Plan Document, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Plan Administrator or, where responsibility has been delegated to others, to such delegates for decision. The decision of the Plan Administrator or its delegates shall be binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court having jurisdiction over such matters.

IV. BASIC BENEFITS

A. OUTPATIENT PRESCRIPTION DRUG CARD BENEFITS

The Plan provides a special benefit for the purchase of Prescription Drugs. We have contracted with MedTrak Services to give You coverage for both singular prescriptions and maintenance-type prescriptions. These programs are outlined below.

MedTrak Services

Your ID card will provide the personalized information necessary for purchasing prescriptions at a participating Pharmacy. Participating pharmacies are found throughout the United States. It is likely Your local pharmacist participates in the MedTrak Services network.

Copay/Deductible and Coinsurance

If You are covered under a type of Plan that has a Prescription Drug Copay, the Prescription Drug Copay shown in Your Schedule of Benefits is applied to each covered Prescription Drug. It is the amount of each prescription for which no benefits are payable.

If You are covered under a High Deductible Health Plan, Prescription Drugs are subject to the medical Deductible and Coinsurance out of pocket limit as shown in Your Schedule of Benefits.

Mail Order Prescriptions

Covered Persons who require 90-day supplies of maintenance medications have the opportunity to purchase these Prescription Drugs through the Walgreens Mail Pharmacy. Maintenance drugs are defined as any prescription that is taken on a daily basis for long-term treatment. If You want to obtain prescriptions through the mail, You must use the Walgreens Mail Pharmacy program. To participate, simply follow these easy steps:

1. Ask Your Physician for a 90-day prescription.
2. Fill out the Walgreens Mail Pharmacy application.
3. Include Your Copay amount (Refer to Your Schedule of Benefits).
4. Mail it in the pre-addressed envelope.

Allow up to 10 business days for delivery. If You have questions or need forms, please contact MedTrak Services or Your Human Resource Department. Specialty Drugs are not Covered Expenses under Mail Order Prescriptions.

Specialty Drugs

Prior Authorization is required for all Specialty Drugs. Select medications must be filled through a Preferred Specialty Pharmacy. For specific information about Specialty Drugs, contact MedTrak Services at (800) 771-4648.

Charges Payable

If You are covered by a type of Plan with a Prescription Drug Copay, then the covered Prescription Drug charge, in excess of the Copay, is payable in full by the Plan. If you are covered by a High Deductible Health Plan, the cost of the covered Prescription Drug in excess of the Deductible and Coinsurance out of pocket limit is payable in full by the Plan. To receive these benefits You must present Your ID card to the Member Pharmacy.

Benefit Limits

The covered drug charge for any one prescription will be limited to:

1. An amount not to exceed a 34-day supply for acute medications.
2. An amount not to exceed a 90-day supply for maintenance medications.
3. Refills only up to the number of times specified by Your Physician.
4. Refills up to one year from the date of order by Your Physician.

Secondary Coverage

The Prescription Drug benefit does not pay secondary to any other benefit plan including, but not limited to, a discount plan, governmental program, group insurance, individual insurance, student insurance, HMO, or Medicare.

Insulin, Hypodermic Needles, Test Strips and Lancets

Insulin, hypodermic needles/syringes/pen needles, test strips and lancets are Covered Expenses under the Prescription Drug Card when dispensed with a written prescription. When insulin and hypodermic needles/syringes/pen needles are purchased at the same time, there will be one combined Copay. The Mail Order Prescription Drug Program is also available for ordering of insulin and hypodermic needles/syringes/pen needles.

Generic Program

If a Generic equivalent is available, then that equivalent is the benefit. If the patient or Physician, for whatever reason, demands the more expensive branded product be dispensed, the patient pays in addition to the appropriate Copay, the difference in cost between the generic and branded product.

Step Therapy Program

Many prescriptions are available in a Generic form. Generic drugs reduce Plan costs and should be tried first before purchasing a Brand Name drug. The Step Therapy Program requires a participant to try a Generic Step One drug prior to obtaining a Step Two drug. Step Therapy drugs involve the following classifications:

Antidepressants	Anti-Arthritics	Nasal Steroids
Proton Pump Inhibitors	Lipid Lowering Agents	Bisphosphonates
Anti-Hypertensives	Sedative Hypnotics	Triptans
Muscle Relaxants	Alpha 1 Blockers	

Examples:

- Patient must try Generic Ambien before Ambien CR.
- Patient must try a generic of Zocor, Pravachol or Mevacor before Lipitor.
- Patient must try Generic Prilosec, PrilosecOTC, or Generic Protonix before Nexium or Aciphex.

Contact MedTrak Services at (800) 771-4648 if You have questions about the Step Therapy Program.

Covered Expenses Under the Prescription Drug Card Plan

The following is a general listing of Covered Expenses:

1. Non-injectable legend drugs.
2. Insulin and diabetic test supplies by prescription.
3. Acne Medications through age 25 then prior approval required.
4. Compounded medication of which at least one ingredient is a legend drug.
5. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber.
6. Contraceptives which require a prescription for dispensing.
7. Prenatal vitamins as prescribed by a Physician.
8. Vitamin K with Prior Authorization.
9. AIDS - Related drugs.
10. Emergency contraceptives.
11. Anti-Fungals only with prior approval (except those used to treat nail infections).
12. Anti-Migraine Medications, quantities limited.
13. ADD/ADHD Medications.
14. Chemotherapy Medications. Prior Authorization required.
15. Injectables with Prior Authorization.
16. Immunosuppressants.
17. Non-Insulin Syringes.

18. Schedule V Cough Syrups.
19. Vaginal Estrogen (90-day supply only).
20. Prilosec OTC.
21. Aspirin for men from ages 45 up to 79.
22. Aspirin for women from ages 55 up to 79.
23. Folic acid supplementation for women of childbearing age.
24. Oral fluoridation supplementation for Children 6 months of age up to 6 years.
25. Iron supplementation for Children 6 months of age up to 13 months of age.
26. Tobacco deterrents (limitations may apply).

Expenses Not Covered Under the Prescription Drug Card Plan

The following is a list of expenses not covered:

1. A charge excluded under the Prescription Drug Card Plan Provisions.
2. A drug or medicine that can legally be bought without a written prescription.
3. 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.
4. Immunization agents; biological sera; blood or blood plasma; or oxygen, including its administration.
5. A drug or medicine labeled: "Caution - limited by Federal law to investigational use".
6. Experimental or Investigational drugs and medicines, even though a charge is made to You.
7. Any charge for the administration of a covered Prescription Drug.
8. Any drug or medicine that is consumed or administered at a place where it is dispensed.
9. A drug or medicine that is to be taken by You, in whole or in part, while Hospital confined. This includes being confined in any other institution that has a facility for the dispensing of drugs and medicines on its premises.
10. Prescription Drugs which may be properly received without charge under local, state or federal programs.
11. Vaccines/Serums/Toxoids/Allergens.
12. A charge for the use of hypodermic syringes and/or needles.
13. Infertility medications.
14. Growth hormones (i.e., Humatrope, Protropin) and any future growth hormone.
15. Contraceptive devices
16. Impotency drugs.
17. Anorectics (any drug used for the purpose of weight loss).
18. Minerals.
19. Cosmetic Drugs including Minoxidil (Rogaine), Propeica for the treatment of alopecia and Botox used for Cosmetic purposes.
20. Vitamins, singly or in combinations (except as stated).
21. Lavonorgestral (Norplant).
22. Non-legend drugs other than those listed above.
23. Prescriptions which an eligible person is entitled to receive without charge from any Workers' Compensation Laws.
24. Any prescription refilled in excess of the number specified by the Physician, in excess of the limits of the Plan, or any refill dispensed after one year from the Physician's original order.
25. Abortifacients.
26. Anabolic Steroids including but not limited to Testosterone.
27. Diagnostic Test Supplies.
28. Fluoride Preparations, except as stated above.
29. Hematinics.
30. Homeopathic Drugs.
31. Inhaler Devices.
32. Ostomy Supplies.
33. Therapeutic Devices & Appliances.

Non-member Pharmacy Claims

If You purchase a drug from a Non-Member pharmacy, MedTrak Services may require, as a condition of claim payment, that the pharmacy furnish information relating to the prescription, including a copy of the order or any other information deemed necessary to process the claim. Your Outpatient Prescription Drug Card Benefit may be limited or restricted if You purchase a Prescription Drug from a Non-Member Pharmacy.

B. SECOND SURGICAL OPINION EXPENSE BENEFIT
(Inpatient and Outpatient Surgery)

The Second Surgical Opinion Expense Benefit is designed to provide You with the complete information as to the advisability of a Surgical Procedure as well as assist You in determining if any alternative treatment may be available for the medical condition involved.

An opinion confirming the advisability for surgery can provide You and Your Dependents greater peace of mind, and a non-confirming opinion may provide an alternative non-surgical method of treatment for the medical condition.

Listed below are some of the Surgical Procedures You may want to consider obtaining a second opinion for:

Adenoidectomy	Jaw Surgery	All Foot Procedures
Joint Surgery to Knee,	Appendectomy	Shoulder, Elbow or Toes
Cataract Surgery	Mastectomy Surgery	Cholecystectomy
Prostate Surgery	Deviated Septum	(gall bladder)
Salpingo-Oophorectomy	Hysterectomy	Spinal Surgery (all types)
(removal of tubes/ovaries)	Hemorrhoidectomy	Tonsillectomy
Hernia Surgery	Tympanotomy (inner ear)	Varicose Vein Ligation

You may choose any PPO Specialist who is not an associate of the referring Physician and who treats medical conditions like the one for which surgery was recommended. The benefit also covers any additional x-ray and laboratory tests the Physician might need. If You need any assistance in selecting a Physician for obtaining the second opinion, contact the local Academy of Medicine.

If the second opinion Specialist does not confirm the advisability of the proposed surgery, a third opinion may be arranged (and will be covered) in the same manner as the second.

V. MEDICAL EXPENSE BENEFITS

A. DEDUCTIBLE / OUT-OF-POCKET

DEDUCTIBLE

A Deductible must be met for each Covered Person as stated in the Schedule of Benefits. Each Plan Year a new Deductible must be met. Only those expenses, as described in this Plan Document as Covered Expenses, will be counted toward meeting the Deductible. Each person must meet the PPO or Non-PPO Deductible in full before any benefits are paid unless stated otherwise in Your Schedule of Benefits.

When the maximum amount shown in Your Schedule of Benefits has been incurred by members of a Family Unit toward the Plan Year Family Unit Deductible, the Deductibles of all members of that Family Unit will be considered satisfied for that year. No one individual in the Family Unit shall contribute more than the individual Deductible amount.

DEDUCTIBLE ACCUMULATION PERIOD

Covered Expenses used to meet the Deductible must be incurred from July 1 through June 30. There is no carry-over of Deductible from Plan Year to Plan Year.

BENEFIT PAYMENT

Each Plan Year benefits will be paid for the Covered Expenses of a Covered Person that are in excess of the Deductible. Payment will be made at the rate shown in Your Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

COINSURANCE OUT-OF-POCKET

Except as limited, once You pay the Deductible and Coinsurance out-of-pocket amounts for Covered Expenses in a Plan Year, all further Expenses Incurred during that Plan Year are payable at 100%. However, the following expense(s) will not be used to satisfy the Coinsurance out-of-pocket maximum and will not be paid at 100%:

1. Expense Incurred as a result of Deductibles and Copayments,
2. Expenses You must pay as a result of failure to comply with the cost containment provision of the Plan.
3. Copays paid for Prescription Drugs under the Prescription Drug Card Benefits.
4. Amounts over the Usual, Customary and Reasonable Charge.

When the maximum amount shown in Your Schedule of Benefits has been incurred by members of a Family Unit toward the Plan Year Family Unit Coinsurance out-of-pocket maximum, the Coinsurance out-of-pocket of all members of that Family Unit will be considered satisfied for that year. No one individual in the Family Unit shall contribute more than the individual Coinsurance out-of-pocket maximum amount.

B. COVERED MEDICAL EXPENSES

Covered Expenses are the Medically Necessary, Usual, Customary and Reasonable Charges that are incurred for the following items of treatment, service or 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 treatment, service or supply is performed or furnished. The "Definitions" page also sets out the meaning of certain terms, which may contain additional limitations.

We will consider an Expense Incurred by a Covered Person for a Sickness or Injury. When a claim is submitted, You will be required to meet any applicable Deductible, Copayment or Coinsurance. A Deductible is considered to be met when Covered Expenses equal the Deductible. After such Deductible is met, We will pay the remaining Covered Expenses at the percentage shown in Your Schedule of Benefits for the rest of the Plan Year.

1. **Abortion.** A Medically Necessary or elective abortion for a Covered Person.
2. **Allergy Services.** Allergy testing, antigens/serums, injections and evaluations to determine the need for the same as shown in Your Schedule of Benefits.
3. **Ambulance service.** Local ambulance service, if Medically Necessary, to transport You from the place where You are injured or stricken by Sickness to the first Hospital where treatment is given, between Hospitals, and between Hospitals and a Skilled Nursing Facility. Air ambulance service is limited to the first trip to and from the nearest facility qualified to render the medically required treatment.
4. **Anesthetics.** Anesthetics and the administration thereof by a professional anesthetist.
5. **Bereavement Counseling.** Bereavement Counseling provided within six (6) months of death as shown in Your Schedule of Benefits under Mental and Nervous Disorders.
6. **Blood and blood derivatives.** Charges for services and supplies required for the administration of blood transfusions, including blood, blood plasma, and plasma expanders, when not available to the Covered Person without charge. Charges incurred for the processing and storage of a Covered Person's own blood, in anticipation of a possible need for a blood transfusion, as a result of a scheduled surgery are Covered Expenses.
7. **Clinical Trials.** Covered expenses include routine patient care costs incurred as a result of Phase I, Phase II, Phase III, and Phase IV Clinical Trials designed to evaluate new treatments, prescription drugs, or devices and:
 - a. Involves the treatment of life threatening medical conditions;
 - b. Are medically indicated and preferable for the Covered Person compared to available non-investigational treatment alternatives;
 - c. Have clinical and preclinical data that shows the trial will likely be more effective for the Covered Person than available non-investigational alternatives;
 - d. Includes a recommendation from the Covered Person's treating Physician, who is providing covered health care services to the Covered Person under the Plan, that participation in the Clinical Trial has a meaningful potential benefit to the Covered Person, or the Covered Person provides medical and scientific information that establishes that the Covered Person meets the conditions for participation in the Clinical Trial; and
 - e. The Clinical Trials are conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

Covered Clinical Trials describes any of the following:

- (1) Is federally funded or approved by at least one of the following agencies:
 - i. National Institutes of Health (NIH),
 - ii. Centers for Disease Control and Prevention (CDC),

- iii. Agency for Health Care Research and Quality (AHCRO),
 - iv. Centers for Medicare and Medicaid Services (CMS),
 - v. A cooperative group or center of any of the above agencies, or the Department of Defense (DOD), Veterans Affairs (VA), or the Department of Energy (DOE), or
 - vi. A qualified nongovernmental research entity identified by NIH guidelines for grants.
- (2) A study or trial conducted under a Food and Drug Administration (FDA) approved investigational new drug application;
- (3) A drug trial that is exempt from investigational new drug application requirements.

As used in this Clinical Trials section, the terms “routine patient care costs” and “life-threatening medical condition” shall mean:

Routine patient care costs include all items and services consistent with the coverage provided in the Plan that is typically covered for a Covered Person who is not enrolled in a clinical trial, such as doctor visits, hospital stays, x-rays, etc. Routine patient care costs exclude:

- i. The investigational item, device, or service itself;
- ii. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Person,
- iii. Costs for a service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Items and services customarily provided by the research sponsors free of charge for any enrollee in the Clinical Trial;

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

8. **Chemotherapy Services.** Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included. Chemotherapy treatments are complex and many times cutting-edge care. Contact the Claims Administrator to help You determine whether Your course of treatment is a Covered Expense.
9. **Contact lenses.** Initial contact lenses, eyeglasses or intraocular lens following cataract surgery.
10. **Cosmetic or Reconstructive Surgery.** Charges for Cosmetic or Reconstructive Surgery only when the service meets one of the following guidelines.
- a. The surgery corrects a function disorder.
 - b. The surgery corrects a condition caused by an Accident.
 - c. The surgery corrects a Congenital Birth Defect resulting in the malformation or absence of a body part.
 - d. The surgery is for breast reconstruction following a total or partial mastectomy, reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and physical complications from all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).
11. **Dental Services.** Dental Services are covered for the repair of Injury to natural teeth due to an Accident (provided treatment and/or consultation commences within six (6) months after the Accident) only when the Covered Expenses are not payable under any dental insurance plan. Injury as a result of chewing or biting shall not be considered an Accident or Injury.

Oral surgery is limited to cutting procedures for the removal of tumors or cysts and the excision of partially or completely unerupted impacted wisdom teeth only when the Covered Expenses are not payable under any dental insurance plan.

Facility Charges determined to be Medically Necessary for dental care are covered only if they are provided to the following persons:

- a. Covered Child and Qualified Dependents five (5) 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.

Benefits will be paid only for expenses incurred for the least expensive service that will produce professionally adequate results as determined by the Plan. No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth or periodontal disease.

- 12. **Diabetic Supplies, Equipment and Self-Management Programs.** Covered services are limited to self-management training (including diet counseling from a registered dietician or certified diabetes educator) and Physician prescribed Medically Necessary equipment and supplies used in the management and treatment of diabetes. Benefits are available only for Covered Persons with gestational, type I or type II diabetes. Insulin, oral anti-diabetic agents, syringes, test strips, lancets, needles and glucometers are covered under the Prescription Drug Card.
- 13. **Diagnostic Infertility Services.** Care, supplies and services to diagnose the cause of infertility 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 Expenses.
- 14. **Diagnostic x-rays and laboratory services.**
- 15. **Dialysis Services.** 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.
- 16. **Durable Medical Equipment.** Rental of Durable Medical Equipment if deemed Medically Necessary subject to the following:
 - a. The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury.
 - b. 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.
 - c. Benefits are limited to standard models, as determined by the Plan.
 - d. 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.
 - e. 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.

Transcutaneous Electrical Nerve Stimulator (T.E.N.S.) units and muscle stimulators are considered by the Plan as Durable Medical Equipment.

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.

17. **Home Health Care.** Home Health Care Services and Supplies are covered only 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 are subject to the Home Health Care limit shown in the Schedule of Benefits.

Charges that are made by a Home Health Care Agency for one or more of the following are Covered Expenses:

- a. Part-time or intermittent home nursing services by or under the supervision of a licensed Nurse.
- b. Health services provided by a physical, occupational, respiratory or Speech Therapist.
- c. Health services provided by a Home Health Aide to the extent that such services would be covered charges if provided to You on an Inpatient basis.
- d. Medical Supplies, drugs, medicines and laboratory services to the extent that they would be covered if provided to You on an Inpatient basis.

The Plan does not cover the following services:

- a. General housekeeping services.
- b. Services for Custodial Care.
- c. Service by the Patient's Immediate Family.
- d. Transportation services.
- e. Dialysis treatment.
- f. Dietician services.

18. **Hospice Care Services.** Inpatient pre-certification is required. Covered Expenses are charges incurred by You or Your Dependent who is Terminally Ill. Covered Expenses for Hospice Care Services are payable as shown in Your Schedule of Benefits.

Treatment provided in a Hospice Care Facility must be in place of a stay in the Hospital. The Hospice Care Facility must be licensed and qualified to render the appropriate treatment. Two (2) or more occurrences of Inpatient Hospice Care will be considered one unless the occurrences are separated by at least 180 consecutive days during which the Hospice Care Program is not in effect.

19. **Hospital Care.** Charges for the room and board and Miscellaneous Hospital Expenses furnished by a Hospital, Ambulatory Surgical Center or Birthing Center as shown in Your Schedule of Benefits. After 23 observation hours, a confinement will be considered an Inpatient confinement. Inpatient hospital care requires pre-certification.

Room charges by a facility having only private rooms will be considered 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 are payable as shown in Your Schedule of Benefits.

20. **Medical/Surgical Supplies.** Medical/Surgical Supplies, which serve only a medical purpose and are Medically Necessary to treat a specific condition. Covered supplies do not include items usually stocked in the home for general use such as, but not limited to, band-aids, thermometers and petroleum jelly.

21. **Mental/Nervous Disorders and Substance Abuse.** Covered Expenses for care, supplies and treatment of Mental Disorders as shown in Your Schedule of Benefits.

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.

22. **Newborn Nursery Care.** Charges for newborn nursery care. Newborn nursery care is routine care of the child while Hospital-confined as a result of the birth and includes room, board and other routine care for which a Hospital or Physician makes a charge. The benefit is limited to Usual, Customary and Reasonable charges. Circumcision performed while Hospital confined following birth will be considered as part of the newborn's nursery care. If the newborn is ill, suffers an Injury, or requires care other than routine care, benefits will be provided on the same basis as any other Covered Expense and applied to those of the newborn.

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.

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

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

23. **Organ Transplant.** Pre-certification is required prior to surgery; failure to obtain pre-certification may result in non-payment of the related transplant surgery. We will assign Case Management to You which can help You coordinate the care and services. Only those transplants, or combinations thereof, shown in Your Schedule of Benefits are eligible transplants under the Plan. The types of approved transplants and medical criteria for those transplants must be deemed Medically Necessary and appropriate for the medical condition for which the transplant is proposed. Corneal transplants and skin grafts/transplants are considered the same as any other illness and are not subject to the Organ Transplant procedures or limitations described herein.

If a Covered Person is denied a transplant procedure, the Covered Person may seek a second opinion for evaluation. If the second opinion determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, no benefits will be provided for further transplant related services and supplies regardless of a third facility's acceptance of the Covered Person.

Transplant Definitions: For purposes of this section, the following definitions apply.

- a. **Approved Transplant Services:**
Services and supplies for eligible transplants when ordered by a participating Physician, provided at or arranged by a Designated Transplant Facility. Such services include, but are not limited to, Hospital charges, Physician charges, organ procurement, tissue typing and ancillary services rendered during the Transplant Benefit Period, when such transplants are Medically Necessary and medically appropriate, but not Experimental or Investigational. For information regarding Designated Transplant Facilities and transplant procedures, contact the Claims Administrator.

Donor charges include those for:

- i. Evaluating the organ or tissue;
- ii. Removing the organ or tissue from the donor; and
- iii. Transportation of the organ 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.

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 donor charges are not covered under this Plan.

- b. **Transplant Benefit Period:**
The period of time commencing 5 days prior to the Covered Person's transplant until the earliest of the following:
 - i. One year from the date the transplant procedure was actually performed; or
 - ii. The date coverage under this provision terminates.
- c. **Designated Transplant Facility:**
A facility that has entered into an agreement through a national organ transplant network to render Approved Transplant Services, to which the Plan has access. The Plan Administrator will determine the Designated Transplant Facility. If a Designated Transplant Facility is utilized, Covered Expenses relating to the transplant will be payable at the Designated Transplant Facility contracted rate. A Designated Transplant Facility is considered a PPO facility. The Designated Transplant Facility contracted rate supersedes any negotiated PPO Network discount.
- d. **Non-Designated Transplant Facility:**
A facility that has not entered into an agreement through a national network to provide Approved Transplant Services.

Limitations:

A Covered Person is eligible for coverage under the Plan for up to two (2) transplants per Lifetime. Multiple organ transplants performed at the same time such as heart/lung are considered to be one procedure.

Exclusions:

- a. Any expenses incurred for:
 - i. Allogenic or autologous bone marrow transplantation, peripheral blood stem cell transplantation, or solid organ transplantation when such procedures are considered Experimental, Investigational or unproven, or not considered appropriate for the condition being treated.
 - ii. Services for non-human organ transplants.
 - iii. Appetite suppressants and supplies of a similar nature.
 - iv. Artificial or mechanical devices designated to replace human organs.
 - v. Nutritional supplements.
 - vi. Rehabilitation services.
 - vii. Lodging and meals.
 - viii. Expenses related to the Covered Person's transportation.
 - ix. The purchase price of any bone marrow, organ, tissue, or any similar items which are sold rather than donated.

All exclusions listed herein include complications resulting from any excluded procedure.

The Plan is not responsible for any participant's decision to receive treatment, services or supplies from a

facility, nor does the Plan make warrants or representations regarding the qualifications of providers of treatment, services or supplies provided by a Designated Transplant Facility.

24. **Orthotic Appliances.** The initial purchase, fitting and repair of Orthotic Appliances which are required for support of an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness (excluding dental orthotics). Orthotic Appliances made specifically for the Covered Person's feet must be prescribed by a Physician and are limited to two pairs per Plan Year. Benefits are not payable for special or extra-cost convenience features. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered. Over the counter shoe inserts or orthotic devices are not Covered Expenses.

25. **Physician Services.** Medical care or surgery performed by a licensed Physician. Surgical expenses in connection with charges by a Physician assisting in surgery are limited to 25% of the Usual, Customary and Reasonable amount allowed by the primary surgeon.

If two (2) or more Surgical Procedures due to the same or related causes are performed at the same time, through the same incision or in the same operative field, the maximum amount payable for the Surgical Procedure will be the Usual, Customary and Reasonable charge for the major procedure and 50% for the second procedure and each additional procedure will be at 50%

26. **Podiatry Services.** 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.

27. **Pre-Admission Testing.**

28. **Pregnancy Services.** Pregnancy benefits for the Covered Person are Covered Expenses. Coverage of the Usual, Customary and Reasonable charges for the care and treatment of Pregnancy are covered as shown in Your Schedule of Benefits.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

29. **Prescription Drugs.** Prescription Drugs as defined by the Plan when prescribed by a Physician's written order. Prescription Drugs must be Medically Necessary and not subject to a separate exclusion described elsewhere in this Plan Document. The Plan, at its discretion, may provide coverage subject to the medical Deductible and Coinsurance for a medication that meets any of the following additional criteria:

- a. the Outpatient Prescription Drug is not covered under the Prescription Drug Card Benefit,
- b. the Specialty Drug was not purchased at a Preferred Specialty Pharmacy (authorization by the Plan Administrator is required).

Some Prescription Drugs may be subject to dispensing limits. To verify if a Prescription Drug has dispensing limits, call the MedTrak Services toll free customer service phone number on the back of Your ID card.

30. **Preventive Care Services.** Covered Expenses under Medical Expense Benefits are payable for Preventive Care Services as follows:

- a. Birth to age 21 years Preventive Care Services includes but is not limited to the following when age appropriate:
 - i Physical examination including anticipatory guidance.
 - ii Developmental and behavioral assessments:
 - (a) Developmental screening.

- (b) Autism screening.
- (c) Developmental surveillance.
- (d) Psychological/Behavioral assessment.
- (e) Alcohol and Drug Use assessment.
- iii Newborn Screenings:
 - (a) Hearing loss.
 - (b) Hemoglobinopathie (Sickle Cell disease).
 - (c) Congenital hypothyroidism.
 - (d) Phenyketonuria (PKU).
- iv Prophylactic medication against (gonorrhoea) gonococcal ophthalmia neonatorum.
- v Procedures of the following types:
 - (a) Newborn Metabolic/Hemoglobin screening.
 - (b) Immunizations.
 - (c) Hematocrit or Hemoglobin.
 - (d) Lead screening.
 - (e) Tuberculin test.
 - (f) Dyslipidemia screening.
 - (g) Screening, counseling and behavioral counseling for sexually transmitted infections when performed by a Physician or specialist.
 - (h) Cervical Dysplasia screening.
 - (i) Screening, counseling and behavioral intervention for obesity or Morbid Obesity when performed by a Physician or specialist such as a licensed nutritionist or dietitian.
 - (j) Screening for human immunodeficiency virus (HIV).
 - (k) Screening for depression.
 - (l) Sensory screening for vision and hearing.
 - (m) Oral health risk assessment.

b. Additional Preventive Care Services includes but is not limited to the following:

- i Physical examination.
- ii Pap smear limited to once per Plan Year.
- iii Mammogram beginning at age 35 and limited to once per Plan Year.
- iv Prostate examination beginning at age 50 and limited to once per Plan Year.
- v Colorectal Cancer Screening beginning at age 50 up to 75 years unless family history present:
 - (a) Fecal Occult Blood Testing
 - (b) Sigmoidoscopy
 - (c) Colonoscopy
- vi Preventive laboratory services.
- vii Immunizations, except those required for overseas travel.
- viii Counseling for a healthy diet when the Covered Person has hyperlipidemia or other known risk factors for cardiovascular and diet-related chronic disease. Counseling must be performed by a Physician or specialist such as a licensed nutritionist or dietitian.
- ix Procedures of the following types:
 - (a) Screening, counseling and behavioral counseling for sexually transmitted infections when performed by a Physician or specialist.
 - (b) Genetic Testing for BRCA 1 and BRCA 2 when supported by family history.
 - (c) Screening, counseling and behavioral intervention for obesity or Morbid Obesity when performed by a Physician or specialist such as a licensed nutritionist or dietitian.
 - (d) Screening for depression.
 - (e) Screening for hepatitis B virus (HBV) during pregnancy.
 - (f) Screening for iron deficiency anemia for asymptomatic women during pregnancy.
 - (g) Screening for Rh (D) blood typing and antibody testing including appropriate treatment.
 - (h) Screening for syphilis infection during pregnancy.
 - (i) Screening for human immunodeficiency virus (HIV).
 - (j) Bone density screening for females beginning at age 60 years.

- (k) Tobacco cessation interventions for tobacco use disorder including augmented, pregnancy-tailored counseling during pregnancy for a female with a history of tobacco use or smoking complications.
- (l) Interventions during pregnancy and after birth to support breastfeeding.
- (m) Screening for bacteriuria during pregnancy.
- (n) Counseling and behavioral counseling interventions to reduce alcohol misuse when performed by a Physician or specialist.
- (o) Screening for abdominal aortic aneurysm (AAA) by ultrasonography for males ages 65 up to 75 years, one time only.

Additional Preventive Care Services shall be provided as required by applicable law when provided by a Network Provider. A current listing of required Preventive Care can be accessed at www.healthcare.gov/center/regulations/prevention.html. Contact the Claims Administrator if you have questions about these benefits. Preventive benefits do not include school or sport physicals, work related physicals or physical exams required for licensure.

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 if the provider properly files the claim with this information, We will process the claim as a diagnostic procedure according to the benefit provisions of the Plan dealing with diagnostic x-rays.

If You are at high risk of developing breast cancer or You have a family history of breast cancer and if the provider properly files the claim with this information, We will process the claim as a routine Preventive Care procedure according to the benefit provisions of the Plan's Routine/Preventive Care Benefits.

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

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 if the provider properly files the claim with this information, We will process the claim as a diagnostic procedure according to the benefit provisions of the Plan dealing with diagnostic tests.

If You have a family history of colon cancer and if the provider properly files the claim with this information, We will process the claim as a routine Preventive Care procedure according to the benefit provisions of the Plan's Routine/Preventive Care Benefits.

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

31. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted Prosthetic Devices which replace body parts. 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. The Plan will determine when a device is special or an extra-cost convenience feature. Dental plates, bridges, orthodontic braces, and dental prosthesis are not Covered Expenses.

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.

Coverage is available for one wig per Lifetime for Covered Persons undergoing chemotherapy treatment.

32. **Rehabilitation Services.** Except as limited, the following Rehabilitation Services that are Medically Necessary are covered on both an Inpatient and Outpatient basis only if they are expected to result in significant improvement in the patient's condition. Maintenance Therapy with no further medical improvements being made and therapy that no longer requires the supervision of a medical professional are not covered. Covered therapy services include but are not limited to:

Respiratory therapy.

Neuropsychological testing.

Pulmonary Rehabilitation.

Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (i) under the supervision of a Physician; (ii) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (iii) initiated within 12 weeks after other treatment for the medical condition ends.

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 Expenses do not include recreational programs or supplies used in Occupational Therapy.

Physical Therapy/Physiotherapy by a licensed physical therapist following a Sickness, Injury or loss of body part. Services provided by a member of the Patient's Immediate Family or by someone who ordinarily resides in the Covered Person's home are not eligible. Covered services include Inpatient and Outpatient services, which are subject to significant improvement through short-term therapy. Physician order for frequency and duration required.

Speech Therapy by a certified Speech Therapist to:

(Physician order for frequency and duration required.)

- i. Restore speech loss; or
- ii. Correct an impairment due to a Congenital Birth Defect for which corrective surgery has been performed; or
- iii. Correct an impairment caused by an Injury or Illness (not caused by a psychoneurotic, or personality disorder).

SPEECH THERAPY EXCEPTION: No benefit payment will be made for screening examinations or for services rendered under any program offered by any governmental body or entity including school districts.

33. **Septoplasty.** Septoplasty (nasal surgery) if determined to be Medically Necessary.
34. **Skilled Nursing Facility.** Pre-Certification required. The benefit will be determined by applying any Deductible, Copayment and maximum provisions shown in the Schedule of Benefits to the Covered Expenses listed below. Care and treatment in a Skilled Nursing Facility must be prescribed by a Physician in place of a stay in a Hospital.

Covered Expenses are charges for room and board and routine nursing care. No coverage is provided for Custodial Care, care for service deterioration, mental deficiency or mental retardation.

We will consider benefits only if Your Physician certifies that 24-hour nursing service is Medically Necessary. The stay in a Skilled Nursing Facility must follow a covered Hospital confinement of least three (3) days and begin within 14 days of release from the Hospital.

Successive periods of Skilled Nursing Facility confinement due to the same or related causes are considered one period of confinement unless separated by more than seven (7) consecutive days during which the Covered Person was not confined in a Hospital or a nursing home, or under 24-hour nursing care.

35. **Sleep Disorders.** Care and treatment for sleep disorders when deemed Medically Necessary. A CPAP machine is considered Durable Medical Equipment and subject to the Durable Medical Equipment benefit shown in Your Schedule of Benefits.
36. **Spinal Manipulation/Chiropractic Services.** Spinal Manipulation/Chiropractic services by a licensed M.D., D.O. or D.C. as shown in the Schedule of Benefits. 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.
37. **Surgical dressings** splints, casts and other devices used in the reduction of fractures and dislocations.
38. **Surgical Sterilization.** Charges for voluntary sterilization are covered for the Employee and Spouse. Reversals are excluded.
39. **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 dietitians.

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.

VI. COST CONTAINMENT PROVISIONS

A. PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization, known as a "PPO", is contracted by the Plan to provide discounted medical services through a network of local Physicians, Hospitals and other health care providers. Your identification card carries information about the PPO network including claims address and phone number.

As an enrollee covered by this Plan, You may choose to use the PPO providers, also called Network Providers, and have medical benefits paid at a higher percentage amount.

The Plan will pay benefits for Covered Expenses by Non-Network Providers based on Usual, Customary and Reasonable charges, but at a lower percentage amount. You are responsible for payment of any amount in excess of Usual, Customary and Reasonable. Medical care for services provided outside the PPO network area will be paid according to the Schedule of Benefits.

When choosing Your health care provider, choose carefully. When utilizing the PPO network, make certain the Physician, Hospital or other health care provider is a member of the network.

If the need arises for Your Network Physician to refer You to another provider, confirm with the second provider that he or she is a member of the network as well.

Covered Expenses for ancillary services (assistant surgeon, lab, radiology, anesthesia and emergency room Physician) rendered by a Non-Network Provider at a Network facility and/or services performed were provided outside the patient's control or election will be covered at the Network Deductible, Copay or Coinsurance. Charges in excess of the Usual, Customary and Reasonable will not be considered Covered Expenses and may be the responsibility of the Covered Person.

The Network associated with Your Plan is named on Your identification card. Included on the card are the Network logo, phone number, physical claim address, EDI filing number and web address. To obtain information about Network Providers call the Network PPO telephone number listed on Your identification card. A list of Network Physicians, Hospitals and other health care providers is also available by accessing MPR's website www.mprhealthplan.org or by accessing the PHP website at www.phpkc.com.

B. COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Your identification card carries the name of the Cost Management Service and its 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 Deductible or Coinsurance maximum out-of-pocket limit.

1. 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) Pre-Certification 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.

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

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

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

The pre-certification procedure does not apply if the Plan is not the primary coverage.

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

Here's how the program works.

Pre-Certification. Before a Covered Person enters a Hospital 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 Hospital 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 Member Group
- 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 Hospital, the patient, patient's family member, authorized representative, Hospital 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 Hospital 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 pre-certification for inpatient admissions as explained in this section, the benefit payment will be reduced by 20% before any eligible benefits are considered for reimbursement

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Hospital are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Hospital stay or use of other medical services and coordinate with the attending Physician, Hospital and Covered Person either the scheduled release or an extension of the Hospital 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 Hospital for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

2. 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. Some of the diagnostic profiles for "Case Management" claims include, but are not limited to:

SICKNESS

Neonatal High Risk Infant
Cancer
Acquired Immune Deficiency Syndrome (AIDS)
Cerebral Vascular Accident (CVA)
Severe Stroke
Transplants
Dialysis

INJURY

Major Head Trauma
Spinal Cord Injury
Amputations
Multiple Fractures
Severe Burns

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:

- a. Working with Your attending Physician to assess Your condition and medical needs.
- b. Contacting medical consultants, when necessary, for further evaluation and input and to recommend alternative medical treatments.
- c. Acting as an information resource for You, Your family and the Provider of care.
- d. Helping Your family manage Your Sickness or Injury.
- e. Monitoring Your progress throughout the entire treatment period.

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.

VII. GENERAL PLAN EXCLUSIONS

Unless otherwise specified by a specific benefit provision or amendment, the exclusions and limitations listed in this section apply to all charges incurred. The "Definitions" page also sets out the meaning of certain terms, which may contain additional limitations. The following expenses for care, treatment and services are excluded from coverage under this Plan.

Benefits will not be paid for:

1. **Acupuncture.** Acupuncture or acupressure except when done by a medical doctor as an anesthetic.
2. **Adoptive birth mother.** Expenses incurred by an adoptive birth mother.
3. **Alternative medicine.** Biofeedback, hypnosis and other forms of self-care or self-help training.
4. **Autopsies.**
5. **Blepharoplasty.** Blepharoplasty (eyelid surgery).
6. **Breast reductions.** Breast reduction or procedures to correct problems caused by or due to breast implants and complications arising there from or for a mastectomy for reasons other than diagnosed cancer.
7. **Cognitive Therapy.** Except as may be required by applicable law, Cognitive Therapy is not a Covered Expense.
8. **Complications of non-covered services.** Services or supplies received for complications resulting from services, which are not covered.
9. **Counseling services.** Charges for or in connection with counseling or educational services of the following types: marital, family, career, social adjustment, pastoral, financial, phase-of-life problems, vocational or employment counseling and sex therapy unless required by applicable law.
10. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care..
11. **Dental Services.** Except as specifically stated, charges incurred for Dental Services.
12. **Dermabrasion.** Surgical treatment of scarring secondary to acne or chickenpox to include, but not to be limited to, dermabrasions, chemical peel, salabrasion, and collagen injections.
13. **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.
14. **Evaluations and diagnostic tests to determinate familial responsibility. Evaluations and diagnostic tests** ordered or requested in connection with determinations of paternity, divorce, child custody, or child visitation proceedings.
15. **Excess Charges.** The portion of an expense which is in excess of the Usual, Customary and Reasonable charge.
16. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, Occupational or Physical Therapy covered by the Plan.
17. **Experimental Investigational or not Medically Necessary.** Care and treatment that is Experimental, Investigational or not Medically Necessary is excluded. Clinical Trials, as set forth in the Covered Medical Expenses Section, are not excluded.

18. **External defibrillators.**
19. **Eye.** Charges incurred in connection with radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations (except as may be covered by the Preventive Care Benefit for a Covered Child or Qualified Dependent under the age of 21), including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be.
20. **Foreign Travel.** Charges for services received or supplies purchased outside the United States unless the charges are incurred while traveling on business or pleasure; provided the treatment is approved for use in the United States.
21. **Government coverage.** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to covered expenses 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.
22. **Growth hormones.**
23. **Hearing aids and exams.** The purchase or fitting of hearing aids or similar devices. This exclusion shall not apply to the initial purchase of a hearing aid if the loss of hearing is a result of a Surgical Procedure. However, such expenses will only be covered to the extent of the least expensive service, supply or procedure, which will correct the condition. Surgical procedures for the implantation of Bone Anchored Hearing Aids (BAHA) are covered; the device itself is not a Covered Expense.
24. **House Physician.** Charges for services provided by interns, residents, fellows or other Physicians in the status of house doctors.
25. **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.
26. **Jaw Joint/Temporomandibular Joint Syndrome (TMJ).** Diagnosis, prevention or correction of the Temporomandibular Joint (TMJ) or myofacial dysfunction; for appliances, medical or surgical treatment, Physical Therapy or restoration for TMJ including orificial muscle disorders and facial cranial pain syndrome.
27. **Massage therapy.** Massage therapy, rolfing, and other related treatment.
28. **No Charge.** Charges that would not have been made if no coverage existed or charges that You are not required to pay.
29. **No legal obligation to pay.** Any expenses where there is no legal obligation or financial liability to pay, or where charges would not be made if there were no coverage under this Plan, except where required to pay by law. This is not applicable to any Expenses Incurred as a result of expert medical opinion arranged through or coordinated by the case manager.
30. **No Physician recommendation.** Treatment which has not been recommended by a Physician.
31. **Not specified as covered.** Charges made for treatment, services or supplies not specified as a Covered Medical Expense. 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.

32. **Nutritional consultation.** Except as stated, nutritional consultation, instruction, services, supplies, supplements or vitamins.
33. **Obesity/Morbid Obesity.** Except as stated, charges related to or as a result of treatment for obesity or morbid obesity or complications arising from, including, but not limited to: mason shunt; banding gastroplasty; or intestinal bypass. This includes any care which is primarily for dieting or exercise for weight loss.
34. **Occupational.** Benefits will not be provided for services for injuries or diseases related to Your job to the extent that You are covered or are required to be covered by the Workers' Compensation law. If You enter into a settlement giving up Your right to recover future medical benefits under a Workers' Compensation law, the policy will not pay those medical benefits that would have been payable in absence of that settlement.
35. **Orthopedic shoes.** Orthopedic shoes and devices prescribed primarily for use during participation in sports, recreational and similar activities.
36. **Payable under another provision.** To the extent that benefits are payable under more than one provision of this Plan and would be more than the actual Expense Incurred.
37. **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, dehumidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, hypo-allergenic pillows, power assist chairs, railings, ramps, waterbeds, non-prescription drugs and medicines (except as may be required by applicable law), hot water bottles, home enema equipment, 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. Additionally, Inpatient personal expenses, such as guest meals, TV rental and hair care are not Covered Expenses Charges for electrical power, water and disposal systems, baths, hot tubs and pools or their installation.
38. **Relative giving services.** Services provided by the Patient's Immediate Family, whether by blood or law.
39. **Sales tax.**
40. **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.
41. **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.
42. **Sexual dysfunction.** Any expense relating to or as a result of treatment for impotency, frigidity, sterility, infertility (except as stated under Covered Expenses), contraceptive devices, supplies or drugs, procedures or removal of contraceptive devices or for services or supplies for a prosthesis for impotency.
43. **Stand-by availability.** Hospital or Physician charges for stand-by availability.
44. **Take home drugs.** Drugs dispensed in a doctor's office or "take home" drugs upon Hospital discharge.
45. **Vision training.** Charges for orthoptics, vision training, vision therapy or subnormal vision aids.
46. **War.** Charges incurred in connection with the care or treatment of any Sickness contracted or Injury sustained which results from war or any act of war, declared or undeclared.

VIII. DEFINITIONS

"Accident" means an event that is sudden, unexpected, unintended and over which You have no control.

"Actively at Work" and **"Active Work"** means You must work for Your Member Group at Your usual place of work or such other place or places as required by Your Member Group in the course of such work for the full number of hours and full rate of pay, as set by the employment practices of Your Member Group.

"Aggregate" means an accumulation of Covered Expenses to meet the Deductible and/or out-of-pocket amounts by more than one, either by a Covered Person as shown in Your Schedule of Benefits.

"AIDS" (Acquired Immune Deficiency Syndrome) means a condition manifested by the presence of a terminal infection or opportunistic infection such as kaposi's sarcoma or pneumocystis carinii - pneumonia with no other known cause.

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

"Ambulatory Surgical Center" means an establishment with an organized medical staff of Physicians, permanent facilities that are equipped and operate primarily for the purpose of performing Surgical Procedures, continuous Physician services and registered professional nursing services available whenever a patient is in the facility, which does not provide services or other accommodations for patients to stay overnight and which offers the following services whenever a patient is in the center:

1. Drug services as needed for medical operations and procedures performed.
2. Provisions for the physical and emotional well being of the patients.
3. Provision of Emergency Services.
4. Organized administrative structure.
5. Administrative, statistical and medical records.

The establishments must be licensed and operated under the direction and/or supervision of a Hospital or a staff of qualified Physicians.

"Assignment of benefits" means an assignment by a Covered Person of Plan benefit payments to a health care provider through written permission.

"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, artificial insemination, intracytoplasmic sperm injection, embryo transport, selective reduction, and cryo-preservation.

"ARC" (AIDS Related Conditions) means a syndrome in which the covered Individual displays many of the same symptoms of AIDS, including the presence of the HTLV-III virus, but presently does not have the terminal infection.

"Benefit Management, Inc." ("BMI") means the firm providing claim and administrative services to the Plan Administrator.

"Bereavement Counseling" means counseling provided to a covered family member of the deceased Covered Person who was the recipient of Hospice Care.

"Birthing Center" means a facility that meets all the following requirements:

1. Is licensed as such by the jurisdiction it is in.
2. Is set up, equipped and run solely as a setting for prenatal care, delivery and immediate postpartum care.
3. Is run under the direction of at least one MD or DO specializing in obstetrics and gynecology.
4. Has an MD or DO or certified Nurse midwife present at all births and during the immediate postpartum period.

5. Extends staff privileges to Physicians who have privileges to provide obstetrical and gynecological care in an area Hospital.
6. Has a minimum of two (2) beds or two (2) birthing rooms for patients in labor and during delivery.
7. Provides in the delivery and recovery rooms, full-time skilled nursing services under the direction of RN's or certified Nurse midwives.
8. Has diagnostic x-ray and laboratory equipment needed to perform tests on the mother and the newborn or has access thereto through a contract with an area medical facility.
9. Has equipment and supplies needed to perform minor surgery, including episiotomy and repair of perineal tear and to administer a local anesthetic.
10. Has equipment and trained personnel needed to handle medical emergencies and provide immediate support measures to sustain life for:
 - a. Complications which arise during labor.
 - b. Newborns with abnormalities which impair function or threaten life.
11. Has an admission policy of accepting only patients with low risk pregnancies.
12. Has a written agreement with an area Hospital for immediate transfer in case of Emergency and displays written procedures for such a transfer and makes sure the staff is aware of them.
13. Provides an ongoing quality assurance program with review by MD's or DO's other than those who own or direct the facility.
14. Maintains written medical records on each patient admitted to and each infant born at the center.

"Brand Name" means a trade name medication.

"Calendar Month" means any one of the twelve months of the Calendar Year.

"Calendar Year" means a 12 continuous month period of time that begins on each January 1 and ends the following December 31.

"Cardiac Rehabilitative Services/Therapy" means treatment for vascular deficiency administered to regain a Covered Person's functional ability or symptom improvement.

"Case Management" means the service coordinated by the Utilization Review Firm for those Covered Persons with catastrophic conditions or injuries. These services may allow for procedures, practices and services not normally covered under the Plan.

"CHIP" means the Children's Health Insurance Program administered by each State.

"CHIPRA" means the Children's Health Insurance Program and Reauthorization Act of 2009.

"Claimant" means the person for whom expense is incurred.

"Clean claim" means a claim for benefits that has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment.

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

"Cognitive Therapy" means treatment given to improve a Covered Person's thinking processes and intellectual capabilities.

"Coinsurance" means the percentage of the Usual, Customary and Reasonable charge for a covered service at which payment is made after any applicable Deductible amount has been satisfied.

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

"Copay/Copayment" means the portion of a Provider's Usual, Customary and Reasonable Charge that is the Covered Person's financial responsibility, not including any Deductibles.

“Cosmetic” means any procedure which is primarily directed at improving a Covered Person’s appearance and does not meaningfully promote the proper function of the body or prevent or treat Injury or Sickness or disease. This does not include Reconstructive Surgery resulting from an Illness or Injury.

"Covered Expenses" means charges made to You which are Usual, Customary and Reasonable (UCR), necessary for the treatment of non-occupational Sickness or Injury and performed or ordered by a Physician or other provider, and listed in Section V of this Plan.

"Covered Person" means an Employee, Eligible Retiree or Elected Official who is covered by this Plan and his or her eligible Dependents, as defined, who are covered by this Plan.

“Creditable Coverage” means the following Hospital, medical, or surgical coverage a Covered Person had prior to the Enrollment Date under this Plan.

1. a group health plan;
2. health insurance;
3. Health Maintenance Organization coverage;
4. Medicare;
5. Medicaid;
6. Military health care;
7. a medical care program of the Indian Health Services or of a tribal organization;
8. a state health benefits risk pool;
9. a health plan offered under the Federal Employee Health Benefits Program;
10. a health benefit plan under Section 5(e) of the Peace Corps Acts;
11. any other similar coverage permitted under State/Federal law or regulations.

Creditable Coverage does not include coverage consisting solely of dental, vision, or disability benefits.

"Custodial Care" means care comprised of services and supplies, including room and other institutional services, which are provided to a person, whether disabled or not, primarily to assist in the activities of daily living such as walking, bathing, eating, dressing and taking medicine. It is care which is primarily for the purpose of meeting personal needs that could be provided by persons without professional skills or training.

"Deductible" means a set amount of Covered Expenses which must be paid by the Covered Person.

"Dental Services" mean the act of:

1. Adjusting, removing or replacing teeth, except the removing of wholly or partially unerupted impacted wisdom teeth will be considered a Surgical Procedure.
2. Providing care and treatment for teeth, gums and related parts of the oral cavity.
3. Performing any other procedure normally rendered by a doctor of Dentistry.

"Dentist" means a person duly qualified and legally licensed to practice Dentistry.

"Dependent" means:

1. **A Spouse of a covered Employee.**

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

2. A Child(ren) of a covered Employee.

The term "Child(ren)" shall mean the natural child, stepchild, or adopted child of an Employee. The term "Child(ren)" shall also mean a child placed for adoption with the Employee. A Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase "placed for adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

3. A Qualified Dependent of a covered Employee.

If a covered Employee or Spouse is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as Qualified Dependents. The Legal Guardianship must be established by a court of law before the child reaches the age of 18. Plan coverage terminates on the last day of the calendar month in which Legal Guardianship ends.

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. Coverage shall be effective on the first day of the month immediately following the date the Member Group qualifies the medical support order.

A Covered Person of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order determinations from the Member Group.

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

4. A Child or Qualified Dependent who is Totally Disabled.

A covered 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 reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; a Spouse living outside the USA; the legally separated or divorced former Spouse of the Employee; any Dependent who is on active duty in any military service of any country for more than 90 days; Foster Child(ren), or any person who is covered by the Plan as an Employee, Eligible Retiree or Elected Official.

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

"Dialysis Facility" means a facility (other than a Hospital) whose primary function is the provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

"Durable Medical Equipment" means medical equipment which:

1. Can withstand repeated use.
2. Is not disposable.
3. Is prescribed by a doctor only when Medically Necessary.

4. Is appropriate for use in the home.
5. Is not useful in the absence of an Illness or Injury.

“Elected Official” means a person who is voted into public office by the constituents of the municipality, school district, or governmental agency that they will serve and who is serving in that capacity after being duly sworn into office.

“Eligibility Date” is the first day one is eligible for coverage under this Plan after the fulfillment of any applicable Waiting Period.

“Eligibility Period” means the 31-day period immediately following Your date of employment or the acquisition of a Dependent eligible for coverage.

“Eligible Retiree” is a former Employee of the Member Group who was retired while employed by the Member Group under the formal written policies and procedures of the Member Group and elects to contribute to the Plan the contribution required from the Eligible Retiree.

Teachers First Choice “Eligible Retiree” means a retiree and his or her Dependent(s) or survivors of such retiree who are receiving or are eligible to receive retirement benefits under chapter § 169.590 of the Missouri Revised Statutes.

Non-Teachers First Choice “Eligible Retiree” means a former Employee who has met all of the following requirements:

1. was a Full-time Employee as determined by the individual Member Group
2. worked for an MPR Member Group for at least ten (10) continuous years,
3. is NOT eligible for Medicare at the time of retirement, and
4. applied for Retiree coverage within 31 days of retirement.

“Enrollment Date” means the first day of coverage, or if there is a Waiting Period, the first day of the Waiting Period. For a “Late Applicant” the “Enrollment Date” means the date in which the applicant enrolls for coverage.

“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” is defined by the MPR individual Member Group’s personnel policy pursuant to the Midwest Public Risk’s Underwriting Guidelines.

“Employer” means the participating Member Group of Midwest Public Risk.

“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.

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

“Expense Incurred” means the charge made for a service, supply or treatment that is covered by this Plan. The expense is considered to be incurred on the date the service or treatment is given or the supply is received.

“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 approval for distribution from the U.S. Food and Drug Administration (FDA).

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; provided, however, the participation in a clinical trial shall not be the sole basis for a denial. (The Plan provides coverage for certain costs within Clinical Trials, as set forth in the Covered Medical Expenses Section.)
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.

A Regimen shall not be considered Experimental and Investigational if medical or scientific experts (as reflected in published reports or articles in medical and scientific literature) deem the Regimen appropriate care or standard of care for the Injury or Illness being treated.

The Plan Administrator has the discretionary authority to consult a medical expert to make a determination concerning whether a Regimen is an Experimental or Investigational Regimen. If, after consulting the medical expert, the Plan Administrator does not authorize the drug, device, treatment or procedure, it will not be a Covered Medical Expense.

In making such determinations, the Plan Administrator and medical expert may rely upon any or all of the following, at his or her discretion:

- a. The Covered Person's medical records; or
- b. The protocol(s) under which proposed service or supply is to be delivered; or
- c. Any consent document that the Covered Person has executed or will be asked to execute, in order to receive the proposed service or supply; or
- d. The published authoritative medical or scientific literature regarding the proposed services or supply in connection with the treatment of Injuries or Illnesses such as those experienced by the Covered Person; or
- e. Regulations or other official publications issued by the FDA.

As used in this definition of Experimental and Investigational, the terms "appropriate care" and "standard of care" shall mean:

Appropriate Care is a diagnostic or treatment measure whose expected health benefits exceed its expected health risks by a wide enough margin to justify the measure.

Standard of Care is a diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance. The level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

"Family Unit" is the covered Employee, Eligible Retiree or Elected Official and the family members who are covered as Dependents by the Plan.

"FMLA" means the Family Medical Leave Act of 1993 as amended.

"FMLA Leave" means an Employee's absence from work pursuant to a qualifying leave as described in the FMLA and for which all requirements for such leave have been executed by the Employee pursuant to the Member Group's written procedures.

"Formulary" means a list of prescription medications compiled by the third 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.

"GINA" means the Genetic Information Nondiscrimination Act of 2008.

"Grace Period" means the period of 30 days immediately following the contribution due date.

"Gross Misconduct" means disloyalty, dishonesty or breach of trust against Midwest Public Risk, conviction or indictment of a felony, conviction of a misdemeanor involving moral turpitude or any other Gross Misconduct of the Employee, Eligible Retiree or Elected Official that adversely affects Midwest Public Risk.

"HIPAA" is the Health Insurance Portability and Accountability Act of 1996, see Section VIII.

"Home Health Aide" is a person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

"Home Health Care Agency" means an institution which is licensed as a Home Health Care Agency and which fully meets the following requirements:

1. Operated mainly for the purpose of providing skilled nursing care and therapeutic services in Your home for the treatment of Sickness or Injury.
2. Maintains clinical records on each patient and the services provided to You are under the direction of a Physician.

"Home Health Care Plan" means a program for continued care and treatment of You which must be established and approved in writing by Your Physician. That Physician must also state that confinement to a Hospital or Skilled Nursing Facility would be necessary for Your treatment of Sickness or Injury if a Home Health Care Plan were not provided.

"Hospice Care" means care provided as part of a Hospice Care Program to a Terminally Ill Covered Person by or under arrangements with a Hospice Care agency.

"Hospice Care Agency" means an agency or organization that meets all of the following requirements:

1. Has Hospice Care available 24 hours a day.
2. Is licensed as such by the jurisdiction it is in.
3. Provides:
 - a. Skilled nursing services.
 - b. Medical social services.
 - c. Psychological and dietary counseling.

4. Provides or arranges for other services which will include:
 - a. Services of a Physician.
 - b. Physical or Occupational Therapy.
 - c. Part-time or Home Health Aide services consisting of primarily caring for a Terminally Ill Covered Person.
 - d. Inpatient care in a facility when needed for pain control and other acute and chronic symptom management.

"Hospice Care Facility" means a facility or a distinct part of one such as a Hospital or convalescent facility that meets all of the following requirements:

1. Is set up, equipped and run mainly as a setting for providing Inpatient Hospice Care to Terminally Ill persons.
2. Charges for the services and supplies it provides.
3. Is licensed as such by the jurisdiction it is in.
4. Keeps a medical record on each patient.
5. Provides an ongoing quality assurance program with reviews by MD's or DO's other than those who own or direct the facility.
6. Is run under the direction of a staff of MD's or DO's with at least one such Physician on call at all times.
7. Provides 24-hour-a-day skilled nursing services under the direction of RN's.
8. Has a full-time Administrator.
9. Has personnel which includes at least:
 - a. One Physician.
 - b. One RN.
 - c. One licensed or certified Social Worker employed by the agency.
 - d. One pastoral or other counselor.
10. Has established policies governing the provision of Hospice Care.
11. Assesses the patient's medical and social needs and develops a Hospice Care Program to meet those needs.
12. Permits all area medical personnel to utilize its services for their Terminally Ill patients.
13. Utilizes volunteers trained in providing services to Terminally Ill patients to meet their non-medical needs.

"Hospice Care Program" means a written plan of Hospice Care, which:

1. Is established by and periodically reviewed by:
 - a. A Physician attending the Covered Person.
 - b. Appropriate personnel of a Hospice Care Agency.
2. Is designed to provide palliative and supportive care to Terminally Ill persons.
3. Includes an assessment of the medical and social needs, and a description of the care to be rendered to meet those needs.

"Hospital" means 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.

"Injury" means bodily Injury entirely due to an Accident, independent of disease or other contributing causes. It must be evidenced by a visible contusion or by internal injuries. The Injury which occurs from the Accident must arise from a source external to the body.

"Illness" means a bodily or mental disorder, including Pregnancy. All disorders which are due to the same or related causes are deemed to be one Illness.

"Independent Laboratory" means a medical laboratory that is CLIA-certified by the Centers for Medicare and Medicaid Services to perform diagnostic and/or clinical tests and is independent of a Hospital, Medical Care Facility or Physician's office.

"Inpatient" means a resident patient using and being charged for room and board at a Hospital. A person is not an Inpatient on any date on which he or she is on leave or otherwise gone from the Hospital. This applies to whether or not a room and board charge is made.

"Intensive Care Unit, Cardiac Care Unit or Burn Unit" means an accommodation or part of a Hospital established for a formal intensive care program and which, in addition to providing room and board, is exclusively reserved for critically ill patients requiring constant observation by a Physician or at the direction of a Physician, by a registered graduate Nurse trained for service in such unit and which provides all necessary life-saving equipment, drugs and supplies in the immediate vicinity on a standby basis.

"Late Applicant" means a person who requires enrollment under this Plan other than during the initial or any applicable subsequent enrollment periods including periods provided for in the Special Enrollment provisions.

"Legal Guardian/Legal Guardianship" 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 You are covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person. In no event will Lifetime maximum benefits include benefits paid by the Plan(s) in effect prior to July 1, 1984.

"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 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 Necessary or Medical Necessity" means services or supplies provided by a Hospital, Physician or other provider not excluded under this Plan, to treat or diagnose a Sickness or Injury and which, as determined by the Plan Administrator are:

1. Consistent with the symptom or diagnosis and treatment of the Sickness or Injury.
2. Not primarily for Your convenience or that of a Physician or other provider.
3. The most appropriate standard or level of services, which accord with good medical practice and can be safely provided to You.

Note: The fact that a Physician may prescribe, recommend, order or approve a service or supply does not in itself, determine Medical Necessity or make a charge for such service or supply a Covered Expense, even if not expressly excluded under this Plan.

"Medicare" means the Health Plan for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

"Member Group" means a participating entity who has entered into an agreement with Midwest Public Risk for the purposes of coverage through the self-funded Plan.

"Mental or Nervous Disorders and Substance Abuse" 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.

"Miscellaneous Hospital Expenses" means those charges for necessary medical or surgical treatment billed by the Hospital, Ambulatory Surgical Center or Birthing Center, excluding professional fees.

"MPR" means Midwest Public Risk and its Governing Board.

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

"Nurse" means a person who is a legally licensed Registered Graduate Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), a Certified Nurse Midwife (CNM) or a Licensed Nurse Practitioner.

"Occupational Therapy" means treatment which consists primarily of instructing a Covered Person to perform the normal activities of daily living.

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

"Outpatient" means a person who receives services and treatments but is not a registered bed patient of a Hospital, Birthing Center, Skilled Nursing Facility or other medical care facility licensed for overnight professional medical care on an Inpatient basis.

"Patient's Immediate Family" means the patient's Spouse, children, parents or siblings.

"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 lives.

"Physical Therapy/Physiotherapy" means treatment given to improve the physical capabilities of a Covered Person in an attempt to restore such person to a previous level of good health. Treatment must be for acute conditions where rehabilitation potential exists and the skills of the Physician or other professional are required.

"Physician" means a practitioner of the healing arts, acting within the scope of his or her license and performing a service provided for in this Plan. Such person must be licensed by the State in which he or she practices and may not be related to You as a Spouse, child, brother, sister or parent, whether related by blood or by law.

"Plan" means Midwest Public Risk of Missouri Health Care Plan currently and previously in effect.

"Plan Administrator" means the person or persons responsible for the management of the Plan. The Plan Administrator may appoint persons or firms to process claims and perform other services for the Plan. The Plan Administrator is MPR.

"Plan Year" means a 12 consecutive month period, beginning July 1st and ending each June 30th.

"Pre-Admission Testing" means x-rays, laboratory examinations or other tests performed in the Outpatient department of a Hospital or other medical care facility prior to Outpatient treatment or confinement as an Inpatient provided:

1. Such tests are related to the scheduled Hospital confinement or Outpatient treatment;
2. Such tests have been ordered by a Physician after a condition requiring such confinement or Outpatient treatment has been diagnosed and, if applicable, Hospital admission has been requested by the Physician; and
3. The Covered Person is subsequently admitted to the Hospital, or the confinement or Outpatient treatment is canceled or postponed because a Hospital bed is unavailable, or under the directions of the attending Physician, or because there is a change in the patient's condition which precludes the confinement or Outpatient treatment.

"Pregnancy" means resulting childbirth, abortion, miscarriage and any complication of Pregnancy.

"Prescription Drug" means any of the following:

1. A drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without Prescription."
2. Compounded medicines of which at least one ingredient is included under item one above.
3. Injectable insulin.
4. Hypodermic needles or syringes, but only when dispensed upon a written prescription.
5. Oral contraceptives including patches and rings obtainable only upon written prescription of a Physician.

"Primary Care Physician" means a Physician or other health care professional who provides primary care health services (family practice or general practice, internist or pediatrician).

"Prior Authorization" means the process of obtaining approval for the determination of appropriateness of care, treatment, services, equipment, or supplies prior to incurring the expense.

"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.

"Psychiatric Treatment" means treatment or care for a mental disease or disorder or a functional nervous disorder as recognized or defined by the American Psychiatric Association.

"Pulmonary Rehabilitative Services/Therapy" means treatment administered to retain or improve a Covered Person's pulmonary function or symptom improvement.

"Reconstructive Surgery" means surgery that is incidental to an Injury, Illness, or Congenital Birth Defect 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 Birth Defect does not classify surgery done to relieve such consequences or behavior as Reconstructive Surgery.

"Rehabilitation Center" means a legally operating institution or facility providing a program of coordinated and integrated services including evaluation and treatment with an emphasis on education and training of those who have severe disabling impairments of recent onset or recent progression or those who have had prior exposures to rehabilitation and require an identifiable intensity of services. It must be under the supervision and direction of one or

more Physicians and 24-hour nursing care as provided by Registered Nurses (RN's) and not used as a place of rest, as a nursing home or a place for the aged.

“Routine” means not associated with an Injury or Sickness.

"Routine Physical Exam" means an assessment by a Physician for the screening of health risk factors.

"Second Surgical Opinion" means a consultation with a surgeon who is certified by the American Board of Surgery. For purposes of this definition, consultation includes a written medical opinion.

"Sickness" means disease or Illness. NOTE: Pregnancy and complications of Pregnancy are covered on the same basis as any other Sickness.

"Skilled Nursing Facility" means an institution or a distinct part of one that is operating pursuant to the law for such an institution. In addition, We require that:

1. Its main purpose is to provide 24-hour a day accommodations and skilled nursing care for patients recovering from Sickness or Injury.
2. It is not used mainly as a place for the aged, drug addicts, alcoholics, the mentally ill or a place for rest.
3. It requires compensation from its patients.
4. It is under the full-time supervision of a Physician or registered graduate Nurse.
5. It admits patients only upon recommendation of a Physician.
6. It has an agreement to have a Physician's services available when needed.
7. It maintains adequate medical records for all patients.
8. It has a written transfer agreement with at least one Hospital.

“Social Worker” means a licensed certified Social Worker.

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

“Specialty Drugs” means high-cost, complex pharmaceuticals (usually injectable) that have unique clinical, administration, distribution, or handling requirements that are not commonly available in traditional community and mail-order pharmacies.

"Speech Therapist" means someone who is licensed by the state in which he or she performs his or her services, if that state requires licensing.

"Speech Therapy" means treatment administered to improve a Covered Person's speech capabilities after a decrease in those capabilities following an Injury or Sickness.

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

"Surgical Procedure" means any of the following:

1. To incise, excise or electro cauterize any organ or body part, except for Dental Services.
2. To repair, revise or reconstruct any organ or body part.
3. To reduce by manipulation, a fracture or dislocation.
4. Using endoscopy to explore for, or to remove, a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or ureter.
5. A puncture for aspiration.
6. An injection for contrast media testing.

Any other procedure not stated above may be considered a Surgical Procedure if deemed such by the Claim Administrator and the Plan Administrator.

"Temporomandibular Joint Dysfunction" means the disease or symptoms of the jaw joint(s) and/or symptoms of the associated parts resulting in pain or the inability of the jaw to work properly. "Associated parts of the jaw" means those functional parts that make the jaw work.

"Terminally Ill" means a medical prognosis of six (6) months or less to live.

"Totally Disabled" or "Total Disability" means that, due to Sickness or Accidental bodily Injury, You or Your Dependent are not able to work at any job for pay or profit and are not able to engage in the normal activities of a person of like age and gender in good health.

"Underwriting Guidelines" means the written Underwriting Guidelines established by the Plan Administrator.

"Urgent Care means" services that are Medically Necessary and required for an Illness or Injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. An urgent care condition could be a sprain, sore throat or rising temperature.

"Usual, Customary and Reasonable (UCR)" - means:

1. Usual - A fee consistently charged by a Physician or provider to a patient for a specific service or supply.
2. Customary - A fee:
 - a. For medical care received from a Network Provider, the Customary fee is the negotiated fee between the Network Provider and the Preferred Provider Organization.
 - b. For a Non-Network Provider the Customary fee, using a Relative Value Scale determined by the Claims Administrator, is a fee that is not in excess of the fees charged by 70% of providers within the geographical area.
3. Reasonable -
 - a. A fee that is usual and customary.
 - b. A fee that local medical organization's review committee or Physician's Review Organization (PRO) deems just, due to specific conditions in a specific case.

"Utilization Review Firm" means the consulting firm retained by the Plan to assist in the certification of Medical Necessity, evaluation and review of medical care and treatment for Covered Persons.

"Waiting Period" means the length of time an Employee must continuously work for the Member Group before he or she is eligible for coverage. For Member Groups, with no more than 50 Employees, the Waiting Period shall not exceed 90 days.

"We, "Our, or Us" means Plan Administrator.

"Workers' Compensation" means a fund administered under any Workers' Compensation, Occupational Diseases Act or Law or any other act or law of similar purpose to which the Member Group contributes, which provides the Employee with coverage for job-related accidental Injuries and Illnesses.

"You, Your, Yours" means a Covered Person who is receiving Plan benefits.

IX. ELIGIBILITY PROVISIONS

Eligible Classes of Employees:

1. Employees of the individual Member Group.
2. Eligible Retirees of the individual Member Group.
3. Elected Officials of the individual Member Group.

Eligible Employees

All Employees as defined by the individual Member Group's personnel policy pursuant to the Plan Administrator's Underwriting Guidelines for coverage.

Elected Officials

The individual Member Group will determine if coverage is extended to Elected Officials through its written policies and procedures. In addition, the Member Group must meet requirements pursuant to the Plan Administrator's Underwriting Guidelines. Contact Your Member Group's Human Resource/Personnel Department. for more information.

Eligible Retirees

The individual Member Group will determine if coverage is extended to retirees through its written policies and procedures. In addition, the retiree must meet the minimum requirements pursuant to the Plan. Contact Your Member Group's Human Resource/Personnel Department. for more information about coverage at retirement. Also, see Section XIII "Coverage at Retirement" for additional information.

Dependents

Only eligible Dependents, as defined by the Plan, may be enrolled for coverage. If Dependent coverage is desired, then the Employee is required to enroll the Dependent on a form satisfactory to the Plan Administrator. Employee coverage must be in effect coincidental with or prior to the Dependent(s) coverage becoming effective.

EFFECTIVE DATES OF COVERAGE

Employees

An Employee will be covered by this Plan the first day he or she satisfies all of the following:

1. The individual Member Group's Waiting Period
2. The Eligibility Requirement.
3. The Active Employee Requirement as defined by the individual Member Group.
4. The Enrollment Requirements of the Plan.
5. The next open enrollment period when the Employee is a Late Enrollee.

The Waiting Period is determined by each individual Member Group. The Waiting Period may be waived by the Plan Administrator, but only if the waiver is in writing.

Eligible Retiree

The first day of the month following the date the Eligible Retiree meets all of the requirements for retiree coverage.

Elected Official

Each individual Member Group determines the effective date of coverage for newly elected officials.

Dependents

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.

If the Dependent was not covered under the Plan, the Dependent will become covered on the later of:

1. The date the Employee's coverage with Us begins.
2. The first day of July, provided the Employee elects coverage during the open enrollment period for all Dependents electing coverage.

3. The effective date of coverage as determined under the Special Enrollment section of this document if the Employee has a "change in life status" or special enrollment qualifying event.

In no event will a Dependent be covered prior to the date the Employee is covered.

The above statements do not apply to newborn infants. Refer to the Newborn Infant Requirement section for those special conditions. The Employee must notify the Plan Administrator of the addition of a new Dependent by properly enrolling the Dependent within 31 days after the date he or she becomes a Dependent.

NEWBORN INFANT REQUIREMENT

Coverage for a newborn Dependent is not automatic; a newly born Dependent must be enrolled for coverage within 31 days of birth if coverage is to begin from the moment of birth. Upon such timely enrollment, the effective date of the newborn's coverage will be the later of:

1. The date of the child's birth if the child is enrolled within 31 days after the date of birth.
2. The date the Employee's coverage begins with Us.

All other Dependents must satisfy all the Effective Dates of Coverage provisions found in this Plan Document.

ANNUAL OPEN ENROLLMENT/ELECTION PERIOD

The open enrollment period is March through May of each Calendar Year as determined by each individual Member Group. During this period, the Employee may elect to participate in the Plan or move from one Plan to another Plan offered by the Member Group; however, once an Eligible Retiree elects coverage under the Plan R benefit option, there is no opportunity to elect another benefit option. Coverage elected during open enrollment will be effective July 1st.

TIMELY OR LATE ENROLLMENT

1. Timely Enrollment - The enrollment will be "timely" if the completed form is received by the individual Member Group no later than 31 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 July 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 31 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 31 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 contact the Human Resource/Personnel Department of Your Member Group.

SPECIAL ENROLLMENT PERIODS

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

1. Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage 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 first day of the month coincidental to or next 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 on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits. This provision shall no longer apply for Plan Years starting after September 22, 2010.
 - b. 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).
 - c. 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.
 - d. 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).
 - e. 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 has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
 - 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 31 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 31-day period.

The special enrollment is effective as follows:

- a. For marriage, the first of the month coincidental to or next following the marriage event;
 - b. For birth, the date of the birth;
 - c. For adoption or placement for adoption, the date of adoption or placement for adoption; or
 - d. For Legal Guardianship, the date established by a court of law.
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 60 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 60 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 of the month coincidental to or next following the loss of coverage, the date eligibility assistance is established or the date established by regulation.

TERMINATION PROVISIONS

Employee

The Employee's coverage under any benefit provision will end on midnight of the first of the following dates:

1. The date the Plan is canceled.
2. The last day of the month through which the required contribution for health care coverage has been made.
3. The last day of the month in which the Employee's employment ends. However, the Employee may be eligible for COBRA continuation coverage.
4. The last day of the month the Employee does not meet the definition of an eligible Employee.

5. The date he or she begins active duty in the Armed Forces of any country for longer than 90 days.
6. The last day of the month following the date of a request for voluntary termination from the Plan. Written proof of other comparable group insurance (not individual) must be submitted to terminate coverage other than at open enrollment.

Employees on Military Leave - Uniformed Services Employment and Reemployment Rights Act (“USERRA”).

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 under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service. Dependents do not have an independent right to elect USERRA health Plan continuation, and Dependents and Eligible Retiree’s who perform military service do not have any rights to continue health insurance under USERRA.

1. The Maximum period of coverage of a person 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 may be charged up to 102% of the full contributions 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.

Dependent’s Coverage will end on midnight of the first of the following dates:

1. The date the Employee’s coverage ends for a reason other than death.
2. The last day of the month the Dependent no longer meets the definition of Dependent.
3. The last day of the month through which the required contribution for Dependent health care coverage has been made.
4. The last day of the month which next follows the Employee’s date of death.
5. The date the Dependent begins active duty in the Armed Forces of any country for longer than 90 days.
6. The last day of the month following the date of a request for voluntary termination from the Plan. Written proof of other comparable group insurance (not individual) must be submitted to terminate coverage other than at open enrollment.

See Section XII “Health Insurance Continuation Information: COBRA Continuation Coverage” and Section XIII “Coverage And Retirement” for additional information that may apply for a Dependent’s continued coverage.

REINSTATEMENT AFTER TERMINATION OF EMPLOYMENT

An Employee who returns to Active Work, after coverage under this Plan ends due to termination of employment, must meet all requirements of a new Employee. An Employee returning to work directly from coverage under the Plan’s COBRA (continuation of coverage) need not satisfy the employment Waiting Period.

X. FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) is Federal legislation that became effective August 5, 1993. It requires the Member Group to provide up to 12-weeks of unpaid, job-protected leave to eligible Employees for specific family and medical reasons.

Eligibility Requirements for Leave

An Employee must meet all of the following criteria to qualify under FMLA:

1. Employed by the Member Group for at least 12 months.
2. Employed by the Member Group for at least 1,250 hours of service during the twelve-month period immediately preceding the leave.
3. Employed at a worksite where 50 or more Employees are employed by that Member Group within 75 miles of the worksite.

Benefits

If the FMLA eligibility requirements are met by the Employee, they are allowed up to 12-weeks of unpaid leave in any 12-month period. Leave can be taken all at one time, intermittently or by reduced hours. Contact the Member Group's Human Resource/Personnel Department for more information.

Qualifying Events

A qualifying event is any of the following:

1. The birth of a child of an Employee.
2. The placement in the Employee's home of a child for adoption or acquiring of a Dependent through legal guardianship.
3. The care for an immediate family member, i.e. Spouse, child or parent (not including a parent-in-law) with a serious health condition.
4. The Employee's inability to work because of a serious health condition.
5. Military Family Leave Entitlement as adopted by the National Defense Authorization Act (NDAA) for FY 2008.

Leave for the birth or placement of a child must take place within 12 months of the birth or placement of a child and may not be taken intermittently or on a reduced schedule unless the Employee and Member Group both agree to do so.

Benefit Protection

For the duration of the leave, the Member Group must maintain the coverage that was in effect at the time the FMLA began. The Employee is responsible for paying any contribution of the medical/dental premiums, if any, to continue coverage while on leave.

Coverage will end on the last day of the month following the date the Member Group is informed that the Employee does not intend to return to work at the end of the leave, or the last day of the month following the expiration of the Employee's leave when he or she does not return to work. If the Employee does not return to work after the leave they will be eligible for COBRA, and they may be required to reimburse the Member Group for premiums paid by the Member Group for continued coverage during the leave.

FMLA Benefit Period

The FMLA benefit period will be determined by each individual entity member. Contact the Member Group's Human Resource/Personnel Department for specific details. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person. FMLA runs concurrent with any continuation during a period of disability, leave of absence or layoff.

Notification and Certification of Leave

Notification of leave must be provided 30 days in advance. For emergency situations, notification is to be given as soon as possible. Medical certification supporting the leave due to a serious health condition to the Employee or an immediate family member may be required by the Member Group.

Certification of ongoing leave due to a serious health condition must be from Your health care provider. The Member Group may require at the Member Group's expense, a second or third opinion. Periodic recertification may also be requested.

An Member Group may request periodic updates (reports) during an Employee's leave as to their intent to return to work.

To return from leave, a medical certification will be needed from the Employee's health care provider stating they are physically able to return to Active Work.

Please contact the Member Group's Human Resource/Personnel Department for more information on the Family and Medical Leave Act of 1993, or contact the local Wage and Hour Division listed in most telephone directories under U.S. Government, Department of Labor.

XI. CONTINUATION DURING PERIODS OF DISABILITY, LEAVE OF ABSENCE OR LAYOFF

Continuation During Periods of Disability, Leave of Absence or Temporary Layoff.

A person may remain eligible for a limited time if Active Work ceases due to disability, leave of absence or temporary layoff. This continuance will end on the last day of the month as follows:

For disability leave only: following the latest of these dates:

1. The 90-day period that next follows the date in which the Employee was Actively at Work.
2. The end of the period in which the person was entitled to regular pay as an Actively at Work Employee or through personal paid time off, sick leave, vacation time or other defined salary compensation of the individual Member Group.

Two (2) or more periods of Total Disability due to the same or related Illness will be considered one period of Total Disability unless separated by the person's return to Active Work for at least two (2) weeks between periods of disability. Two (2) or more periods of Total Disability due to unrelated Illnesses will be considered one period of Total Disability unless separated by the person's return to Active Work for at least one full day. The Employee may be responsible for the cost of coverage.

For leave of absence or layoff only: following the 90-day period that next follows the date in which the person was an Actively at Work Employee. The Employee may be responsible for the cost of coverage.

While continued, coverage will be that which was in force on the last day the Employee was Actively at Work. However, if benefits reduce for others in the class, they will also reduce for the continued person. FMLA runs concurrent with any continuation during a period of disability, leave of absence or temporary layoff.

XII. HEALTH INSURANCE CONTINUATION INFORMATION: COBRA CONTINUATION COVERAGE

All family members must read this information carefully. This information explains Your rights under a federal law relating to Your health insurance benefits. This information applies to any Employee, Spouse and/or Dependent covered by the Member Group's group health Plan. By law, all family members have independent rights.

These pages contain a summary of Your health insurance continuation rights under the federal COBRA law. Covered Persons insured under the Member Group's group health Plan have rights under COBRA. **This information DOES NOT change or alter Your current status in the insurance Plan(s) in any way.** If You are (or become) covered by the Member Group's group health Plan, You may be eligible for continuation coverage if You would lose coverage due to a qualifying event such as:

- | | |
|---------------------------------------|---|
| 1. Employee's Voluntary Termination | 5. Employee's Medicare Entitlement |
| 2. Employee's Involuntary Termination | 6. Divorce or Legal Separation |
| 3. Employee's Reduction of Hours | 7. A Dependent Ceasing to be a Dependent |
| 4. Death of the Employee | 8. The Bankruptcy of the Member Group (Title XI, US Code) |

PLAN INFORMATION: NOTE: The information contained in the SPD may not be altered by any statements made by representatives of the Member Group. You may also find more information on the Plan's benefits on Your Certificate of Coverage. Some states also have health insurance continuation rules.

QUESTIONS: If You have any questions regarding any of the information contained in these pages, it is Your responsibility to contact the Member Group or Plan Administrator.

YOUR REPORTING RESPONSIBILITIES: The Covered Person has the responsibility to inform the Member Group or Plan Administrator of a divorce or legal separation or a Dependent ceasing to be a Dependent within 60 days, using the procedures specified below. Plan terms regarding a Dependent's eligibility status may be found in the Plan document. The 60-day period would run from the later of the event date, or the date coverage is lost due to the event. 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 Dependent who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

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:

MPR
P.O. Box 1090
Great Bend, Kansas 67530
(877) 627-2481

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.

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

COBRA QUALIFYING EVENT NOTICE: If a loss of group health insurance coverage would occur due to a qualifying event, the Member Group or Plan Administrator would notify You of Your right to elect coverage (subject in certain instances to You informing the Member Group or Plan Administrator that an event occurred – see previous paragraph).

COBRA QUALIFIED BENEFICIARIES: Each person who is covered by the Plan at the time of a qualifying event would have independent rights under COBRA. Additionally, a Child or Qualified Dependent born to, adopted or placed for adoption, or for who legal guardianship is established through a court of law during the period of continuation coverage will be provided qualified beneficiary status under COBRA if enrolled on the Plan. Incapacitated qualified beneficiaries would have special rights. If a qualified beneficiary were incapacitated, certain Individuals could elect on his/her behalf. Anyone acting on behalf of an incapacitated beneficiary should call the Member Group or Plan Administrator. COBRA qualified beneficiaries may also be allowed all options that active Employees have under the Plan, under the same terms and conditions as active Employees. COBRA qualified beneficiaries may elect the coverage they have at the time of the qualifying event.

COBRA ELECTIONS: You would be allowed 60 days to make an election of continuation coverage (60 days from the later of the date of the notice or the date Your group health insurance would end due to the qualifying event). In most instances, if continuation coverage were elected and paid for within the proper time frames, Your coverage would continue without interruption. The Member Group or Plan Administrator does reserve the right to verify Your eligibility if You did elect continuation coverage, and if You were not eligible; they reserve the right to terminate that coverage retroactively. Under certain circumstances, COBRA time frames could be extended beyond those listed in this information.

SIGNING AND REVOKING WAIVERS: If You sign a waiver regarding Your continuation coverage, You may revoke the waiver during the election period. Any claims that occur within the waiver period might not be covered.

PREMIUM PAYMENTS: If You were to elect, You would have 45 days to pay the initial/retroactive premium. The 45-day period would begin on the date Your election was sent to the Member Group or Plan Administrator. To continue Your coverage beyond the date of election, the entire initial/retroactive premium should be paid within the 45-day period. Depending on when the initial/retroactive premium was paid, additional premiums might be required to bring payments current. Premium payments may be made in monthly installments. Under certain circumstances, COBRA premiums may be paid on a pre-tax basis under a Section 125 (cafeteria) Plan established by the Member Group. For additional information, contact the Member Group/Plan Administrator. The Member Group may charge up to 102% of the regular group premium for continuation coverage. You would be allowed a 30-day Grace Period on each monthly premium (longer than 30 days if the Member Group or an active Employee has a longer period). Failure to pay any premium (initial, monthly, etc.) could cause Your continuation coverage to be retroactively terminated.

DURATION OF COVERAGE: If You were to continue Your group health insurance coverage under COBRA, You would be provided the same coverage as similarly situated active Employees. Under COBRA, health insurance coverage may be continued for 18 months if the qualifying event were termination or a reduction of hours. Bankruptcy of the Member Group has special rules that would pertain to the company's retirees. The other events (excluding bankruptcy) would allow 36 months of continuation coverage. The continuation time periods will run from the date of the qualifying event.

COBRA EXTENSIONS: The 18-month period (following a termination or a reduction of hours) could be extended if another qualifying event (death of the Employee, divorce or legal separation, or a Child or Qualified Dependent ceasing to be a Dependent) were to occur during that 18-month period. You would need to notify the Member Group or Plan Administrator if You were to experience a secondary qualifying event and would like to extend Your coverage.

If any qualified beneficiary were to be deemed disabled by the Social Security Administration before the end of the first 60 days of continuation coverage, all qualified beneficiaries may be eligible to extend their COBRA coverage up to 29 months from the date of the termination or reduction of hours. To receive this additional coverage, the Member Group or Plan Administrator would also need to be notified if that qualified beneficiary were deemed no longer disabled within 30 days of that determination. If deemed no longer disabled, all qualified beneficiaries would no longer be eligible for the additional 11 months of continuation coverage. From the 19th month to the 29th month, up to 150% of the applicable group health premium for this extension of coverage could be charged.

Employees on Military Leave - Uniformed Services Employment and Reemployment Rights Act ("USERRA").

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 under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service. Dependents do not have an independent right to elect USERRA health Plan continuation.

1. The Maximum period of coverage of a person 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 may be charged up to 102% of the full contributions 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.

REASONS CONTINUATION COVERAGE COULD TERMINATE: The law also provides that Your continuation coverage could be terminated before the end of the 18, 24, 29 or 36 months for any of the following reasons:

1. The Member Group no longer provided group health coverage to any Employees;
2. The premium for Your continuation coverage was not paid in a timely manner;
3. After the date You elected COBRA continuation coverage, You became entitled to Medicare, or;
4. After the date You elected COBRA continuation coverage, You became covered under another group health Plan which did not contain any exclusion or limitation with respect to any Pre-Existing Condition affecting You, or if such a Pre-Existing Condition limitation does not apply, or You have satisfied any Pre-Existing Condition clauses which did apply to You.

ADDITIONAL INFORMATION: If You would experience a qualifying event, You would not have to show that You were insurable in order to continue coverage under COBRA. Coverage might also extend if You are covered under a retiree Plan and lost that coverage due to a COBRA qualifying event. The Member Group or Plan Administrator must allow You to enroll in a conversion Plan, if such a Plan is available under the Member Group's group health insurance Plan.

COBRA notifications will be sent to Your last known address. This makes it imperative that You keep the Member Group informed of Your current address and address changes. Please notify the Member Group if You add a Spouse or Dependent to Your group health insurance coverage.

"You" in this notice refers to the Employee, Eligible Retiree, Elected Official, Spouse, Child or Qualified Dependent who is (or becomes) covered under the health Plan.

Special Provisions for A Child Over Age 26

Except for a Child who is Totally Disabled, the Plan terminates coverage for all Children on the last day of the month in which they reach their 26th birthday. Covered Children who lose coverage because of this Plan limitation may continue coverage through COBRA continuation. Qualified Dependents who lose coverage because they no longer meet the definition of a Qualified Dependent of this Plan may continue coverage through COBRA continuation. See Section XII "Health Insurance Continuation Information: COBRA Continuation Coverage" for more information about Your rights under COBRA.

Health Conversion Privilege

If Your coverage terminates while the Plan is in force, You may be entitled to convert Your coverage to Conversion Coverage (available through Celtic Life Insurance Company) at Your expense, provided You have been covered under the Plan for at least 90 days.

A Dependent may also be entitled to convert to Conversion Coverage under certain circumstances. If You or Your Dependents are entitled to convert to Conversion Coverage, it must be applied for within 31 days after the applicant's coverage terminates.

For more details of the Conversion Privilege (i.e., who is eligible to convert, what benefits are provided by the Conversion Coverage, who is covered under the Conversion Coverage, when the Conversion Coverage becomes effective, cost, etc.) contact the Plan Administrator.

Note: You may elect Conversion Coverage only after coverage is no longer available under the COBRA Continuation Coverage.

XIII. COVERAGE AND RETIREMENT

Teachers First Choice (TFC) is a term used to identify a benefit program for Covered Persons who are associated with member school districts in the state of Missouri. The TFC program is designed to meet the regulations for continuation of coverage when an Employee formally retires. Your **Schedule of Benefits will designate if You are enrolled in a Teachers First Choice benefit program.** If Your Schedule of Benefits does not designate that You are enrolled in a Teachers First Choice benefit program, then You are enrolled in a Non-Teachers First Choice program.

It is important that You know the benefit package for which You are a participant. Your option at retirement is contingent upon only one of these benefit packages.

MPR offers continued health coverage to Eligible Retirees. This benefit is dependent upon the Member Group:

1. Electing the retiree benefit program for its Employees,
2. Offering the coverage at the time of the Employee's retirement, and
3. Continuing the retiree benefit program for as long as the Eligible Retiree is covered on the MPR Plan.

Please contact the Member Group's Human Resource/Personnel Department to find out if such retiree coverage is offered.

Teachers First Choice Retirement:

To be eligible for retirement continuation under the TFC program the Eligible Retiree and Dependents or survivors of such Eligible Retiree must be receiving or are eligible to receive retirement benefits under chapter § 169.590 of the Missouri Revised Statutes.

Non-Teachers First Choice Retirement:

Individuals may continue coverage as an Eligible Retiree if they meet all of the following criteria:

1. Were Full-time Employees as determined by the individual Member Group,
2. Worked for an MPR Member Group for at least ten (10) continuous years,
3. Are NOT eligible for Medicare* at the time of retirement, and
4. Apply for coverage within 31 days of retirement

Coverage ceases the earliest of these dates:

1. The last day of the Calendar Month following a request for voluntary termination.
2. The last day of the month through which the required contribution for health care coverage is made.
3. The date the Eligible Retiree's former MPR Member Group is no longer a member entity.
4. The date the Eligible Retiree's former MPR Member Group elects to discontinue coverage for Eligible Retirees.

If items 1, 2, 3 and 4 are not applicable, the Eligible Retiree's coverage terminates on the latest of these dates:

1. The date the Eligible Retiree is eligible for Medicare *,
2. The first of the month in which the Eligible Retiree turns 65, if Medicare* eligibility is due to a disability,

Eligible Dependents of a Non-Teachers First Choice Eligible Retiree are also eligible for continued coverage for such time that the Eligible Retiree is covered by the Plan.

Upon initial entitlement to Eligible Retiree coverage, the Eligible Retiree may elect to move from one Plan to another Plan. The Eligible Retiree will have the same rights as any active Employee including the right to choose between MPR plans at open enrollment; however, once Plan R is selected, there is no opportunity to return to another Plan. The Member Group will be responsible for collecting applicable premium from the retiree and remitting it to MPR unless this service is provided by a third party administrator.

Individuals who (a) retire from their employment with an MPR Member Group and (b) are on the date of retirement eligible for Medicare*, do not qualify for MPR coverage upon retirement other than federally mandated coverage.

*Qualification/eligibility for Medicare includes eligibility for a supplemental or tie-in plan.

XIV. COORDINATION OF BENEFITS

If a Covered Person has health coverage under another plan, this Plan will coordinate benefits with the other plan. One plan is primary, one is secondary. When this Plan is Primary, its benefits are determined before those of the other plan. The benefits of the other plan are not considered. When this Plan is secondary, its benefits are determined after those of the other plan. This Plan's benefits may be reduced because of the other plan's benefits. When there are more than two plans, this Plan may be primary, as to one and may be secondary as to another.

What this Plan Pays as the Secondary Plan.

When this Plan is the Secondary Plan, it considers the total Covered Expense to determine what the Plan would have paid had it been the Primary Plan. We will consider the amount of any PPO discount or other managed care discount applied by the Primary Plan as a payment toward the total expense by the other plan. If no discount exists, we will apply the appropriate discount this Plan would have taken had this Plan been the Primary Plan. Then, this Plan will pay:

1. The lesser of the Plan's contractual obligation as the Primary Plan, or
2. An amount equal to the difference between what the Primary Plan paid and the amount of the total expense.

In no event will this Plan pay more than 100% of the Allowable Expenses.

A. DEFINITIONS

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

1. Allowable Expense

"Allowable Expense" means the Usual, Customary and Reasonable expenses for medical care or treatment. Part of the expenses must be covered under at least one of the plans covering You or Your covered Dependent(s) in order to be an allowable expense.

Allowable Expense to a Secondary Plan includes amounts of any Deductible or benefit percentage under the Primary Plan, or the amount of expenses covered by the Secondary Plan which were not paid by the Primary Plan.

2. Plan

Plan means these types of medical and health care benefits providing payment because of an Injury or Sickness:

- a. Any group, blanket or franchise health insurance, or coverage similar to same, including student coverage obtained through an educational institution;
- b. A Health Maintenance Organization (HMO), whether group practice or individual practice association, Preferred Provider Organization (PPO) or any such combination of this type of managed care;
- c. Any labor-management trustee plans or a union welfare plans, employer organizations plans, or employee benefit organization plans;
- d. A governmental medical benefit program, such as Medicare or TriCare;
- e. Coverage under a governmental program provided or required by statute, including no fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation;
- f. Any private or association plan, which is group rated;

The term "Plan" does not include any of the following: individual health insurance policies or contracts; group or group-type Hospital indemnity benefits; group or group-type Accident only coverages; and public medical assistance programs such as Medicaid, except as otherwise provided herein. The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

B. ORDER OF DETERMINATION

This Plan determines its order of benefits using the first of the following which applies:

1. EMPLOYEE

When this Plan and another plan cover the Employee, the order of determination is as follows:

- a. The plan that does not coordinate with other plans is always the Primary Plan.
- b. The plan that covers You as an Employee, laid-off Employee, former Employee, Retiree, member or subscriber is the Primary Plan. The plan that covers the person as a dependent is the Secondary Plan.
- c. When both husband and wife are covered under this plan as Covered Employees the Plan cannot coordinate benefits with itself.

However, a person may be covered as an active Employee by one plan and as a retired or laid-off person by another plan. In that case, if both plans contain a provision regarding retired or laid-off Employees, the plan that covers the person as an active Employee is considered to determine its benefits before the plan that covers the person as a retired or laid-off Employee. If either one of the plans does not contain a provision for retired or laid-off Employees, the order of benefits determination will be used to determine the order of payment by the plans.

2. SPOUSE

When this Plan and another plan cover the Spouse, the order of determination is as follows:

- a. The plan that does not coordinate with other plans is always the Primary Plan.
- b. The plan that covers Your Spouse as an Employee, laid-off Employee, former Employee, retiree, member or subscriber is the Primary Plan. The plan that covers Your Spouse as a dependent is the Secondary Plan.
- c. When both husband and wife are covered under this plan as Covered Employees, the Plan cannot coordinate benefits with itself.

3. COVERED CHILD AND QUALIFIED DEPENDENTS/PARENTS NOT DIVORCED OR SEPARATED

When this Plan and another plan cover the same child as a dependent of different parents, the order of determination is as follows:

- a. The plan that does not coordinate with other plans is always the Primary Plan.
- b. The Primary Plan is the plan of the parent whose birthday (month and day) falls earlier in the year. The Secondary Plan is the plan of the parent whose birthday falls later in the year. Birth year is not taken into account.
- c. If both parents have the same birthday, the benefits of the plan that covered the parent the longest is the Primary Plan; the plan that covered the parent the shortest time is the Secondary Plan.

- d. If the other plan does not have the birthday rule, but has the gender rule and if, as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- e. When both husband and wife are covered under this plan as Covered Employees, the Plan cannot coordinate benefits with itself.
- f. If none of the above applies, coordination of benefits will be determined by the Plan Administrator.

4. COVERED CHILD AND QUALIFIED DEPENDENTS/PARENTS SEPARATED OR DIVORCED

If two or more plans cover a person as a dependent child of divorced or separated parents (whether or not the parents were ever married to each other), benefits for the child are determined in this order:

- a. The plan that does not coordinate with other plans is always the Primary Plan.
- b. When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan pays first on the child; the plan of the parent without custody pays second.
- c. When the parent with custody has remarried, the order of determination is as follows:
 - i. The plan which covers the parent as an Employee, laid off Employee, former Employee, Retiree, member or subscriber is the Primary Plan, then
 - ii. The plan which covers the stepparent as an Employee, laid off Employee, former Employee, Retiree, member or subscriber pays second, and
 - iii. The plan, which covers the parent without custody, pays last.
- d. If there is a court decree that would otherwise establish financial responsibility for the health care expenses of a child, the benefits of the plan that covers the parent with financial responsibility is the Primary Plan.
- e. If none of the above applies, coordination of benefits will be determined by the Plan Administrator.

In the case where the parents of a dependent child were never married to each other, these rules shall apply as though such parents were divorced or separated.

5. LONGER/SHORTER LENGTH OF COVERAGE

If none of the above rules determines the order of benefits, the Primary Plan is the plan that covered the Employee, laid off Employee, former Employee, Retiree, member or subscriber longer; the Secondary Plan is the plan which covered that person the shorter time.

6. MEDICARE REDUCTION/COORDINATION

- a. **Active Employees, or Dependents of Active Employees Eligible for Medicare Due to Age.** If You are covered under this Plan due to Your or someone else's current employment with the Member Group, and are also eligible for Medicare due to age, You may:
 - i. Continue Your coverage under this Plan (to the extent You remain eligible) and defer enrollment in Medicare; or
 - ii. Continue Your coverage under this Plan and also enroll in Medicare; this Plan would be Your Primary Plan and Medicare Your Secondary Plan as long as Your coverage under this Plan is attributable to current employment with the Member Group; or
 - iii. Drop Your coverage under this Plan and enroll in Medicare, in which case Medicare would be Your primary medical coverage.

CAUTION: If, when Your coverage ceases due to termination of Your or someone else's current employment status with the Member Group You (1) are eligible for Medicare, and (2) You elect COBRA coverage under this Plan, You should know three important facts:

- i. First, Your COBRA coverage is not attributable to "current employment status". That means that if You were enrolled in Medicare this Plan would pay second, behind Medicare (except in some cases where Your Medicare is due to end-stage renal disease).
 - ii. Secondly, under the Plan, if You are eligible for Medicare we'll deem You to be enrolled in Medicare, and only pay benefits after calculating what Medicare would have paid. So if You don't enroll in Medicare after losing Your coverage attributable to current employment status (that is, if You don't enroll in Medicare when You become eligible for COBRA coverage), You may have to pay out of pocket the amount Medicare would have paid had You been enrolled.
 - iii. Thirdly, You have a limited, special enrollment period for Medicare after Your coverage under this Plan ends due to termination of the current employment status. If You wait to enroll in Medicare until after You exhaust COBRA coverage, You may not be able to enroll in Medicare immediately, and You may be required to pay an additional premium for Medicare Parts B and D.
- b. **Covered Person Eligible for Medicare Due to Disability.** This Plan is the Primary Plan and Medicare is the Secondary Plan if You are eligible for Medicare by reason of disability (but not age), and Your coverage under this Plan is on account of Your (or someone else's) current employment with the Member Group.

If coverage under this Plan is not on account of current employment status with the Member Group, and You are eligible for Medicare solely by reason of disability, Medicare is the Primary Plan and this Plan is the Secondary Plan. Note that in this latter case -- where this Plan is secondary -- this Plan will deem You or Your Dependent, as the case may be, to be enrolled in Medicare Parts A, B and D even if You or the Dependent, as the case may be, is not so enrolled. The rules in this section continue to apply for as long as the Plan has at least 100 participants as described in federal Medicare regulations.

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

7. MEDICAID COORDINATION RULES

Eligibility for coverage under this Plan shall not be affected by the fact that You are eligible for or are provided medical assistance under Medicaid, that is, a State plan for medical assistance approved under Title XIX of the Social Security Act. In addition, this Plan's coordination of benefits rules will not apply to benefits You are entitled to receive under Medicaid. Where payment of Your Covered Expense has been made under Medicaid in a case where this Plan has an obligation to make payment for those expenses, this Plan will make payment in accordance with and to the extent required by any State law provided that the State has acquired Your rights to such payment of the expenses.

XV. CLAIM PROCEDURES

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, attach 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 Covered Person's identification card. If you have questions about how to submit a claim or need assistance, contact the Claims Administrator at this address:

Midwest Public Risk
PO Box 1090
Great Bend, Kansas 67530
(877) 627-2481

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 Covered Person seek a second medical opinion.

CLAIMS PROCEDURES

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, or if Plan coverage is rescinded retroactively on the basis of fraud or misrepresentation, 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.

External Review. After receiving a Final Adverse Benefit Determination under the Plan’s internal Appeal procedure, a claimant has the right to request an external review of his/her Claim pursuant to the Plan’s External Review procedures, which are set forth in Section VI below.

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.

Voluntary Review. A claimant has the right to communicate to the Plan Administrator his or her dissatisfaction about a Plan’s administration, services, or Network adequacy. A Voluntary Review 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 a Voluntary Review.

II. Claims Process

Full and Fair Independent Review. Both the Claims and the Appeal procedures (set forth in Sections III and V 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, or the External Review process, 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 V 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 or, if External Review is sought by the claimant, no later than 180 days after the Claim is denied in whole or in part on External Review.

Decision by the Plan Administrator. The decision of the Plan Administrator will be final and binding and will only be subject to review if such decision was arbitrary or capricious or otherwise an abuse of discretion. Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the Claimant is entitled to them. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decision that the Plan Administrator makes, in its sole discretion, and further, constitutes agreement to the limited scope of review described in this Section.

Evidence on Review. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to the Plan Administrator at the time it made the decision now subject to review.

Failure to File a Request an Appeal. If a Claimant fails to file a request for review in accordance with the Claims Procedures outlined herein, such Claimant shall have no rights of review and shall have no right to bring action in any court. The denial of the Claim shall become final and binding on all persons for all purposes.

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 Determination As soon as possible consistent with the medical exigencies, but no later than and 72 hours after Receipt of Claim
- Insufficient information on the Claim, or failure by claimant to follow Plan's procedure for filing a Claim:
 - Notification to claimant, orally or in writing 24 hours (after Receipt of Claim)
 - Response by claimant, orally or in writing 48 hours (after Receipt of request for information)
 - 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 Covered Person 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 24 hours (after Receipt of Claim, provided claimant files Claim at least 24 hours prior to expiration of course of treatment; if Claim is not filed within 24-hour window, the decision deadline is 72 hours)

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 V 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:
 - Notification to claimant 15 days (after Receipt of Claim)
 - Response by claimant 45 days (after Receipt of request for information)
 - Benefit determination 15 days (after Receipt of additional information from claimant)

- Need for extension due to matters beyond the control of the Plan:
 - Notification to claimant 15 days (after Receipt of Claim)
 - Benefit determination (after extension) 30 days (after Receipt of Claim)

- Claimant's failure to follow Plan's procedures for filing a claim:
 - Notification to claimant 5 days (after Receipt of claim)
 - Response by claimant 45 days (after Receipt of notice of proper claim procedures)
 - 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
 - Notification to claimant 15 days (after Receipt of Claim)
 - Benefit determination (after extension) 45 days (after Receipt of Claim)

- Insufficient information provided by claimant on the Claim:
 - Notification to claimant 30 days (after Receipt of Claim)
 - Response by claimant 45 days (after Receipt of request for information)
 - Benefit determination 15 days (after Receipt of additional information from claimant)

E. Rescission of Coverage

Definition of Rescission of Coverage. A “Rescission of Coverage” refers to the Plan’s total rescission of a claimant’s coverage under the Plan on the basis of fraud or misrepresentation.

Timetable for Notice of Rescission to Claimant. In the case of a Rescission of Coverage Claim, the Plan must provide notice to the claimant of the rescission of his/her coverage at least 30 days prior to the effective date of the rescission. This notice serves as an Adverse Benefit Determination. If the claimant wishes to challenge the rescission, he/she may appeal the rescission of coverage pursuant to Appeal procedures set forth in Section V.B.5. below.

F. 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.) Upon request, the Adverse Benefit Determination notice will be provided in a culturally and linguistically appropriate 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 (including date of service, the healthcare provider, the claim amount, and, if applicable, the treatment code and its corresponding meaning);
- (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 internal and external 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;
- (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; and

- (8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and External Review process.

IV. Voluntary Review

The Plan has a two step process for resolving issues regarding claims or plan administration: Voluntary Review and Appeals. In many cases, issues can be resolved through a voluntary review without the necessity of instituting a formal Appeal. For example, a participant could discuss additional documentation necessary to complete a request for precertification or a claim for payment. Should the Covered Person have a problem with or question about the Plan, the Covered Person has the following options:

- Contact the Plan Administrator with the complaint; or
- File a written complaint with the Plan Administrator. The written complaint should be addressed to: President and Chief Executive Officer, Midwest Public Risk, 19400 E. Valley View Parkway., Independence, MO 64055. Phone: (816) 292-7500.

The Covered Person will receive a response within 30 calendar days of the Plan's receipt of the complaint. If the Plan Administrator is unable to resolve the Covered Person's complaint in 30 calendar days, the Covered Person will be notified on or before the 30-day period if an additional 30 calendar days is required to resolve the Covered Person's complaint.

V. Appeals

The Plan is committed to providing a full and fair process for resolving disputes and responding to request to reconsider decisions the claimant finds unacceptable. 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 internal and external review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action 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;
- (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; and
- (9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and External Review process.

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 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 Determination)
- Notification to claimant of decision on Adverse Benefit Determination Appeal 60 days (after Receipt of Appeal)

5. Rescission of Coverage Claims

The timetable for appealing a Rescission of Coverage is as follows:

- Claimant's Appeal Deadline 180 days (after Receipt of notice of Rescission of Coverage / Adverse Benefit Determination)
- Notification to claimant of decision on Adverse Benefit Determination Appeal 60 days (after Receipt of Appeal)

VI. External Review Process

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he/she may (but does not have to) request that the Claim be reviewed under the Plan's External Review process. As described in detail below, the External Review process entails a review of the Claim by an independent third-party organization.

Deadline for Requesting External Review of Final Adverse Benefit Determination. A request for External Review of a Final Adverse Benefit Determination must be filed by the claimant in writing within four (4) months after Receipt of the Final Adverse Benefit Determination.

Determination Whether Claim is Eligible for External Review. Within five (5) days after receiving a claimant's request for External Review, the Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

- The claimant is or was covered under the Plan at the time the Claim was made or incurred;
- The denial relates to the claimant's failure to meet the Plan's eligibility requirements. (If the Claim involves an eligibility issue, external review is not available);
- The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and
- The claimant has provided all the information required to process an External Review.

Within one (1) business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the Plan Administrator's notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

Assignment to Independent Review Organization for External Review. If the claimant's request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice will include a statement that the claimant may submit in writing, within ten (10) business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

Evaluation of Claim by IRO. If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;
- The terms of the Plan;
- Appropriate practice guidelines;
- Any applicable clinical review criteria developed and used by the plan; and
- The opinion of the IRO's clinical reviewer.

Claim Decision by IRO. The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

- A general description of the reason for the External Review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- References to the evidence or documentation the IRO considered in reaching its decision;
- Discussion of the principal reason(s) for the IRO's decision;
- A statement that the determination is binding (except to the extent other remedies may be available under State or Federal law);
- A statement that judicial review may be available to the claimant; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

Availability of Expedited External Review. Generally, a claimant must exhaust the Plan's Claims and Appeal Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review. Expedited External Review is available if either of the following two conditions is satisfied:

- **Requiring Appeal of Adverse Benefit Determination Under Plan's Internal Claims and Appeal Procedure Timetable Would Seriously Jeopardize Claimant's Life or Health.** The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or
- **Final Adverse Benefit Determination Involves Emergency Services and Claimant Remains Hospitalized.** The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon Receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO.

The IRO must then make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours.

XVI. THIRD PARTY RECOVERY

RIGHT OF SUBROGATION AND REIMBURSEMENT

Pursuant to RSMo. §376.433, Midwest Public Risk shall have the right of reimbursement against Covered Persons who receive a recovery from third parties for benefits paid by the Plan and shall also have a right of subrogation against third parties who are liable by reason of contract, neglect or willful acts for causing health expenses to be paid out by Midwest Public Risk under its Plan of self-insurance. Accepting benefits under this Plan for those health expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any liable third party. The rights, obligations and remedies available to Midwest Public Risk are the same as those set forth in RSMo. §208.215.

These rights, obligations and remedies include, but are not limited to:

1. When any third party is liable, either pursuant to contract, tort or otherwise, to a Covered Person on account of personal injury to or disability or disease, payments made by the Plan relating to such injury, disability or disease shall be a debt due to the Plan and recoverable from the liable party or Covered Person for all payments made on behalf of the Covered Person. The debt due the Plan shall not exceed the payments made by the Plan for payments on account of the injury, disease, or disability to which the Covered Person may be entitled.
2. Any Covered Person, a legal representative or any other party claiming through the Covered Person who pursues legal rights against a third party liable to a Covered Person for injuries, disease or disability shall, upon actual knowledge that the Plan has paid benefits, promptly notify the Plan Administrator as to the pursuit of such legal rights.
3. Every Covered Person assigns his rights to the Plan of any funds recovered or expected to be recovered to the extent provided for in this section.
4. All Covered Persons, their legal representatives or any other party claiming through the Covered Person shall cooperate at every stage of the Plan's actions to recover any funds due it, including, but not limited to, claim investigation, recovery of overpayments and recovery of funds from liable third parties. Failure to cooperate or prejudicing a right of the Plan may result in a loss of benefits.
5. A Covered Person or their legal representative who has notice or actual knowledge of the Plan's rights to reimbursement and who receives any third-party benefits, proceeds or other recovery for a covered illness or injury is either required to:
 - Pay the Plan within sixty days after receipt of settlement proceeds the full amount received from the third-party up to the total benefits provided by the Plan, or
 - To place the full amount received from the third-party in a trust account for the benefit of the Plan pending judicial or administrative determination of the Plan's right to be reimbursed such amounts.
6. Every person, corporation, partnership or other entity who acts for or on behalf of a Covered Person for purposes of pursuing the Covered Person's claim which accrued as a result of an incident or occurrence resulting in the payment of Plan benefits shall notify the Plan Administrator upon agreeing to assist such Covered Person and further shall notify the Plan Administrator of any commencement of a proceeding or settlement or the results of the pursuit of the claim and give thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the Covered Person to recover damages for such injuries, disease or disability to which the Covered Person may be entitled.
7. Every Covered Person, their legal representative, or any other party claiming through the Covered Person or their attorney shall promptly notify the Plan Administrator of any recovery received by them from a third party and shall immediately reimburse the Plan from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party up to the total benefits provided by the Plan. A judgment, award, or settlement in an action by a Covered Person to recover damages for injuries or other third-party benefits in which the Plan has an interest may not be satisfied without first giving the Plan notice and a reasonable opportunity to proceed with any action permitted by law.
8. The Plan shall have the right to recover the amount of payments made to a provider under this section because of an injury, disease, or disability, to which the Covered Person may be entitled for which a third party is or may be liable in contract, tort or otherwise under law of equity.

9. The Plan shall have a lien upon any moneys to be paid by any insurance company or other business enterprise, person, corporation, institution, public agency or private agency in settlement or satisfaction of a judgment on any claim for injuries or disability or disease to which the Covered Person may be entitled which resulted in medical expenses for which the Plan made payment. This lien shall also be applicable to any moneys which may come into the possession of any attorney who is handling the claim for injuries, or disability or disease to which the Covered Person may be entitled which resulted in payments made by the Plan.
 - In each case, a lien notice shall be served by certified mail or registered mail by either the attorney handling the claim, the Covered Person, their representative or the Plan, if applicable, upon the party or parties against whom the Covered Person has a claim, demand or cause of action.
 - The lien shall claim the charge and describe the interest the Plan has in the claim, demand or cause of action. The lien shall attach to any verdict or judgment entered and to any money or property which may be recovered on account of such claim, demand or cause of action or suit from and after the time of the service of the notice.
10. Each Covered Person hereby agrees to execute and deliver all necessary instruments or other documents as the Plan Administrator may require to facilitate the enforcement of the Plan's rights and not to prejudice such rights.
11. The Plan shall also have all other rights, obligations and remedies provided in RSMo. §208.215. If any portion of this section conflicts with RSMo. §208.215, the language of the statute will control.

XVII. GENERAL PROVISIONS

Plan is Not A Contract

The Plan shall not be deemed to constitute a contract between the Plan Administrator or Member Group and any Employee or to be a consideration for or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Member Group or to interfere with the right of the Member Group to discharge any Employee at any time. However, the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement which may be made by the Member Group with the bargaining representatives of any Employees.

Plan Modification and Amendment

The Plan Administrator can modify or amend the Plan from time to time at its sole discretion and such amendments or modifications which affect covered Employees will be communicated to them.

Plan Termination

The Plan Administrator can terminate the Plan at any time. Upon termination, Your rights to benefits are limited to claims incurred and due up to the date of termination and benefits under continuation of coverage, if any. Any termination of the Plan will be communicated to You. If the Plan Administrator has established a trust under Section 501(c)(9) of the Internal Revenue Code to fund this Plan, the trust shall also be terminated but no trust funds may revert to or inure to the benefit of the Plan Administrator or any Member Group, affiliate or subsidiary of a Member Group.

Spendthrift Clause

To the full extent permitted by law, all rights and benefits under this Plan for You shall be exempt from execution, attachment, garnishment or other process in equity or at law for Your debts.

Waiver Not Estoppel

Any waiver of the Plan Administrator or Claims Administrator to enforce a provision of this Plan shall not affect any right thereafter to enforce such provision or any other provision of this Plan.

Construction of Terms

In this Plan the singular number includes the plural; the plural includes the singular. Any word that refers to one gender includes all genders, unless the context requires one gender. Section headings are reading aids only and should not be used to construe the text.

Assignments

You may assign benefits to a Physician, Hospital or other provider of service under this Plan. The assignment must be received by the Claims Administrator with the written Proof of Claim or such assignment will not be binding upon the Plan. In the absence of a written assignment, the Plan can pay any benefits, for any service provided to a deceased Covered Person, to any person appearing to the Plan Administrator to be entitled to payment.

Agent for Process

Legal process may be served on the Plan Administrator at the address shown in the General Plan Information.

Clerical Error

Any clerical error (by the Member Group, Plan Administrator or the Claim Administrator) in keeping pertinent records, or a delay in making any entry, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. When an error delay becomes known, the contributions will be adjusted. Retroactive credits will be limited to 90 days. Upon demonstration of clerical error by the Member Group or Plan Administrator, the Claims

Administrator will initiate coverage retroactively to the correct effective date and charge premium retroactively to the latest of these dates in the Calendar Year:

1. The effective date that should have been assigned upon timely enrollment; or
2. The date of July 1st in the current Plan Year.

Fiduciary

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

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Covered Person and defraying reasonable expenses of administering the Plan. These duties must be carried out:

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

The Named Fiduciary

A "named fiduciary" is the one named in the Plan. A "named fiduciary" can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan.

Claims Administrator Is Not A Fiduciary

The Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the funds of the Plan's rules as established by the Plan Administrator.

Funding The Plan and Payment of Benefits

The Plan is a self-funded plan. The cost of the Plan for Employee or Dependent coverage is derived solely from the funds of the Member Group and contributions by the Employee. The level of any Employee contributions will be set by the Pool Member. 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.

Legal Status

The Plan is a non-ERISA plan formed pursuant to Missouri Revised Statutes Chapter 537.

Physical Exam and Autopsy

The Plan has the right to have You examined, at its expense, pending payment of a claim. It also has the right, at its expense, to have an autopsy performed at Your death, unless forbidden by law.

Right to Receive and Release Information

This Plan may release or obtain any information necessary in order to determine benefit payments or eligibility of a person to be covered by the Plan. Any Covered Person claiming benefits under this Plan must furnish to the plan such information as may be necessary to determine payments.

Conformity to Law

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

Compliance with HIPAA Privacy Standards.

Certain members of the Member Group'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 only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the following provisions apply:

1. **General.** The Plan shall not disclose Protected Health Information to any member of the Member Group'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 Member Group's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
3. **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Member Group'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 Member Group's workforce" shall refer to all Employees and other persons under the control of the Member Group.
 - a. **Updates Required.** The Member Group shall amend this document 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 Member Group'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 Member Group'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 Member Group. The Member Group 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 Member Group 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 Member Group;
 - 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 permitted by this Amendment, 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 Member Group 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 Member Group's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of the Member Group's workforce are designated as authorized to receive Protected Health Information from MPR ("the Plan") in order to perform their duties with respect to the Plan: designated appointees from the member entities.

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 Plan documents must be amended to reflect certain obligations required of the Member Group.

Therefore, the following provisions apply:

1. The Member Group 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 Member Group 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 Member Group 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.

The Member Group 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 Member Groups described above.

XVIII. GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION: This is a self-funded Plan with the administration provided through a third party claims payor.

PLAN NAME: MIDWEST PUBLIC RISK OF MISSOURI HEALTH CARE PLAN

FEDERAL TAX ID NUMBER: 43-1297967

RESTATEMENT DATE: July 1, 2011

PLAN YEAR ENDS: June 30th of each Calendar Year

TYPE OF PLAN: Health and Welfare

PLAN ADMINISTRATOR: Midwest Public Risk
19400 E. Valley View Pkwy.
Independence, MO 64055
(816) 292-7500

NAMED FIDUCIARY: Midwest Public Risk
19400 E. Valley View Pkwy.
Independence, MO 64055

AGENT FOR
LEGAL PROCESS: Midwest Public Risk
19400 E. Valley View Pkwy.
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CLAIM
ADMINISTRATOR Benefit Management, Inc. (BMI)
PO Box 1090
Great Bend, KS 67530
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(877) 627-2481