WELFARE EMPLOYEE BENEFIT PLAN DOCUMENTS

for

FOUR COUNTY MENTAL HEALTH CENTER, INC.

Documents prepared by:

HINKLE

LAW FIRM LLC

FOUR COUNTY MENTAL HEALTH CENTER, INC. - SUMMARY OF WELFARE BENEFIT PLAN INFORMATION

Plan Name	Plan Number	Plan Funding	Insurance Company/ Claims Administrator	Contract Number	Eligibility Conditions (hours per week)	Entry Date	Plan Year	Premiums Paid
Welfare Benefit Plan	501	N/A	N/A	N/A	Regularly scheduled to work at least 30 hours per week.	1st day of the month coincident with or next following 30 days of employment.	July 1 – June 30	N/A
Medical Plan (includes Prescription Drug and CancerCare benefit)(non-grandfathered)	501	Self-Funded	Claims Administrator: Meritain	18122	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Part Employer Paid, part Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Dental Plan	501	Fully-Insured	Delta Dental of Kansas	02705000000010 0000	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Part Employer Paid, part Employee Paid on a Pre-Tax basis through Welfare Benefit Plan.
Health Flexible Spending Account	501	Self-Funded	Claims Administrator: Paylocity	N/A	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Employee paid on a Pre-Tax basis through Welfare Benefit Plan.
Dependent Care Assistance Plan	501	Self-Funded	Claims Administrator: Paylocity	N/A	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Employee paid on a Pre-Tax basis through Welfare Benefit Plan.
Vision Plan	501	Fully-Insured	EyeMed	1011732	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Employee paid on a Pre-Tax basis through Welfare Benefit Plan.

FOUR COUNTY MENTAL HEALTH CENTER, INC. - SUMMARY OF WELFARE BENEFIT PLAN INFORMATION

Plan Name	Plan Number	Plan Funding	Insurance Company/ Claims Administrator	Contract Number	Eligibility Conditions (hours per week)	Entry Date	Plan Year	Premiums Paid
Accident Plan	501	Fully-Insured	AFLAC	Ind. Policies	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Employee paid on a Pre-Tax basis through Welfare Benefit Plan.
Cancer Plan	501	Fully-Insured	AFLAC	Ind. Policies	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Employee paid on a Pre-Tax basis through Welfare Benefit Plan.
Hospital Plan	501	Fully-Insured	AFLAC	Ind. Policies	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Employee paid on a Pre-Tax basis through Welfare Benefit Plan.
Short Term Disability Plan	501	Fully-Insured	AFLAC	Ind. Policies	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Employee paid on an After-Tax basis through Welfare Benefit Plan.
Health Savings Account Plan	501	N/A	Trustee / Custodian: Health Equity for prior accounts and Paylocity for new accounts	N/A	Same as Welfare Benefit Plan.	Same as Welfare Benefit Plan.	July 1 – June 30	Employee and Employer Contributions Pre-Tax through the Welfare Benefit Plan.

FOUR COUNTY MENTAL HEALTH CENTER

WELFARE BENEFIT PLAN

FOUR COUNTY MENTAL HEALTH CENTER
WELFARE BENEFIT PLAN

Four County Mental Health Center, Inc. ("Employer") adopts this amended and restated Four County Mental Health Center Welfare Benefit Plan ("Plan") for the benefit of its Eligible Employees. This Plan is an amendment and restatement of the Plan originally adopted effective July 1, 2004, as subsequently amended and restated effective July 1, 2024.

ARTICLE I
PURPOSE AND LEGAL STATUS OF THE PLAN

Section 1.01 Purpose of Plan. The purpose of this Plan is to provide Eligible Employees of the Employer a choice between taxable compensation and nontaxable benefits, and after-tax benefits offered by the Employer. Additionally, this Plan provides certain Employer-Paid Benefits to Eligible Employees of the Employer.

Section 1.02 Cafeteria Plan Status. It is the intent of the Employer that this Plan qualify as a "cafeteria plan" within the meaning of Section 125 of the Internal Revenue Code, as amended, and the regulations issued thereunder, and that any "qualified benefits" paid under this Plan be eligible for exclusion from the Participant's gross income for federal income tax purposes.

Section 1.03 Exclusive Benefit. It is intended that the Plan terms, including those related to coverage and benefits, be legally enforceable and that this Plan be maintained for the exclusive benefit of Employees and their covered dependents.

Section 1.04 Single Plan. It is the intent of the Employer that this Plan, including any underlying Benefit Package Options, be considered to be a single plan. For purposes of COBRA continuation rights, however, each underlying Benefit Package Option shall be considered to be a separate plan.

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ARTICLE II
DEFINITIONS

Section 2.01 [Reserved]

Section 2.02 "After-Tax Benefits" means the after-tax benefit options under the AFLAC Plan.

In addition, the term After-Tax Benefit means any Pre-Tax Benefit provided under this Plan in which individuals described in Section 2.14(b) are participating, but only with regard to requiring those individuals to pay for such Pre-Tax Benefits on an after-tax basis.

Section 2.03 "Annual Enrollment Period" means the period defined in Section 5.03(b) of this Plan.

Section 2.04 "Benefits" means After-Tax Benefits, Pre-Tax Benefits, and Employer-Paid Benefits.

Section 2.05 "Benefit Package Option" means a benefit that is offered under this Plan on a pre-tax basis or an option for coverage that is offered under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

Section 2.06 "Claim" means any formal request for a Plan benefit or benefits made by a Claimant or his/her representative in accordance with the Plan's procedures for filing benefit claims as set forth in Article IX and/or Appendix C. 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 the Plan's procedures for filing a Claim will not be treated as a Claim.

Section 2.07 "Claimant" means a Participant who files a Claim for benefits pursuant to Article IX and/or Appendix C of this Plan.

Section 2.08 "Claims Administrator" means the Plan Administrator, unless the Employer retains another person to serve as the claims fiduciary for one or more of the Benefits with the authority to grant or deny claims for benefits.

Section 2.09 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Section 2.10 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

Section 2.11 "Compensation" means wages, salary and other remuneration paid to a Participant by the Employer, but does not include amounts contributed by the Employer to a qualified plan, other than elective deferrals made to a 401(k) plan or 403(b) plan or arrangements on behalf of the Participant, and does not include any other fringe benefits or medical benefits provided by the Employer.

Section 2.12 "Effective Date" means the original date on which this Plan took effect, which date is July 1, 2004; provided, however, that if this Plan is subsequently amended, such new or amended provisions shall be effective on such later date as shall be determined by the Employer.

Section 2.13 "Election Change Event" means an event which would allow a Participant to change the Participant's elections during a Plan Year, subject to the requirements of Article V and as set forth in more detail in Sections 5.06 through 5.16.

Section 2.14 "Eligible Employee" means an individual who is actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding thirty (30) hours per week, subject to the following:

(a) Special Rules:

(i) *Status During Leaves of Absence.* An Employee's status as an Eligible Employee shall be deemed to continue as follows:

(A) During a paid leave of absence approved by the Employer (including a paid leave of absence while on active service in the armed forces (within the meaning of USERRA));

(B) During an unpaid leave of absence approved by the Employer (including an unpaid leave of absence while on active service in the armed forces (within the meaning of USERRA), subject to Subsection (D)) not to exceed six weeks;

(C) If the FMLA is applicable to the Employer, during a leave of absence taken pursuant to the FMLA; provided, however, any period of unpaid leave shall run concurrently with any FMLA leave; or

(D) During a paid or unpaid leave of absence of less than 31 days while on active service in the armed forces (within the meaning of USERRA). To the extent the length of the leave of absence in Subsection (B) exceeds the length of the leave of absence in this Subsection (D), Subsection (B) shall control;

(ii) *All Disability Leave.* Whether treated as unpaid or paid (i.e., taxable or non-taxable compensation) – all disability leave shall be treated as "unpaid leave" for purposes of plan eligibility. However, nothing in this Subsection shall preclude a Participant on FMLA leave from maintaining eligibility during such FMLA leave; and

(iii) *Status During Military Service.* An Employee ceases to be an Eligible Employee during the period of time such Employee enters active service in the armed forces of any country, except for temporary active service of two weeks or less.

(b) Any individual who is, with respect to the Employer, (i) a self-employed individual, or (ii) a more-than-two-percent shareholder of an S corporation under Section 1372(b) of the Code shall not be an Eligible Employee for purposes of making pre-tax salary reductions pursuant to Article V. However, such individual shall be an Eligible Employee for purposes of participating in underlying Benefits *on an after-tax basis*.

Note: The underlying Benefits may have additional eligibility requirements. Such additional requirements, if any, are set forth separately in this Plan document.

Section 2.15 "Employee" means an individual employed by the Employer, excluding those persons covered by a collective bargaining agreement and further excluding those persons classified by the Employer on its payroll records as "leased employees" as that term is used in Section 414(n) of the Code.

Section 2.16 "Employer" means Four County Mental Health Center, Inc.

Section 2.17 "Employer-Paid Benefit" includes contributions made by the Employer to a Health Savings Account ("HSA").

Section 2.18 "FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

Section 2.19 "Group Health Plan" means a Benefit that provides health care to the Participants in the Plan and their beneficiaries. The term includes the following benefits:

(a) Four County Mental Health Center Medical Plan ("Medical Plan");

(b) Four County Mental Health Center Dental Plan ("Dental Plan");

(c) Four County Mental Health Center Health Flexible Spending Account ("Health FSA"); and

(d) Four County Mental Health Center Vision Plan ("Vision Plan").

The term does not include a HSA.

Section 2.20 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Section 2.21 "Participant" means an Eligible Employee who has entered the Plan pursuant to Section 3.01 and whose participation in the Plan has not been terminated pursuant to Section 3.02.

Section 2.22 "Plan" means the Four County Mental Health Center Welfare Benefit Plan.

Section 2.23 "Plan Administrator" means the Employer. The Employer may designate from time to time one or more individuals or other persons to carry out various administrative and other duties with respect to this Plan in a manner consistent with the terms of this Plan and ERISA.

Section 2.24 "Plan Year" means the fiscal year of this Plan, the 12 consecutive month period beginning every July 1 and ending the subsequent June 30.

Section 2.25 "Pre-Tax Benefits" means one or more of the following:

(a) Four County Mental Health Center Medical Plan;

(b) Four County Mental Health Center Dental Plan;

(c) Four County Mental Health Center Health Flexible Spending Account;

(d) Four County Mental Health Center Dependent Care Assistance Plan ("DCAP");

(e) Four County Mental Health Center Vision Plan; and

(f) Four County Mental Health Center AFLAC Plan ("AFLAC Plan"), but only with respect to those benefits under the AFLAC Plan which may be paid for on a pre-tax basis.

In addition, the term "Pre-Tax Benefits" also includes contributions made by a Participant on a pre-tax basis to an HSA.

Section 2.26 "Spouse" means a person of the same or opposite sex to whom an Eligible Employee is legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which the couple currently resides. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a "Spouse" for purposes of this Plan if (a) his/her marriage to the Eligible Employee has been terminated by a court having jurisdiction over one or both parties to the marriage or (b) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

Section 2.27 "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

ARTICLE III
PARTICIPATION IN THE PLAN

Section 3.01 Entry into the Plan.

(a) *General Rule.* An Eligible Employee becomes a Participant on the first day of the month following or coincident with thirty (30) days of continuous, active employment as an Eligible Employee.

An Eligible Employee who has entered into the Plan pursuant to this Section is a Participant without regard to whether he/she elects to reduce his/her Compensation in order to purchase benefits under one or more of the Benefits under this Plan.

(b) *Effective Date of this Plan.* Notwithstanding any other provision of this Plan, no Eligible Employee may become a Participant prior to the Effective Date of this Plan.

Section 3.02 Termination of Participation.

(a) *General Rule.* A Participant will cease participation in this Plan on the earlier of the following dates:

(i) The date on which this Plan terminates; or

(ii) The date on which the Participant ceases to be an Eligible Employee.

Although a Participant's participation under this Plan terminates on the above date, coverage or benefits under the underlying Benefits may continue if, and to the extent, provided by such Benefits.

Section 3.03 Family and Medical Leave Act of 1993.

(a) *General Rule.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain the Participant's benefits under a Group Health Plan on the same terms and conditions as though the Participant were still an active Employee (that is, the Employer will continue to pay its share of the premium to the extent the Participant opts to continue his/her coverage). If the Participant is a participant in the Health FSA, additional rules may apply to the Participant's coverage under the Health FSA as set forth in the Appendix for the Health FSA.

(b) *Options for Payment of Participant's Share of the Premium.* If the Participant opts to continue his/her coverage, the Participant may pay his/her share of the premium in one or more of the following ways:

(i) The Participant may pay his/her share of the premiums with after-tax dollars while on leave (or with pre-tax dollars to the extent the Employee receives Compensation during the leave).

(ii) The Participant may pay his/her share of the premium pursuant to such other arrangement as may be agreed upon between the Participant and the Plan Administrator.

(c) *Return from FMLA Leave.* If the Participant's coverage ceases while the Participant is on FMLA leave, the Participant will be permitted to reenter the Plan immediately upon his/her return from FMLA leave on the same basis that the Participant was participating in the Plan prior to his/her leave, or as otherwise required by the FMLA.

(d) *Failure to Pay Premiums While on FMLA Leave.* If the Participant fails to remit his/her premium payments within thirty (30) days after the premium payment is due, then the Employer – following any requisite notice mandated by FMLA regulations – may terminate the Participant's coverage retroactive to the date the unpaid premium payment was due.

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ARTICLE IV
PLAN BENEFITS

Section 4.01 Pre-Tax Benefits. Each Participant may elect to reduce his/her Compensation and have the amount applied by the Employer toward the cost of benefits available under one or more of the Pre-Tax Benefits under this Plan. For those benefits that are provided through a policy of insurance, the monthly premiums are determined by the applicable insurance company and may change from time to time.

(a) *Terms and Conditions of the Pre-Tax Benefits.* The terms and conditions of the Pre-Tax Benefits are as follows:

(i) *Medical Plan*. Participants may elect to receive medical coverage through the Medical Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix A.

(ii) *Dental Plan*. Participants may elect to receive dental coverage through the Dental Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix A.

(iii) *Vision Plan*. Participants may elect to receive vision coverage through the Vision Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix A.

(iv) *AFLAC Plan*. Participants may elect to receive cancer coverage, accident coverage, and/or hospital coverage through individual policies or group contracts, as applicable, under the AFLAC Plan. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix B.

(v) *Health Flexible Spending Account.* Participants may elect to make contributions to the Health FSA. A Health FSA enables Participants to elect pre-tax salary reduction and receive reimbursements for their unreimbursed Qualified Medical Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Section 105(h) of the Code so that the Employer's reimbursements from the Health FSA are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix C.

(vi) *Dependent Care Assistance Plan*. Participants may elect to make contributions to the DCAP. A DCAP enables Participants to elect pre-tax salary reduction and receive reimbursements for their Qualified Dependent Care Expenses incurred during a Plan Year. The Employer intends that this benefit qualify under Section 129 of the Code so that the Employer's reimbursements from the DCAP are excludable from the Participant's gross income. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix D.

(vii) *Health Savings Account.* Participants may elect to make contributions on a pre-tax basis to an HSA. The HSA is not an employer-sponsored employee benefit plan. It is an individual trust or custodial account that Eligible Employees open with an HSA trustee/custodian and which may be used to reimburse Participants for "eligible medical expenses" as set forth in Code § 223. The terms and conditions of this Pre-Tax Benefit are set forth in Appendix E.

(b) *Election of Pre-Tax Benefits.* The election of a Pre-Tax Benefit is subject to the terms and conditions of Article V.

(c) *Cessation of Participation in a Pre-Tax Benefit.* Except as otherwise expressly provided in the Pre-Tax Benefit, a Participant will cease to be a participant in the Pre-Tax Benefit on the date that he/she ceases to be a Participant in this Plan.

Section 4.02 After-Tax Benefits. Each Participant may elect to have the cost of one or more of the After-Tax Benefits deducted from his/her Compensation on an after-tax basis. The monthly premiums for insurance coverage are determined by the applicable insurance company and may change from time to time.

(a) *Terms and Conditions of the After-Tax Benefits.* The terms and conditions of the After-Tax Benefits are as follows:

(i) *AFLAC Plan*. Participants may elect to receive short term disability coverage through individual policies or group contracts, as applicable, under the AFLAC Plan. The terms and conditions of this After-Tax Benefit are provided in Appendix B.

(b) *Election of After-Tax Benefits.* A Participant may make and/or change his/her elections with respect to an After-Tax Benefit at any time in accordance with the rules and procedures established by the Plan Administrator. Any such election change shall take effect on the earliest administratively practicable date after the request to change an after-tax election is received by the Plan Administrator.

ARTICLE V
ELECTION OF PRE-TAX BENEFITS

Section 5.01 Benefit Plans. Each Participant may elect to receive the Participant's entire Compensation in cash or to reduce the Participant's Compensation and have the Employer apply the amount by which the Participant's Compensation is reduced toward the cost of benefits that are available on a pre-tax basis under this Plan.

Section 5.02 Method of Making an Election. In order to purchase a Pre-Tax Benefit through this Plan, a Participant must execute an agreement to reduce his/her Compensation on the salary reduction form provided by the Plan Administrator. The Plan Administrator may require such agreement to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

Section 5.03 Timing of Elections.

(a) *Initial Elections for Newly Eligible Employees.* To make an election to purchase Pre-Tax Benefits through this Plan, a newly Eligible Employee must execute a salary reduction form and deliver it to the Plan Administrator prior to or on the date he/she becomes a Participant in this Plan, except that an individual eligible to contribute to the HSA may elect to begin coverage at any time. The election will be given effect as of the earliest administratively practicable date on or next following the date on which the Eligible Employee delivers the salary reduction form to the Plan Administrator, provided that no such election may take effect prior to the date the Participant becomes a Participant in this Plan. Notwithstanding the foregoing, with regard to a newly hired Participant, the Participant may have up to thirty (30) days after his/her date of hire to make his/her elections, and execute and deliver a salary reduction form to the Plan Administrator. Such an election may be given retroactive effect to the first of the month following the Participant's date of hire. This special rule for new hires does not apply to elections under the Health FSA and DCAP, which shall be prospective only.

(b) *Annual Elections for Current Participants.* At least 30 days prior to the beginning of each Plan Year, the Plan Administrator must provide each Participant with the opportunity to make elections for the following Plan Year. Participants desiring to make elections during the Annual Enrollment Period for the next Plan Year must do so in the manner and within the deadlines prescribed by the Plan Administrator. Elections made during the Annual Enrollment Period shall become effective for the following Plan Year.

(c) *Election Changes during a Plan Year.* A Participant may change his/her elections with respect to a Pre-Tax Benefit during a Plan Year *only if* an election change is permitted as a result of one or more of the events listed in Sections 5.06 through 5.16. Such events may be referred to generally in Plan documents as an "Election Change Event." Except as otherwise provided in this Article V, any election change as a result of an event qualifying as an Election Change Event must be made no later than 30 days (or such longer period as may be

specified in the group insurance contract/policy or, in the case of a self-funded plan, the separate plan document or benefit description, as applicable) after the event. Election changes made as a result of an Election Change Event may *not* be given retroactive effect except as specifically set forth below. Additional restrictions and/or rules may apply to election changes made during a Plan Year with respect to a Health FSA and/or a DCAP.

Section 5.04 Failure to Make an Election.

(a) *Failure to Make Initial Election.* A Participant's failure to return a completed salary reduction form by the required date as set forth in Section 5.03(a) constitutes an election to receive the Employee's entire Compensation for the Plan Year in cash. In such an event, no portion of the Employee's Compensation will be applied toward the cost of any benefits available under any of the Pre-Tax Benefits. Such an Employee will not be permitted to change such an election until (i) the next Annual Enrollment Period *or* (ii) the Employee experiences an Election Change Event, as a result of which an election change would be permitted under this Article V.

(b) *Failure to Change Existing Elections During Annual Enrollment Period.* Once a Participant has completed a salary reduction form for a Plan Year, a failure to complete a new form for a subsequent Plan Year during the Annual Enrollment Period shall be considered to be an election to participate on the same basis as the prior Plan Year, subject, however, to the following rules:

(i) *Change in Cost.* If the cost of the benefits elected by the Participant under one or more Pre-Tax Benefits during the current Plan Year has increased or decreased for the subsequent Plan Year, the Participant's election may be modified for the subsequent Plan Year by the amount of any such increase or decrease.

(ii) *Spending Account Plans.* If the Participant has elected to participate in the Health FSA and/or the DCAP during the current Plan Year, but has failed to complete a new election for a subsequent Plan Year, the Participant's election with respect to such Plans will be reduced to zero dollars for any subsequent Plan Years.

Section 5.05 Irrevocability of an Election Once Made. Once the Annual Enrollment Period has passed, a Participant shall not be permitted to revoke, amend, or change the elections the Participant has made for the affected Plan Year except as provided in this Article V.

Section 5.06 Election Change Due to Change in Status. After a Plan Year has commenced, a Participant shall be permitted to revoke an election in its entirety (or revoke the election and make a new election) for the balance of that Plan Year, if the Participant experiences a Change in Status as defined below and the consistency requirements of this Section are satisfied.

(a) *Change in Status*. The following events constitute a Change in Status:

(i) *Change in Marital Status.* A change in the Participant's legal marital status, including the following: marriage, divorce, the death of a Spouse, legal separation, and annulment.

(ii) *Change in Number of Dependents.* A change in the number of the Participant's dependents, including the following: birth, death, adoption, and placement for adoption.

(iii) *Change in Employment Status.* Any of the following events that change the employment status of the Participant, the Participant's Spouse, or the Participant's dependents:

(A) A termination or commencement of employment;

(B) A commencement of or return from an unpaid leave of absence;

(C) A change in worksite, if such a change affects eligibility under this Plan or a Pre-Tax Benefit;

(D) A change in employment status, such as a change from salaried to hourly employment, if the change affects the eligibility of the Participant, the Participant's Spouse, or the Participant's dependents under this Plan, under a Pre-Tax Benefit, or if the change affects the eligibility of the Participant, the Participant's Spouse, or the Participant's dependents under a cafeteria plan or welfare benefit plan maintained by an employer (other than the Employer) employing the Participant, the Participant's Spouse, or the Participant's dependents;

(E) A reduction in the Participant's hours such that the Participant will no longer be reasonably expected to average at least thirty (30) hours of service per week, even if that reduction does not result in the Participant ceasing to be eligible under a Group Health Plan (other than a Health FSA), so long as both of the following conditions are satisfied:

(1) The revocation of the Participant's election corresponds to the intended enrollment of the Participant, and any Spouse or dependents who cease coverage due to the revocation in another plan that provides minimum essential coverage; and

(2) The new minimum essential coverage in which the Participant (and, if applicable, the Participant's Spouse and/or dependents) enrolls takes effect no later than the first day of the second month following the month that includes the date the coverage under the Group Health Plan (other than a

Health FSA) is revoked. (The Plan Administrator may rely on the Participant's reasonable representations regarding the intention to enroll in other minimum essential coverage and the effective date of such coverage.); or

(F) A strike or lockout.

(iv) *Change in Dependent Eligibility.* An event that causes the Participant's dependent(s) to satisfy or cease to satisfy the eligibility conditions for coverage under a Pre-Tax Benefit on account of the dependent's attainment of a certain age, student status, or any similar circumstances.

(v) *Change in Residence.* A change in the place of residence of the Participant, the Participant's Spouse, or the Participant's dependent(s), if such a change affects eligibility under this Plan or a Pre-Tax Benefit.

(b) *Consistency*. An election change that is made on account of a Change in Status must be consistent with that Change in Status. Whether a particular election change is consistent with a Change in Status will be determined by the Plan Administrator in accordance with Internal Revenue Service ("IRS") regulations.

Section 5.07 Election Change Due to Exercise of HIPAA Special Enrollment Rights.

(a) *HIPAA Special Enrollment Rights.* After a Plan Year has commenced, a Participant may revoke his/her prior election for health coverage and make a new election for such coverage, if the Participant, the Participant's Spouse, or a dependent of the Participant is entitled to special enrollment rights under a group health plan of the Employer as described under either (i), (ii), (iii), or (iv) below:

(i) *Eligibility for a State Premium Assistance Subsidy under the Plan from Medicaid or SCHIP.* A Participant or his/her Spouse or dependent becomes eligible for a state premium assistance subsidy under a group health plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP);

(ii) *Loss of Eligibility for Medicaid or SCHIP Coverage.* The Medicaid or SCHIP coverage of a Participant or his/her Spouse or dependent is terminated as a result of a loss of eligibility;

(iii) *Loss of Other Coverage.* Medical coverage was declined under a group health plan sponsored by the Employer because the Employee and/or dependent was covered under another group health plan or had other health insurance coverage, and eligibility for such coverage is subsequently lost. A loss of eligibility for such other coverage includes the following:

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period;

(B) Loss of eligibility for coverage through an HMO in the individual market because the individual no longer resides, lives, or works in a service area (whether or not the choice of the individual); and

(C) In the case of coverage offered through an HMO in the group market that does not provide benefits to an individual who no longer resides, lives, or works in the service area (whether or not the choice of the individual), and no other benefit package is available to the individual;

A loss of eligibility does not include a loss resulting from the failure of the Employee or dependent to pay premiums on a timely basis or a termination of coverage for cause (e.g., fraud);

(iv) *Acquisition of a New Dependent.* The Participant acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption.

(b) *New Election Must Correspond and be Consistent with HIPAA Special Enrollment Rights.* A change in elections pursuant to this Section must correspond and be consistent with the exercise of the special enrollment rights provided under Code § 9801(f).

(i) *Increase in Salary Reductions.* A Participant may elect to increase the amount by which his/her Compensation is reduced by no more than the additional cost of the benefits provided under the group health plan as a result of the enrollment of the Participant, the Participant's Spouse, and/or a dependent of the Participant in the group health plan.

(ii) *Decrease in Salary Reductions.* A Participant may elect to decrease the amount by which his/her Compensation is reduced by no more than the cost of the premium assistance received by the Participant and/or his/her dependents.

(iii) *Election to Add Previously Eligible Dependents.* An election to add previously eligible dependents as a result of a loss of other coverage or the acquisition of a new Spouse or dependent child shall be considered to be consistent with the special enrollment rights.

(c) *Status Change Form.* Each Participant must complete a status change form and submit such form to the Plan Administrator no later than 60 days after the date of the event giving rise to the exercise of a HIPAA special enrollment right under (a)(i) or (a)(ii) above, or no later than 30 days after the date of the event giving rise to the right to exercise the special enrollment rights under (a)(iii) or (a)(iv) above.

(d) *Approval of Change.* Any change in election resulting from the exercise of the special enrollment rights provided under Code § 9801(f) is subject to the review and approval of the Plan Administrator.

Section 5.08 Election Change Due to Mid-Year Enrollment in a Qualified Health Plan Under the Marketplace.

(a) *Participant's Right to Revoke an Election of Individual Coverage*. After a Plan Year has commenced, a Participant may revoke his/her prior election for individual health coverage and make a new election for such coverage if the Participant enrolls in a Qualified Health Plan through the Health Insurance Marketplace (commonly referred to as the "Exchange" or "Marketplace"), established by the Patient Protection & Affordable Care Act, by virtue of having become eligible for a special enrollment period in the Marketplace or during the Marketplace's annual open enrollment period, so long as both of the following conditions are satisfied:

(i) The revocation of the Participant's election corresponds to the intended enrollment of the Participant, and any Spouse or dependent(s) who cease coverage due to the revocation, in a Qualified Health Plan through the Marketplace; and

(ii) The new coverage under the Marketplace's Qualified Health Plan in which the Participant (and, if applicable, the Participant's Spouse and/or dependent(s)) enrolls takes effect no later than the day immediately following the day that the Participant's coverage under the Medical Plan is terminated. (The Plan Administrator may rely on the Participant's reasonable representation regarding the intention to enroll in a Qualified Health Plan under the Marketplace and the effective date of such coverage.)

(b) *Participant's Right to Revoke an Election of Family Coverage*. After a Plan Year has commenced, a Participant may revoke his/her prior election for other-than-self-only coverage (referred to as "Family Coverage" for purposes of this Subsection) under the Group Health Plan (excluding the Health FSA) to allow a Spouse and/or dependent(s) to enroll in a Qualified Health Plan through the Marketplace, provided the following conditions are satisfied:

(i) The Spouse and/or dependent(s) has become eligible for a special enrollment period in the Marketplace or seeks to enroll in a Qualified Health Plan during the Marketplace's annual open enrollment period; and

(ii) The revocation of the Participant's election corresponds to the intended enrollment of the Spouse and/or dependent(s) in a Qualified Health Plan through the Marketplace, and the new coverage is effective no later than the day immediately following the day that the Participant's coverage under the Medical Plan is terminated.

If the Participant revokes his/her prior election for Family Coverage under this Subsection, and the Participant does not enroll in a Qualified Health Plan through the Marketplace, then the Participant must elect individual coverage under the Group Health Plan (or Family Coverage that includes coverage for one or more individuals already covered by the Participant's prior election).

Section 5.09 Election Change Due to Change in Coverage (Does not apply to Health FSA).

(a) *Cessation or Significant Curtailment in Coverage.*

(i) *Significant Curtailment Without Loss of Coverage.* If the Plan Administrator determines that coverage under a Benefit Package Option is significantly curtailed (but not lost) during the Plan Year, the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. Coverage under a plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the plan so as to constitute reduced coverage to Participants in general.

(ii) *Significant Curtailment With Loss of Coverage.* If the Plan Administrator determines that coverage under a Benefit Package Option is significantly curtailed during the Plan Year and that the curtailment constitutes a loss of coverage with respect to a Participant (or the Participant's Spouse or dependent), the Participant may revoke his/her election for coverage under that Benefit Package Option and may elect coverage, on a prospective basis only, under another Benefit Package Option providing similar coverage. If no similar Benefit Package Option is available, the Participant may elect to drop coverage. For purposes of this Section 5.09(a)(ii), a loss of coverage means a complete loss of coverage under the Benefit Package Option or other coverage option (including the elimination of a Benefits Package Option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion and in accordance with prevailing IRS guidance, may determine that the following constitutes a loss of coverage:

(A) A substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(B) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or the Participant's Spouse or dependent is currently in a course of treatment; or

(C) Any other similar fundamental loss of coverage.

(iii) *Determinations to be Made by the Plan Administrator.* The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing IRS guidance and based upon the surrounding facts and circumstances,

whether a curtailment is "significant," whether a curtailment represents a loss of coverage with respect to a particular individual, and whether a substitute Benefit Package Option provides "similar coverage."

(b) *Addition or Improvement of a Benefit Package Option.* If, during the Plan Year, a new Benefit Package Option or a new coverage option is added, or if coverage under an existing Benefit Package Option or existing coverage option is significantly improved during the period of coverage, a Participant may elect to add the new Benefit Package Option/coverage option, or the improved Benefit Package Option/coverage option, and to make corresponding changes with respect to other Benefit Package Options providing similar coverage. Any such change will take effect on a prospective basis only. The Plan Administrator, in its sole discretion, shall decide, based upon the surrounding facts and circumstances and in accordance with prevailing IRS guidance, whether a new Benefit Package Option/coverage option has been added, whether an existing Benefit Package Option/coverage option has been significantly improved, and/or whether another Benefit Package Option/coverage option constitutes "similar coverage."

(c) *Change in Coverage of Spouse or Dependent under Plan of Another Employer ("Election Lock").* After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis only if the change is on account of and corresponds with a change made under the plan of the employer of the Participant's Spouse, the Participant's former Spouse, or the Participant's dependent. Any such change is permitted only if (i) the cafeteria plan of such other employer permits its participants to make only those election changes that are permitted under proposed or final IRS regulations under Code Section 125; or (ii) the period of coverage under the plan of such other employer is different than the Plan Year for this Plan. The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the plan of the employer of the Participant's Spouse, former Spouse, or dependent. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination.

(d) *Loss of Coverage Under Other Group Health Coverage.* After the Plan Year has commenced, a Participant may change his/her elections on a prospective basis only to add coverage for the Participant or the Participant's Spouse or dependent if the Participant or the Participant's Spouse or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution. For purposes of this provision, this includes the following: (i) A state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian Tribal government or a tribal organization; (iii) a state health benefits risk pool; or (iv) a foreign government group health plan.

Section 5.10 Election Change Due to FMLA Leave. A Participant who is taking leave under the FMLA may revoke an existing election of accident or health plan coverage and may make such other election for the remaining portion of coverage as may be permitted under Section 3.03 of this Plan. Additionally, such a Participant may also be permitted to change his/her elections under Section 5.06(a)(iii), provided the requirements of that Section are satisfied.

Section 5.11 [Reserved]

Section 5.12 Election Change Due to Issuance of a Judgment, Decree, or Order. If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) requires accident or health coverage to be provided for a Participant's dependent child, including a foster child who is a dependent of the Participant, a Participant may (a) change his/her election to provide coverage for the dependent child, provided that the Order requires the Participant to provide such coverage; or (b) change his/her election to revoke coverage for the dependent child if the Order requires that another individual, including the Participant's Spouse or former Spouse, provide coverage under that individual's plan for the dependent child and such coverage is, in fact, provided.

Section 5.13 Election Change Due to Medicare/Medicaid Entitlement. If a Participant, a Participant's Spouse, or a Participant's dependent who is entitled to receive benefits under a Group Health Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits of Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may reduce his/her election to reflect the reduction or cancellation of the coverage provided to such person under the Group Health Plan. Additionally, if a Participant, a Participant's Spouse, or a Participant's dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may increase his/her election to reflect the increased cost of providing coverage under the Group Health Plan. Any change made under this Section shall take effect on a prospective basis only. The Plan Administrator may request and receive any documents it reasonably considers necessary to make such a determination. The right to drop or add coverage under a Group Health Plan is governed by and subject to the terms of the Group Health Plan.

Section 5.14 Election Change Due to Significant Change in Cost.

(a) *Increase in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) increases by a significant amount during a Plan Year, the Participant may either increase his/her election by a corresponding amount on a prospective basis or the Participant may revoke his/her election and, in lieu thereof, receive coverage under another Benefit Package Option (if any) providing similar coverage. If similar coverage is not available under another Benefit Package Option, the Participant may revoke his/her election without electing coverage under another Benefit Package Option.

(b) *Decrease in Participant's Share of the Cost.* If the Participant's share of the premium for coverage under a Benefit Package Option (other than a Health FSA) decreases by a significant amount during a Plan Year, the Participant may decrease his/her election by a corresponding amount on a prospective basis or, if the Participant is not currently enrolled in the Benefit Package Option, the Participant may elect to become covered under that Benefit Package Option.

(c) *Other Provisions.* The Plan Administrator, in its sole discretion, shall decide, in accordance with prevailing IRS guidance, whether a change in cost is significant and what constitutes "similar coverage" based upon all of the surrounding facts and circumstances.

(d) *Special Provisions Applicable to DCAPs.* This Section does not apply to a DCAP unless the change in cost is imposed by a dependent care provider who is not related (as that term is used in IRS regulations) to the Participant.

Section 5.15 Election Change Required by the Plan Administrator. The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount by which they have elected to reduce their Compensation for a Plan Year if the Plan Administrator determines such action is necessary or advisable to (a) satisfy any Code nondiscrimination requirements applicable to this Plan or any Pre-Tax Benefit; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits from any Pre-Tax Benefit than would otherwise be recognized; or (c) maintain the qualified status of benefits received under this Plan. In the event contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the amount by which each affected Participant has elected to reduce his/her Compensation, beginning with the Participant in the class who had elected to reduce his/her Compensation by the highest amount, continuing with the Participant in the class who had elected the next highest amount, and so forth, until the defect is corrected.

Section 5.16 Automatic Election Change for Insignificant Changes in Cost. If the Participant's share of the premium or cost for the benefits provided under a Pre-Tax Benefit increases or decreases during the Plan Year by an insignificant amount, the Participant's election shall be increased or decreased on a prospective basis by the amount of such increase or decrease. The Plan Administrator, on a reasonable and consistent basis, shall automatically effectuate this prospective increase or decrease in the elective contributions of the affected Participants in accordance with such cost changes. The Plan Administrator, in its sole discretion, shall decide whether increases or decreases in cost are "insignificant" based upon all of the surrounding facts and circumstances, including, but not limited to, the dollar amount and/or the percentage amount of the change.

Section 5.17 Requesting and Approving Election Changes. A Participant desiring to make a change in his/her elections pursuant to this Article V must complete and submit a status change form and/or such other forms as the Plan Administrator may require. If an election change is to take effect during a Plan Year, the Plan Administrator may require the Participant to provide such proof as it reasonably considers necessary of the events underlying the request for an election change, including, but not limited to, a marriage certificate, divorce decree, birth certificate, confirming letter from the Spouse's current or former employer, or any other relevant documents. All such requests for an election change must be reviewed and approved by the Plan Administrator before the election change is given effect. All such requests must be submitted within 30 days (or such longer period as may be specified in the group insurance contract/policy or, in the case of a self-funded plan, the separate plan document or benefit description, as applicable) after the date giving rise to the request for an election change, except as provided in Section 5.07(c) with regard to certain HIPAA special enrollment rights that allow such requests to be submitted within 60 days after the date giving rise to the request for an election change.

Section 5.18 Effective Date of Election Changes. Except as specifically provided in this Section, an election change made during the middle of a Plan Year will be given prospective effect only and will take effect as of the first administratively practicable date following the date on which the Plan Administrator approves the new elections that are being made.

(a) *Special Rule for Newly Adopted Dependent Children and Newborns.* Notwithstanding the general rule stated in this Section, and subject to the provisions of the underlying Group Health Plan, an election to increase the amount by which the Participant's Compensation is reduced in order to fund the increased cost of providing benefits under a Group Health Plan to a newly adopted dependent child or newborn may be given retroactive effect to the date of birth or date of adoption.

Section 5.19 Special Rule for Health FSAs. If an election change is permitted under the provisions of this Article V, a Participant may change his/her election as follows:

(a) A Participant may begin to participate in the Health FSA for the balance of the Plan Year; or

(b) A Participant may increase his/her election amount as long as the election does not exceed the maximum election amount permitted under the Plan; or

(c) A Participant may decrease the election amount, provided, however, that the amount elected may not be less than the amount Participant has already been reimbursed.

Section 5.20 Special Election Change Rule for Health Savings Accounts. A Participant, to the extent that he/she is eligible to contribute to an HSA, may increase or decrease his/her HSA contribution election at any time during the Plan Year for any reason by submitting an election change form to the Plan Administrator. In addition, a Participant may revoke his/her contribution election at any time by submitting an election change form to the Plan Administrator. The election change will be effective prospectively on the first day of the next month following the date on which the election change was properly submitted.

Section 5.21 Maximum Benefits. The maximum benefits under this Plan are the maximum benefits specified in the underlying Benefits.

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ARTICLE VI
PLAN ADMINISTRATION

Section 6.01 Plan Administrator. The administration of this Plan shall be under the supervision of the Plan Administrator. The Plan Administrator shall have the responsibility of ensuring that this Plan is carried out, in accordance with its terms, for the exclusive benefit of the persons entitled to participate in this Plan.

Section 6.02 Powers of the Plan Administrator. The Plan Administrator shall have such powers and duties as it considers necessary or appropriate to discharge its duties under this Plan. The powers of the Plan Administrator shall include, but are not limited to, the following:

(a) Establish rules and procedures for the purpose of administration of this Plan;

(b) Require each Participant to supply such information and sign such documents as may be necessary to administer this Plan. In the case of Participant elections, election changes, and other information supplied by the Participant, this power includes requiring elections, election changes, and other information to be submitted using electronic media, subject to and to the extent permitted under applicable IRS and Department of Labor ("DOL") regulations;

(c) Communicate with Participants through electronic media, subject to and to the extent permitted under applicable IRS and DOL regulations;

(d) Interpret, construe, and carry out the provisions of this Plan, and render decisions on the administration of this Plan, including factual and legal determinations as to whether any individual is eligible to be enrolled in and/or receive any benefit under the terms of this Plan;

(e) Appoint such agents, attorneys, accountants, consultants, Claims Administrators, and any other persons as may be needed for proper administration of this Plan; and

(f) Take such corrective action as it might consider appropriate in the event that an error in administering this Plan has taken place. For example, if there is a failure to deduct the correct amount of a Participant's election, in such an event, the Plan Administrator has the authority to deduct an overpayment from future compensation payable to the Participant and/or otherwise recover the amount that is owed.

In exercising these powers, the Plan Administrator shall act in its sole discretion, giving due regard for the reason and purpose for which this Plan is established and maintained. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

The Plan Administrator shall have no power to waive, alter, or fail to apply the terms of this Plan.

Section 6.03 Plan Must Be Nondiscriminatory. The Plan Administrator shall administer this Plan in a nondiscriminatory manner so all persons similarly situated will receive substantially similar treatment.

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ARTICLE VII
HIPAA MEDICAL PRIVACY FOR THE FOUR COUNTY MENTAL HEALTH CENTER MEDICAL PLAN FOUR COUNTY MENTAL HEALTH CENTER HEALTH FLEXIBLE SPENDING ACCOUNT

PART I
PREAMBLE

Section 7.01 Purpose and Effective Date. This HIPAA Medical Privacy Article is adopted in response to the provisions of the Medical Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Section 7.02 Application of Article VII. The Four County Mental Health Center Welfare Benefit Plan is a "hybrid entity." As such, the Plan has made a separate hybrid entity designation to define the medical components from the non-medical components of the Plan.

This Article shall *only* apply to the Four County Mental Health Center Medical Plan and the Four County Mental Health Center Health Flexible Spending Account (hereafter referred to as the "Group Health Plan").

All other benefits provided by the Employer through the Four County Mental Health Center Welfare Benefit Plan are either (a) not "group health plans" as defined by HIPAA or (b) provided solely through an insurance contract with a health insurance issuer or HMO and do not create or receive protected health information (PHI) other than "summary health information" as defined in 45 C.F.R. Section 164.504(a) or enrollment and disenrollment information.

The Article shall supersede the provisions of the Group Health Plan to the extent those provisions are inconsistent with the provisions of this Article.

PART II
DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE EMPLOYER

Section 7.03 Prohibition Against Disclosing Protected Health Information to the Employer. Except as permitted by this Part II, the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may not disclose PHI to the Employer.

Section 7.04 Definitions. For purposes of this Part II, the following definitions shall apply. These definitions are based on and shall be construed and applied in a manner that is consistent with the definitions set forth in Part 160 and Part 164 of Title 45 of the Code of Federal Regulations.

(a) "*Breach*" means the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such PHI. The following three types of unauthorized acquisition, access, use, or disclosure are excluded from the definition of a "breach:"

(i) Any unintentional acquisition, access, or use of PHI by an Employee or individual acting under the authority of the Group Health Plan if such acquisition, access, or use was made in good faith and within the course and scope of employment or other professional relationship of such Employee or individual, respectively, with the Group Health Plan, and the information is not further acquired, accessed, used, or disclosed by any person in a manner not permitted by the HIPAA Medical Privacy or Security Rules;

(ii) Any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by the Group Health Plan to another similarly situated individual at the same facility so long as the information received is not further used or disclosed in a manner not permitted by the HIPAA Medical Privacy or Security Rules; and

(iii) Any disclosure to an unauthorized person where the PHI that was disclosed would not reasonably have been retained by such person.

(b) *"De-identified Health Information"* means health information that does not identify an individual and for which there is no reasonable basis for believing that the information may be identified with a specific individual. Health information will be considered to be De-identified Health Information if the information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed. Information that must be removed, pursuant to this Section of the regulations, includes (but is not limited to) names, geographical locations more specific than the first three digits of a ZIP code, dates (except for the year of birth), telephone and fax numbers, and Social Security numbers.

(c) *"Electronic Media"* means:

(i) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical tape, or digital memory card; or

(ii) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet, extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including paper, facsimile, and voice via telephone are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

(d) *"Electronic Protected Health Information" ("e-PHI")* is PHI that is transmitted or maintained in electronic media.

(e) "*Individually Identifiable Health Information*" means information for which each of the following conditions is met:

(i) The information is created or received by a health care provider, a health plan (including a group health plan or a health insurance issuer), an employer, or a health care clearinghouse;

(ii) The information relates to the past, present, or future physical or mental health of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and

(iii) The information either identifies the individual or provides a reasonable basis for believing that the information can be used to identify the individual.

(f) "*Plan Administration Functions*" means administrative functions performed by the Employer on behalf of the Group Health Plan. Plan Administration Functions do not include any functions performed by the Employer in connection with any other benefit or benefit plan.

(g) "*Protected Health Information (PHI)*" means Individually Identifiable Health Information except that PHI does not include employment records held by a covered entity in its role as an employer, educational records covered by the Family Educational Rights and Privacy Act, or health care records of post-secondary degree students.

(h) "*Security Incident*" (as defined in 45 C.F.R. 164.304) means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(i) "*Security Rule*" shall mean the Security Standards and Implementation Specifications in 45 C.F.R. Part 160 and Part 164, subpart C.

(j) "*Summary Health Information*" means information that summarizes the claims history, claims expenses, and/or types of claims experienced by individuals for whom the Employer has provided medical coverage under the Group Health Plan and from which the identifying information listed in Section 164.514(b)(2)(ii) of Title 45 of the Code of Federal Regulations has been removed, except that geographical locations may be described using a five digit ZIP code.

(k) "*Unsecured PHI*" means PHI that is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services through guidance issued by the Secretary.

Section 7.05 Enrollment and Disenrollment Information. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose information to the Employer as to whether a given individual is enrolled in, or has been disenrolled in, the medical coverage provided under the Group Health Plan.

Section 7.06 Plan Administration Functions. The Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan may disclose PHI or e-PHI to the Employer if the Employer requires such information in order to carry out its responsibilities in connection with the administration of the Group Health Plan. Such responsibilities may include the following:

(a) Reviewing the performance of the Group Health Plan, including the performance of any insurance companies providing group health coverage for the Group Health Plan and the performance of any business associates of the Group Health Plan;

(b) Overseeing the adjudication of benefit claims, including the responsibility to provide coverage upon the initial submission of claims and the disposition of any Appeals that are filed with respect to claims that are denied in whole or in part;

(c) Overseeing the coordination of benefits and pursuing and/or responding to claims for subrogation;

(d) Conducting cost management and planning-related analysis, including the forecasting of expected health care costs based on current utilization of benefits;

(e) Detecting fraud or abuse;

(f) Determining whether charges for services are appropriate or justified;

(g) Requesting underwriting or premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance;

(h) Securing, placing, and/or receiving payments pursuant to a policy of stop-loss or excess loss insurance in the event the Group Health Plan is self-insured in whole or in part;

(i) Ensuring that the required premiums for the coverage provided under the Group Health Plan are obtained from the persons obligated to pay the same and remitting such premiums to the appropriate insurance carriers and/or third party service providers as may be necessary or appropriate;

(j) Providing assistance, upon request, to Participants and their covered dependents in addressing and resolving problems that they may encounter with the approval and payment of claims that have been submitted on their behalf;

(k) Reporting corporate finances with respect to current and projected health care costs;

(l) Providing information that is legally required in response to a court order, subpoena, discovery, or other process or to the Department of Health and Human Services ("HHS") in connection with its enforcement activities, but only to the extent that the Employer is required to act on behalf of the Group

Health Plan in providing such information and only if the Group Health Plan is permitted to make the disclosure under the provisions of the HIPAA Medical Privacy Regulations; and

(m) Performing other functions as required to effectively offer benefits under the Group Health Plan.

The use and disclosure of PHI or e-PHI pursuant to this Section 7.06 is subject to the provisions of Section 7.07.

Section 7.07 Conditions for Disclosure for Plan Administration Functions. With respect to any PHI or e-PHI that is disclosed to the Employer by the Group Health Plan and/or a health insurance issuer with respect to the Group Health Plan pursuant to Section 7.06, the Employer agrees and certifies to the Group Health Plan as required by Section 164.504(f)(2)(ii) of Title 45 of the Code of Federal Regulations to do the following:

(a) Not use or further disclose PHI or e-PHI other than as permitted or required by the Group Health Plan document or as required by law;

(b) Ensure that any agents or subcontractors to whom the Employer provides PHI or e-PHI received from the Group Health Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI or e-PHI;

(c) Not to use or disclose PHI or e-PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans of the Employer;

(d) Report to the Group Health Plan any use or disclosure of PHI or e-PHI that is inconsistent with the uses or disclosures permitted by this Group Health Plan to the extent it becomes aware of such information. If and as required by any applicable HHS regulations, this reporting requirement will also include reporting to the Group Health Plan any Breach of Unsecured PHI that it discovers, so that the affected individual(s), the media (if applicable), and HHS may be appropriately notified of the Breach as required by the regulations issued regarding breach notifications;

(e) Restrict the disclosure of PHI of an individual (unless the disclosure is otherwise required by law) where the disclosure is to the Group Health Plan for purposes of carrying out payment or health care operations (and not treatment) and the PHI pertains to a health care item or service for which the health care provider has been paid out-of-pocket in full;

(f) Make the PHI or e-PHI that it receives from the Group Health Plan and/or health insurance issuer available to the individual to whom it relates in accordance with the individual's right to access his/her own information as that right is set forth in Section 164.524 of Title 45 of the Code of Federal Regulations;

(g) Make PHI or e-PHI available for amendment and to incorporate any requested amendments in accordance with and to the extent required by Section 164.526 of Title 45 of the Code of Federal Regulations;

(h) Make available the information that is required to provide an accounting to an individual of the disclosures that have been made of the individual's PHI or e-PHI in accordance with and to the extent required by Section 164.528 of Title 45 of the Code of Federal Regulations;

(i) Make its internal practices, books, and records relating to the use and disclosure of PHI or e-PHI available to the Secretary of Health and Human Services for purposes of allowing the Secretary to determine compliance by the Group Health Plan with HIPAA's medical privacy and security requirements;

(j) If feasible, return or destroy all PHI or e-PHI received from the Group Health Plan or a health insurance issuer when such information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer may limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

(k) Ensure that adequate separation between the Employer and the Group Health Plan exists, as set forth in more detail in Part III;

(l) Provide a certification to the Group Health Plan as required by Section 7.08; and

(m) If the Employer creates, receives, maintains, or transmits any e-PHI (other than enrollment and disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Group Health Plan, it will do the following:

(i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI;

(ii) Ensure that any agent (including subcontractors) to whom it provides such e-PHI agree to implement reasonable and appropriate security measures to protect the information; and

(iii) Report to the Group Health Plan any Security Incident of which it becomes aware.

Section 7.08 Certification by the Sponsor. The Plan (or a health insurance issuer or HMO with respect to the Plan) will disclose PHI to the plan sponsor only upon the receipt of a certification by the plan sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii) and that the plan sponsor agrees to the conditions of disclosure set forth in Section 7.07.

By adoption of this Plan document and delivery of a copy of the Plan document to the privacy officer, the plan sponsor certifies that (a) the provisions of 45 C.F.R. § 164.504(f)(2)(ii) have been incorporated into the Plan document; and (b) the plan sponsor has agreed to the conditions of disclosure set forth in Section 7.07.

PART III
ADMINISTRATIVE SAFEGUARDS

Section 7.09 Adequate Separation Between the Employer and the Plan. No person employed by the Employer may receive or have access to PHI or e-PHI from the Group Health Plan except as set forth in this Part III. The Employer will ensure that the provisions of this Part are supported by reasonable and appropriate security measures to the extent that the "authorized employees" have access to e-PHI. Further, this Part III does not apply to information that is not considered to be PHI or e-PHI, such as Summary Health Information and De-identified Health Information, or to information that the Employer receives in a way that is separate and independent from this Group Health Plan.

Section 7.10 Authorized Employees. The following Employees ("Authorized Employees") are permitted to use and have access to PHI or e-PHI to the extent necessary to perform the plan administration functions, as set forth in Part II above, that the Employer performs for the Group Health Plan in order to provide benefits to Participants:

Mid-Level Managers
HR Department
Finance Department

In the case of an unanticipated or unusual event, for a limited time and purpose only, Employees designated in writing by the Privacy Officer at the time of such event to resolve the unanticipated or unusual event may have access to PHI or e-PHI. For example, an employee in the IT department may need access, but only for the limited purpose of accessing a database containing PHI or e-PHI to correct a computer virus or similar problem, hardware defect, or other system issue. Similarly, in-house counsel of the Employer (if applicable), including counsel's support staff, may need access to PHI or e-PHI, but only for the limited purpose of assisting in the investigation of and otherwise responding to complaints alleging violations of the policies and procedures established by the Employer.

Such Employees accessing PHI or e-PHI due to an unanticipated or unusual event may be identified by names, job title, or any other designation that adequately identifies the Employees. In addition, the Employees shall receive proper training regarding the HIPAA medical privacy and security rules and shall comply fully with the Plan's policy and procedures. Any such appointment shall be documented and available for inspection and copying.

Section 7.11 Use Pursuant to an Authorization. Employees of the Employer may use and have access to PHI or e-PHI to the extent authorized by a valid authorization for the purposes set forth in the authorization.

Section 7.12 Consequences of Unauthorized Use of PHI or e-PHI. If it is determined that an Employee has obtained, used, or disclosed PHI or e-PHI in a manner or way that is not permitted by this Part III, the Employee will be subject to discipline by the Employer in accordance with policies and procedures established by the Employer.

ARTICLE VIII
GROUP HEALTH PLAN CONTINUATION COVERAGE

This Article VIII applies only to Group Health Plans as that term is defined in Section 2.19. With respect to the Health FSA, however, the specific terms and conditions of continuation coverage as described in this Article are modified by Appendix C, Article C-V.

Section 8.01 Continuation of Coverage under COBRA. If a "qualified beneficiary" loses (or would lose) coverage under this Plan as a result of a "qualifying event," the Plan Administrator will give that qualified beneficiary the opportunity to continue coverage by returning a COBRA election form and by paying the applicable premium. The qualified beneficiary's right to continue coverage under this Plan is subject to the following:

(a) *Qualified Beneficiary.* For purposes of this Section, a "qualified beneficiary" means the Participant, the Participant's Spouse, and the Participant's dependents, but only if such persons were covered under this Plan on the day before the "qualifying event." The term "qualified beneficiary" shall also include any children who are born to or adopted by the Participant while the Participant is continuing his/her coverage under COBRA.

(b) *Qualifying Event.* For purposes of this Section, a "qualifying event" means one of the following if the qualified beneficiary would otherwise lose his/her eligibility for coverage under this Plan as a result of such an event:

(i) Termination of the Participant's employment (other than for "gross misconduct") or a reduction in the number of hours the Participant normally works.

(ii) Death of the Participant.

(iii) Divorce or legal separation of the Participant and the Participant's covered Spouse.

(iv) The Participant's entitlement to Medicare.

(v) A covered dependent no longer satisfies the conditions for being covered as a dependent of the Participant.

(vi) The Employer files a Chapter 11 bankruptcy (but only as to coverage that is being provided to a retired Participant and his/her Spouse and covered dependents *and* only if the Employer is terminating this Plan while continuing to offer group health coverage to some other group of Employees).

(c) *Election to Continue Coverage.* Any election to continue coverage that would otherwise be lost as a result of a qualifying event must be made within the time frame established by the COBRA statute and must be made in accordance with such reasonable procedures as the Plan Administrator may establish.

(d) *Premium for COBRA Continuation Coverage.* A qualified beneficiary who elects to continue coverage must pay the entire cost for such coverage along with an additional two percent charge or, with respect to an extension of the maximum coverage period due to a subsequent disability, an additional fifty percent charge. Premiums must be paid on a timely basis in accordance with such reasonable procedures as the Plan Administrator may establish.

(e) *Maximum Coverage Period.* The maximum period of time for which COBRA continuation coverage will be provided shall be as follows:

(i) *Termination of Employment or Reduction in Hours.* Eighteen months if coverage is lost as a result of termination of the Participant's employment or a reduction in the Participant's hours.

(ii) *Disability Extension.* Twenty-nine months if a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage and the qualified beneficiary notifies the Plan Administrator of such determination while COBRA continuation coverage is still in effect and in accordance with such reasonable procedures as the Plan Administrator may establish.

(iii) *Employer Bankruptcy.* The lifetime of the Participant *if:*

(A) The Employer is providing coverage after the Participant has retired;

(B) The Employer files a Chapter 11 bankruptcy;

(C) The Employer terminates this Plan (or substantially eliminates coverage under this Plan with respect to a qualified beneficiary within a one-year period before or after such bankruptcy proceeding was filed); and

(D) The Employer continues to maintain a group health plan for any other group of employees.

In such an event, the surviving Spouse and surviving covered dependents of the Participant shall further be entitled to elect COBRA continuation coverage for an additional 36 months following the death of Participant.

(iv) *Second Qualifying Event.* Thirty-six months if a second qualifying event takes place while coverage is being continued following the original qualifying event and the second qualifying event is other than the termination of the Participant's employment or a reduction in the Participant's hours.

(v) *Any Other Qualifying Event.* Thirty-six months for any qualifying event for which a shorter maximum coverage period is not set forth in this Subsection (e).

(f) *Termination of COBRA Continuation Coverage.* COBRA continuation coverage may be terminated prior to the expiration of the maximum coverage period if any one of the following events occurs:

(i) A qualified beneficiary becomes covered under another group health plan;

(ii) A required premium is not paid within the applicable deadline (including any applicable grace period);

(iii) The Employer terminates this Plan and no longer offers coverage under a group health plan to any of its Employees;

(iv) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(v) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(vi) Coverage would have been terminated under the same circumstances for a Participant or beneficiary not receiving continuation coverage (e.g., a Participant or beneficiary engages in fraudulent activities against the Plan).

(g) *Coverage Provided During COBRA Continuation Period.* The coverage provided during the COBRA continuation period shall be identical to the coverage provided to similarly situated persons covered under the Plan with respect to whom a qualifying event has not occurred. If coverage under the Plan is modified for any group of similarly situated persons, the coverage shall also be modified in the same manner for all qualified beneficiaries who have elected to continue their coverage under COBRA.

(h) *Calculation of COBRA Deadlines.* The maximum coverage period shall begin as of the date on which the qualified beneficiary would otherwise lose coverage as a result of the original qualifying event (as opposed to beginning on the date of the qualifying event itself). The deadline for the Employer to notify the Plan Administrator of a qualifying event (if applicable) and the deadline for a qualified beneficiary to notify the Plan of a qualifying event (if applicable) shall also be measured from the date that coverage is lost.

(i) *Construction and Application.* This Section shall be construed and applied in a way that is consistent with the requirements of the COBRA statute and COBRA regulations issued by the IRS and the DOL.

(j) *Employers Not Required to Offer COBRA Continuation Coverage.* This Section shall not apply to the Employer if the Employer is not required by law to offer COBRA continuation coverage. The Employer, for example, will not be not required to offer COBRA continuation coverage if the Employer qualified for the "small employer" exception to COBRA based on the number of employees that it

employed during the previous calendar year. Generally, if this number is less than twenty (20), then the Employer is not subject to COBRA. In the event, however, that the Employer has twenty (20) or more employees as determined under COBRA (considering "controlled group" rules and special rules for part-time employees), this Article will apply as described above.

Section 8.02 USERRA Continuation Rights. A Participant who is absent from employment as a result of military service shall have the right to elect continuation coverage for a period of up to 24 months. The Participant's right to continue coverage is subject to the following:

(a) *Payment of Premium.* The Participant must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than 31 days, the Participant may not be required to pay more than the Participant would have paid had the Participant not been on leave. For a leave of absence of more than 30 days, Participant must pay the entire cost of coverage plus an additional two percent.

(b) *Failure to Apply for Reemployment.* Following completion of the Participant's military service, the Participant's right to continue coverage under USERRA shall end if the Participant does not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

(c) *Reasonable Procedures.* The Plan Administrator shall have the authority to adopt such reasonable procedures as the Plan Administrator may consider necessary or advisable in order to implement the provisions of this Section.

(d) *Construction and Application.* This Section shall be construed and applied in a way that is consistent with the requirements of the USERRA statute and any applicable regulations that may be issued by the DOL.

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ARTICLE IX
GROUP HEALTH PLAN CLAIMS PROCEDURES
(Does Not Apply to the Health FSA)

Section 9.01 Where to File Claims. Any Claim for benefits which arises under a Group Health Plan shall be filed with the Claims Administrator.

Section 9.02 Persons Who May File Claims. Claims may be filed by the Claimant or by the Claimant's duly authorized representative.

(a) Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

(b) Notwithstanding the foregoing rule, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant with respect to Urgent Care Claims.

(c) For purposes of these claims procedures, the deadlines applicable to a Claimant shall apply to his/her authorized representative in the event he/she elects to use an authorized representative in filing any Claim or Appeal.

Section 9.03 Claims Procedures for Fully-Insured Group Health Plans. Claims made for benefits, and any Appeals from the denial of such Claims, under the fully-insured Group Health Plans, shall be processed in accordance with the claims procedures of the insurer, which are set forth in the Certificate of Coverage. Unless stated otherwise in the policy of insurance, prior to initiating legal action concerning a Claim in any court, state or federal, against this Plan, any trust used in conjunction with this Plan, the Employer, the Claims Administrator, and/or the Plan Administrator, a Claimant must first exhaust the internal administrative remedies provided by the insurer. Failure to exhaust the internal administrative remedies provided by the insurer shall be a bar to any civil action concerning a Claim for benefits under this Plan. Once a Claimant has exhausted his/her administrative remedies, he/she may file a lawsuit challenging the denial of the Claim. Such lawsuit must be commenced 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.

Section 9.04 Claims Procedures for Self-Insured Group Health Plans. Claims made for benefits, and any Appeals from the denial of such Claims, under the self-funded Group Health Plans (other than a Health FSA), shall be processed in accordance with the claims procedures of the Claims Administrator. Prior to initiating legal action concerning a Claim in any court, state or federal, against this Plan, any trust used in conjunction with this Plan, the Employer, the Claims Administrator, and/or the Plan Administrator, a Claimant must first exhaust all administrative remedies. Failure to exhaust the internal administrative remedies shall be a bar to any civil action concerning a Claim for benefits under this Plan. Once a Claimant has exhausted his/her administrative remedies, he/she may file a lawsuit challenging the denial of the Claim. Unless another timeframe has been established by the Claims Administrator, such lawsuit must be commenced 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.

ARTICLE X
TERMINATION AND AMENDMENT OF THE PLAN

Section 10.01 Termination and Amendment. The Employer may amend or terminate this Plan at any time by written instrument duly adopted by the Employer.

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ARTICLE XI
MISCELLANEOUS

Section 11.01 Construction. Words used in the masculine also apply to the feminine and words used in the feminine also apply to the masculine. Wherever the context dictates, the plural includes the singular and the singular includes the plural.

Section 11.02 Employment Not Guaranteed. Nothing contained in this Plan or in any other plan which is a part of the Plan, or any modification or amendment to this Plan, or in the creation of any account, or the payment of any benefit, gives any Employee, Participant, or beneficiary any right to continue employment, any legal or equitable right against the Employer, its Employees or agents, or against the Plan Administrator, except as expressly provided by this Plan.

Section 11.03 Funding and Expenses. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Any amounts that may be payable under any of the Benefits shall be paid in accordance with the provisions of the plan document for such plans. All administrative costs of this Plan shall be borne by the Employer.

Section 11.04 Indemnification. To the extent permitted by law, the Employer shall indemnify and hold harmless any Employee to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs, and expenses incurred by any such Employee as a result of any act, or omission to act, in connection with the performance of duties, responsibilities, and obligations under this Plan, other than such liabilities, costs, and expenses as may result from the gross negligence or willful misconduct of any such person.

Section 11.05 Information. The Plan Administrator may require each Participant to supply such information and sign such documents as may be necessary to implement this Plan.

Section 11.06 Limitation on Liability. A Plan fiduciary shall be entitled to rely upon information from any source assumed in good faith to be correct. No person shall be subject to any liability with respect to duties under this Plan unless that person acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

Section 11.07 Named Fiduciary. The named fiduciary of this Plan shall be the Employer. The Employer shall have complete authority to control and manage the operation and administration of this Plan. The Employer in writing also may designate other persons as additional named fiduciaries.

Section 11.08 Negative Paychecks. The Employer shall have the power to adopt rules and procedures addressing the sequence in which amounts shall be deducted or withheld from the compensation payable from the Employer to a Participant in the event that such compensation is less than the combined total of the following:

(a) Taxes required to be withheld from the Participant's compensation;

(b) The amounts the Participant has elected to defer into a plan maintained by the Employer;

(c) The salary reductions elected by the Participant under this Plan or under any similar plan maintained by the Employer; and

(d) Such other amounts that the Employer may be required to withhold or deduct from the Participant's compensation.

If no such rules or procedures have been adopted, the Employer shall deduct amounts required to be withheld for taxes and amounts necessary to pay for the Participant's medical coverage prior to deducting any other amounts.

Section 11.09 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant.

Section 11.10 Nonassignability. Benefits payable under this Plan as well as any and all causes of action against this Plan are not subject in any manner to transfer or assignment, unless such benefits are transferred or assigned (a) for the purpose of providing payment for services provided under the terms of the Plan or underlying policy of insurance and/or (b) as expressly permitted under the terms of the Plan or underlying policy of insurance; and any attempt to transfer, assign, or otherwise dispose of any right to benefits payable under this Plan or any cause of action against this Plan, is void. The Employer is not in any manner liable for, nor subject to, the debts, contracts, liabilities, engagements or torts of any person enrolled in any benefits under this Plan. The right of any Participant to receive any benefits under this Plan is not subject to the claims of the creditors of the Participant except to the extent provided by law.

Section 11.11 Prohibition Against Retroactive Entry into the Plan. In the event that a person was determined to be ineligible to participate in the Plan due to the person's classification as an independent contractor and such classification is later determined by a court or administrative agency to have been incorrect, the person shall be eligible to enter the Plan on a prospective basis only. Except as may be required in connection with HIPAA special enrollment rights, no person shall be allowed to enter the Plan on a retroactive basis.

Section 11.12 Reimbursement of Payments Made in Error. The Plan shall have the right to reimbursement from any Participant, covered dependent, or assignee for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which the Participant, covered dependent, or assignee was not entitled.

Section 11.13 Return of Premiums. If money is returned in any form by an insurance company that provided or is providing benefits under this Plan, including, but not limited to, a rebate of premiums previously paid or proceeds from demutualization, or rebates resulting from an insufficient "medical loss ratio" (MLR), the Plan Administrator shall have the discretion to

apply such amounts to the payment of Plan expenses, the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.

Section 11.14 Rights to Employer's Assets. No Participant or beneficiary has any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent that the benefits payable under the component benefit plans are payable solely from the assets of the Employer.

Section 11.15 Separate Liability. Except to the extent imposed by ERISA, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon such other fiduciary by this Plan, by ERISA, by the Code, or by any regulations or rulings issued under ERISA or the Code. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities, it has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

Section 11.16 State Law. The laws of the state of Kansas will determine all questions arising with respect to the provisions of this Plan except to the extent superseded by federal law.

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EXECUTION PAGE

IN WITNESS WHEREOF, the Employer adopts this amended and restated Plan, including the HIPAA certification provisions found in Article VII, effective July 1, 2024.

Four County Mental Health Center, Inc.

By: DocuSigned by: C1B677564C83421...

Greg Hennen, Executive Director

ADDENDUM 1
PPACA ELIGIBILITY PROVISIONS – LOOK-BACK MEASUREMENT METHOD

INTRODUCTION

Unless elected otherwise in Section 5.03, this Addendum applies only during a Plan Year in which the Employer is deemed to be an "applicable large employer" within the meaning of the federal Patient Protection and Affordable Care Act ("PPACA"). This Addendum supplements and supersedes the Plan Document's eligibility provisions regarding Part-Time Employees, Variable Hour Employees, and Seasonal Employees, as those terms are defined in Part I of this Addendum. The rules in this Addendum shall be interpreted in a manner that is consistent with the rules set forth in the Final Regulations issued by the Department of Treasury involving the "shared responsibility" provisions of PPACA. Unless otherwise indicated, all section references in this Addendum are references to sections within this Addendum.

If the Employer (or a Participating Employer) desires to use different eligibility elections for different groups of Employees, as permitted in Section 2.01 of this Addendum, then a separate Addendum will be necessary for each discrete Employee group.

PART I
DEFINITIONS

Section 1.01 Administrative Period. The Administrative Period means:

(a) *Ongoing Employee*. For an Ongoing Employee, the period of time, as elected in Section 4.04, that is no longer than 90 days and that begins on the day immediately following the conclusion of the Standard Measurement Period and ends on the day immediately preceding the first day of the associated Stability Period; and

(b) *New Employee*. For a New Employee, the period(s) of time, as elected in Section 3.04, that include(s) the following:

(i) The period of time that begins on the day immediately following the conclusion of the Initial Measurement Period and ends on the day immediately preceding the first day of the associated Initial Stability Period; and

(ii) If elected by the Employer in Section 3.03(a), the period of time that begins on the date the New Employee commences employment and ends on the day immediately preceding the first day of the Initial Measurement Period.

Section 1.02 Covered Component Benefit Plan(s). The Covered Component Benefit Plan(s) means the Pre-Tax Benefit(s), After-Tax Benefit(s), and/or Employer-Paid Benefit(s) that the Employer has elected – in Section 2.01(b) – to have covered by this Addendum.

Section 1.03 Full-Time Employee. A Full-Time Employee means an Employee who is employed by the Employer and who satisfies one of the following:

(a) *Regularly Scheduled to Work Hours Required by Welfare Benefit Plan*. The Employee is regularly scheduled to work at least the number of hours as is required for eligibility to participate in the Covered Component Benefit Plan(s) pursuant to the terms of the Welfare Benefit Plan; or

(b) *Meets Eligibility Requirements Pursuant to Look-Back Measurement Method or Monthly Measurement Period*. The Employee is a Part-Time Employee, Variable Hour Employee, or Seasonal Employee, and qualifies for full-time status by virtue of the Look-Back Measurement Method or Monthly Measurement Period, as applicable and as set forth in this Addendum.

Section 1.04 Initial Measurement Period. The Initial Measurement Period means the period of time, as elected in Section 3.03, which is used to determine if a New Employee (who is classified as a Part-Time Employee, Variable Hour Employee, or Seasonal Employee) is eligible to participate in the Medical Plan during his/her subsequent Initial Stability Period.

Section 1.05 Initial Stability Period. The Initial Stability Period means the period of time, as elected in Section 3.05, that follows, and is associated with, the Initial Measurement Period of a New Employee (who is either a Part-Time Employee, Variable Hour Employee, or Seasonal Employee).

Section 1.06 New Employee. A New Employee means an Employee who has not been employed by the Employer for at least one complete Standard Measurement Period. Once a New Employee has been employed by the Employer for at least one complete Standard Measurement Period, he/she will cease to be a New Employee and will become an Ongoing Employee, and his/her eligibility to participate in the Medical Plan will be governed by the terms and conditions applicable to Ongoing Employees (unless the Employee is eligible for coverage by virtue of an Initial Stability Period). A rehired Employee may be considered a New Employee or an Ongoing Employee depending on the length of time between his/her termination date and rehire date. *See* Section 5.02 for more details.

Section 1.07 Ongoing Employee. An Ongoing Employee means an Employee who has been employed by the Employer for at least one complete Standard Measurement Period.

Section 1.08 Part-Time Employee. A Part-Time Employee means an Employee who, based on the facts and circumstances at the commencement of his/her employment, is not reasonably expected to average at least the number of hours of service per week (or month) as is required for eligibility to participate in the Covered Component Benefit Plan(s) pursuant to the eligibility conditions set forth in the Welfare Benefit Plan.

Section 1.09 Seasonal Employee. A Seasonal Employee means an Employee who is hired into a position for which the customary annual employment is six months or less.

Section 1.10 Stability Period. The Stability Period means the period of time, as elected in Section 4.05, that follows, and is associated with, a particular Standard Measurement Period.

Section 1.11 Standard Measurement Period. The Standard Measurement Period means the period of time, as elected in Section 4.03, which is used to determine whether an Ongoing Employee is eligible to participate in the Medical Plan.

Section 1.12 Variable Hour Employee. A Variable Hour Employee means a New Employee who, based on the facts and circumstances at the commencement of his/her employment, cannot reasonably be expected to average at least the number of hours of service per week (or month) as is required for eligibility to participate in the Covered Component Benefit Plan(s) pursuant to the terms of the Welfare Benefit Plan.

Section 1.13 Welfare Benefit Plan. The Welfare Benefit Plan means the Four County Mental Health Center Welfare Benefit Plan.

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PART II
SCOPE OF ELECTIONS IN ADDENDUM 1

Section 2.01 Scope of Elections in Addendum 1. The elections of the Employer (or the Participating Employer) in this Addendum 1 shall apply to the following Employees and plans listed below:

(a) *Employees Subject to this Addendum*. The Employer's elections shall apply to the following group(s) of Employees.

[X] (i) All Employees.

[ ] (ii) Only salaried Employees.

[ ] (iii) Only hourly Employees.

[ ] (iv) Only employees whose principal place of employment is in the State of _____.

[ ] (v) Only non-collectively bargained Employees.

Note: Federal regulations implementing PPACA permit Employers to utilize different Standard Measurement Periods and Stability Periods and different Initial Measurement Periods and Initial Stability Periods for certain discrete groups of Employees. (Different Participating Employers that are part of the same "applicable large employer" group also may utilize measurement and stability periods that are different from those used by other members of the same "applicable large employer" group.) The only permitted differential treatments, however, are those that are set forth in the election options above.

(b) *Covered Component Benefit Plan(s)*. The eligibility provisions of this Addendum shall govern the following Component Benefit Plans:

[X] (i) All plans covered by the Welfare Benefit Plan.

[ ] (ii) Medical Plan (including, as applicable, a Health Savings Account).

[ ] (iii) Dental Plan.

[ ] (iv) Health Flexible Spending Account.

[ ] (v) Health Reimbursement Arrangement.

[ ] (vi) Dependent Care Assistance Plan.

[ ] (vii) Vision Plan.

[ ] (viii) Group Life Insurance Plan.

[ ] (ix) Voluntary Life Insurance Plan.

[ ] (x) Short-Term Disability Plan.

[ ] (xi) Long-Term Disability Plan.

[ ] (xii) Other: _____

_____

_____

Note: To the extent that dental benefits are included as part of the standard medical benefits (i.e., the dental benefits are not provided as part of a stand-alone coverage), the dental benefits will be subject to the eligibility provisions in this Addendum to the same extent as the medical benefits.

Section 2.02 Employees Ineligible Notwithstanding Use of a Look-Back Measurement Method. Notwithstanding the Employer's use of a Look-Back Measurement Method, the following categories of Employees will never be eligible to participate in the Medical Plan.

[ ] (a) _____

[ ] (b) _____

[X] (c) No exclusions.

Note: If the Employer fails to offer coverage to an Employee who has averaged at least 30 hours per week (if using the Look-Back Measurement Method), or who has worked at least 130 hours during a month (if using the Monthly Measurement Method), then the Employer may be subject to penalties under the PPACA "shared responsibility" regulations.

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PART III
NEW EMPLOYEE ELIGIBILITY

Section 3.01 Eligibility of New Full-Time (Non-Part-Time / Non-Seasonal / Non-Variable Hour) Employees. A New Employee, who is neither a Part-Time Employee, Seasonal Employee, or Variable Hour Employee, will be deemed to be a Full-time Employee (and thus eligible to participate in the Plan immediately following his/her completion of any Waiting Period that the Plan imposes), if he/she is reasonably expected at his/her start date to work at least the number of hours as is required for eligibility to participate in the Covered Component Benefit Plan(s) pursuant to the terms of the Welfare Benefit Plan.

Note: Federal regulations implementing PPACA require that a New Employee be deemed a full-time Employee (and thus eligible for coverage) if he/she is reasonably expected to average at least 30 hours of service per week or 130 hours of service per month. However, the Employer may select a lower number of hours of service by which the Employee will be deemed to be a full-time Employee and thus eligible for coverage.

Section 3.02 Eligibility of New Part-Time / Seasonal / Variable Hour Employees. Notwithstanding any eligibility exclusions pursuant to the terms of the Welfare Benefit Plan – and subject to any exclusions in Section 2.02 of this Addendum – a New Employee who is either a Part-Time Employee, Seasonal Employee, or Variable Hour Employee will be eligible to participate in the Plan if he/she averages, during his/her Initial Measurement Period, at least 30 hours of service per week or 130 hours of service per month.

(a) If a New Employee who is either a Part-Time Employee, Seasonal Employee, or Variable Hour Employee *does* average, during his/her Initial Measurement Period, at least 30 hours/week or 130 hours/month, then:

(i) He/she may commence participation upon the first day of the Initial Stability Period applicable to his/her Initial Measurement Period if he/she is still employed by the Employer; and

(ii) Subject to subsection (c) below, he/she may continue participation during such Initial Stability Period as long as (and only to the extent that) he/she is still employed by the Employer during such Initial Stability Period.

(b) If a New Employee who is either a Part-Time Employee, Seasonal Employee, or Variable Hour Employee *does not* average, during his/her Initial Measurement Period, at least 30 hours/week or 130 hours/month, then:

(i) Subject to Subparagraph (ii) below, he/she will be excluded from participating in the Medical Plan during the Initial Stability Period applicable to his/her Initial Measurement Period.

(ii) If the New Employee, upon completing a full Standard Measurement Period (and thus becoming an Ongoing Employee), averages, during the Standard Measurement Period, at least 30 hours/week or 130 hours/month, then

he/she will be eligible to participate in the Plan during the Stability Period that follows, and is associated with, the preceding Standard Measurement Period, even if such Stability Period overlaps with the Initial Stability Period during which he/she would not otherwise have been eligible to participate in the Plan; provided, however, the Employee will be eligible to participate in the Plan during such Stability Period only if he/she is still employed by the Employer during the Stability Period.

(c) *Eligibility During an Unpaid Leave of Absence or Disability Leave Arising in Initial Stability Period*. During an Initial Stability in which a New Employee is treated as a Full-Time Employee pursuant to subsection (a) above, his/her eligibility after exhausting the maximum eligibility period for unpaid leaves of absence (including any disability leave that is treated as paid leave) set forth in the Welfare Benefit Plan shall:

[X] (i) Terminate after he/she has exhausted the Welfare Benefit Plan's maximum eligibility period for unpaid leaves of absence; or

[ ] (ii) Continue through the end of the Initial Stability Period.

Section 3.03 Initial Measurement Period. The Employer must make the following elections to determine the applicable Initial Measurement Period for New Employees under the Plan.

(a) *Commencement of Initial Measurement Period.* The Initial Measurement Period for New Employees shall begin:

[ ] (i) On the date that the New Employee commences employment.

[X] (ii) The first day of the first month coincident with, or next following, the date that the New Employee commences employment. (If this option is selected, the Employer may, for administrative simplicity, commence the New Employee's Initial Measurement Period on the first day of the first weekly, bi-weekly, or semi-monthly payroll period that begins after the first day of the first month coincident with, or next following, the date the New Employee commences employment.)

[ ] (iii) Other: _____

_____

_____

Note: The Initial Measurement Period for New Employees must commence no later than the first day of the first calendar month that begins after the New Employee commences employment (or, if later, the first day of the first weekly, bi-weekly, or semi-monthly payroll period that begins on or after the date that the New Employee commences employment).

(b) *Length of Initial Measurement Period.* The Initial Measurement Period shall last for the length of time selected below:

[X] (i) Twelve Months.

[ ] (ii) _____ months/weeks (circle one) (must be between six and twelve months).

Note 1: The combined Administrative Period and Initial Measurement Period cannot last beyond the final day of the first calendar month that begins on or after the first anniversary of a New Employee's first day of employment.

Note 2: If the Employer uses a payroll period methodology in determining its Initial Measurement Period, see Note 2 following Section 4.03(b).

Section 3.04 Administrative Period(s) for New Employees. The Employer must make the following elections to determine the applicable Administrative Period(s) under the Plan for New Employees. For such New Employees, the Plan shall use (an) Administrative Period(s) that run(s) from:

[X] (a) If the Employer elected Option (a)(ii) in Section 3.03, the day that the New Employee commenced employment until the first day of his/her Initial Measurement Period.

[X] (b) The first day following the end of the Initial Measurement Period until the first day of the associated Initial Stability Period. The time period between these two dates shall be one month.

[ ] (c) Other: _____
_____
_____

Note: The Administrative Period(s) cannot exceed a total of 90 days.

Section 3.05 Initial Stability Period. The Employer must make the following election to determine the applicable Initial Stability Period for New Employees under the Plan. The Initial Stability Period shall last for the length of time selected below:

[X] (a) Twelve Months.

[ ] (b) _____ months/weeks (circle one) (must be between six and twelve months).

Note: The Initial Stability Period must be at least six months and also must be the same length of time as the Initial Measurement Period. Moreover, the Initial Stability Period must be the same length of time as the Stability Period applicable to Ongoing Employees (see Section 4.05).

Section 3.06 Eligibility Impact of Change in Employment Status (from Non-Full-Time to Full-Time) of New Employee During Initial Measurement Period. If the employment position or status of a New Employee who is either a Part-Time Employee, Seasonal Employee, or Variable Hour Employee materially changes before the end of his/her Initial Measurement Period in a way that, if the Employee had originally commenced employment in such position or status, he/she would have been reasonably expected to average at least the number of hours per week as is required for eligibility to participate in the Covered Component Benefit Plan(s) pursuant to the terms of the Welfare Benefit Plan, then such New Employee will be eligible to participate in the Plan upon:

[ ] (a) The earlier of:

(i) The first day of the fourth month following the change in employment status; or

(ii) If the New Employee averaged, during his/her Initial Measurement Period, at least 30 hours/week or 130 hours/ month, the first day of the New Employee's Initial Stability Period.

[X] (b) The first day of the first month coincident with, or next following, the New Employee's satisfaction of the applicable plan's Waiting Period.

[ ] (c) The first day of the first month coincident with, or next following, the change in employment status.

[ ] (d) The first effective day of the change in employment status.

[ ] (e) Other: _____

_____

_____

Note: Following the change in employment status described above, the formerly Part-Time Employee, Seasonal Employee, or Variable Employee must be offered coverage in the Plan no later than the time period set forth in Option (a).

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PART IV
ONGOING EMPLOYEE ELIGIBILITY

Section 4.01 Eligibility of Ongoing Employees.

(a) *Full-Time Status During Standard Measurement Period*. If an Ongoing Employee who is not regularly scheduled to work at least the number of hours as is required for eligibility to participate in the Covered Component Benefit Plan(s) pursuant to the terms of the Welfare Benefit Plan, during a Standard Measurement Period, averages at 30 hours of service per week or 130 hours of service per month, then he/she will, subject to subsection (c) below, be deemed to be a Full-Time Employee (and thus eligible to participate in the Plan) during the Stability Period that follows, and is associated with, such Standard Measurement Period as long as (and only to the extent that) he/she is still employed by the Employer during such Stability Period.

(b) *Non-Full-Time Status During Standard Measurement Period*. If an Ongoing Employee who is not regularly scheduled to work at least the number of hours as is required for eligibility to participate in the Covered Component Benefit Plan(s) pursuant to the terms of the Welfare Benefit Plan, during a Standard Measurement Period, does not average at least 30 hours of service per week or 130 hours of service per month, then he/she will not be deemed to be a Full-Time Employee (and thus will not be eligible to participate in the Plan) during the Stability Period that follows, and is associated with, such Standard Measurement Period.

(c) *Eligibility During an Unpaid Leave of Absence or Disability Leave Arising in Stability Period*. During a Stability Period in which an Ongoing Employee is treated as a Full-Time Employee pursuant to subsection (a) above, the Ongoing Employee's eligibility after exhausting the maximum eligibility period for unpaid leaves of absence (including any disability leave that is treated as paid leave) set forth in the Welfare Benefit Plan shall:

[X] (i) Terminate after he/she has exhausted the Welfare Benefit Plan's maximum eligibility period for unpaid leaves of absence; or

[ ] (ii) Continue through the end of the Stability Period.

Section 4.02 Change of Ongoing Employee's Employment Status During Stability Period. If an Ongoing Employee's average hours of service or position of employment changes during a Stability Period, the change will have no effect on the Ongoing Employee's eligibility to participate in the Plan during that Stability Period, except as specifically provided otherwise in Section 4.06 or 4.07 below. In other words, the Ongoing Employee will continue to be eligible (or continue to not be eligible, as applicable) to participate in the Plan during the entire Stability Period.

Section 4.03 Standard Measurement Period. The Employer must make the following election to determine the applicable Standard Measurement Period for Ongoing Employees under the Plan.

[X] (a) From May 1 through the following April 30.

[ ] (b) The _____ month/week (circle one) (select time period that is at least six but less than twelve months) period of time that begins on the day immediately after the conclusion of each Stability Period. However, the first Standard Measurement Period shall begin on _____ (insert specific month, day and year) (Example: July 1, 2014).

[ ] (c) Other: _____

_____

Note 1: The Standard Measurement Period must be between six and twelve consecutive months. Moreover, the Standard Measurement Period must be identical to the Stability Period.

Note 2: The Employer may treat as a measurement period a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the measurement period, provided that the measurement period begins on the first day of the payroll period that includes the date that would otherwise be the first day of the measurement period. The Employer may also treat as a measurement period a period that begins on the first day of the payroll period that follows the payroll period that includes the date that would otherwise be the first day of the measurement period, provided that the measurement period ends on the last day of the payroll period that includes the date that would otherwise be the last day of the measurement period. For example, an Employer using the calendar year as a measurement period could exclude the entire payroll period that included January 1 (the beginning of the year) if it included the entire payroll period that included December 31 (the end of that same year), or, alternatively, could exclude the entire payroll period that included December 31 of a calendar year if it included the entire payroll period that included January 1 of that calendar year.

Section 4.04 Administrative Period for Ongoing Employees. The Employer must make the following election to determine the applicable Administrative Period under the Plan for Ongoing Employees. For such Ongoing Employees, the Plan shall use an Administrative Period that encompasses the following period of time:

[X] (a) From the first day following the end of the Standard Measurement Period until the first day of the associated Stability Period.

[ ] (b) For a period of time equal to _____ days/months (circle one and select a time period). (Choose this option only if the Standard Measurement Period and Stability Period elected in Sections 4.03 and 4.05 are less than twelve months.)

Note: In order to prevent any gaps in coverage, the Administrative Period following a Standard Measurement Period must overlap with the preceding Stability Period. This will ensure that any Ongoing Employees who are covered under the Plan by virtue of their hours worked during the preceding Standard Measurement Period will continue to be covered for the full Stability Period.

Section 4.05 Stability Period for Ongoing Employees. The Employer must make the following election to determine the applicable Stability Period for Ongoing Employees under the Plan. The Stability Period shall last for the following period of time:

[X] (a) From July 1 through the following June 30.

[ ] (b) The _____ month/week (circle one and select time period that is at least six but less than twelve months) period of time that begins on the day immediately after the conclusion of the Standard Measurement Period and any Administrative Period elected in Section 4.04(b).

Note: The Stability Period must be at least six consecutive months and also must be the same length of time as the Standard Measurement Period. Moreover, the Stability Period must be identical to the Initial Stability Period applicable to New Employees. In most circumstances, the Stability Period will run simultaneous with the Plan Year.

Section 4.06 Eligibility Impact of Change in Employment Status from Full-Time to Non-Full-Time During Stability Period. If an Ongoing Employee who is being treated as "full-time" during a Stability Period experiences a change in employment position or status (e.g., shift to a new position, demotion, etc.) such that, in the new position or status, he/she is not reasonably expected to average at least the number of hours per week as is required for eligibility to participate in the Covered Component Benefit Plan(s) pursuant to the terms of the Welfare Benefit Plan, then the Employer may elect to apply the Monthly Measurement Method (rather than the otherwise applicable Stability Period under the Look-Back Measurement Method) to such Ongoing Employee beginning on the first day of the fourth full calendar month following the change in employment position or status. This election may only be made, however, if: (a) the Employer has offered "minimum value" coverage to the Employee from at least the first day of the month following the Employee's initial three full calendar months of employment through the month in which the change in employment position or status occurs; and (b) during each of the three full calendar months following the change in employment positon or status, the Employee averages fewer than 30 hours of service per week. If so elected, the Employer may continue to apply the Monthly Measurement Method for that particular Employee through the end of the first full Standard Measurement Period (and any associated Administrative Period) that would have applied had the Employee remained under the applicable Look-Back Measurement Method. The Employer elects:

[ ] (a) To use the special rule described above, allowing for the application of the Monthly Measurement Method (rather than the otherwise applicable Stability Period under the Look-Back Measurement Method) to an Ongoing Employee who has experienced a change in employment position or status from a Full-Time Employee to a Non-Full-Time Employee, beginning on the first day of the fourth full calendar month following the change in employment position or status.

[X] (b) Not to use the special rule described above, and thus will continue to use the applicable Stability Period under the Look-Back Measurement Method for such Ongoing Employee.

Section 4.07 Eligibility Impact of Change in Employment Status from Non-Full-Time to Full-Time During Stability Period. If an Ongoing Employee who is being treated as "non-full-time" (i.e., ineligible for benefits) during a Stability Period experiences a change in employment position or status (e.g., shift to a new position) such that, in the new position or status, he/she is reasonably expected to average at least the number of hours per week as is required for eligibility to participate in the Covered Component Benefit Plan(s), then such Ongoing Employee will become eligible to participate in the Covered Component Benefit Plan(s) as of the following date:

[ ] (a) The first day of the next Stability Period, but only if the Ongoing Employee, during the Standard Measurement Period associated with that next Stability Period, averaged at least the number of hours per week as is required for eligibility to participate in the Covered Component Benefit Plan(s). (In other words, the Ongoing Employee is not entitled to any accelerated eligibility for the plan by virtue of his/her change in position or status during the Stability Period.)

[X] (b) As applicable, either:

(i) The first day of the first month coincident with, or next following, the Ongoing Employee's satisfaction of the applicable plan's Waiting Period; or

(ii) If the Ongoing Employee already has satisfied the applicable plan's Waiting Period or, if the Employer does not apply a Waiting Period to employees who shift from non-full-time to full-time status, then the first day of the first month coincident with, or next following, the Ongoing Employee's change in employment position or status.

[ ] (c) On the effective date of the change in employment position or status.

[ ] (d) Other: _____

_____

_____

Section 4.08 Change in Status from Position Under Which Look-Back Measurement Method Is Used to Position Under Which Monthly Measurement Method Is Used. If an Employee transfers from a position under which the Look-Back Measurement Method is used to determine his/her status as a Full-Time Employee, to a position under which the Monthly Measurement Method is used to determine his/her status as a Full-Time Employee, the following rules shall apply:

(a) If the Employee, at the time of the change in status or position, is in a Stability Period in which he/she *is* treated as a Full-Time Employee (and thus eligible for coverage), the Employer will continue to treat the Employee as a Full-Time Employee through the end of the Stability Period;

(b) If the Employee, at the time of the change in status or position, is in a Stability Period in which he/she is *not* treated as a Full-Time Employee (and thus not eligible for coverage), the Employer will continue to treat the Employee as a Non-Full-Time Employee through the end of the Stability Period;

(c) For the Stability Period associated with the Standard Measurement Period during which the change in status or positon occurs, the Employer will treat the Employee as a Full-Time Employee during any calendar month in which the Employee either (1) would be treated as a Full-Time Employee under the Stability Period that would have applied based on the Standard Measurement Period in which the change in status or position occurred or (2) would be treated as a Full-Time Employee under the Monthly Measurement Method; and

(d) For any calendar month subsequent to the Stability Period identified in Subsection (c), the Monthly Measurement Method will be used to determine the Employee's status as a Full-Time Employee.

Section 4.09 Change in Status from Position Under Which Monthly Measurement Method Is Used to Position Under Which Look-Back Measurement Method Is Used. If an Employee transfers from a position under which the Monthly Measurement Method is used to determine his/her status as a Full-Time Employee, to a position under which the Look-Back Measurement Method is used to determine his/her status as a Full-Time Employee, the following rules shall apply:

(a) For the remainder of the applicable Stability Period during which the change in status or position occurs, the Employer will continue to use the Monthly Measurement Method to determine the Employee's status as a Full-Time Employee unless the Employee's hours of service prior to the change in positon or status would have resulted in him/her being treated as a Full-Time Employee during the Stability Period in which the change in status or position occurred, in which case the Employer will treat the Employee as a Full-Time Employee during such Stability Period;

(b) For the applicable Stability Period following the Standard Measurement Period during which the change in status or position occurred, the Employer will treat the Employee as a Full-Time Employee for any calendar month during which the Employee either: (1) would be treated as a Full-Time Employee based on the Standard Measurement Period during which the change in status or position occurred; or (2) would be treated as a Full-Time Employee under the Monthly Measurement Method; and

(c) For any calendar month subsequent to the Stability Period referenced in Subsection (b), the Look-Back Measurement Method will be used for determining the Employee's status as a Full-Time Employee.

Section 4.10 Impact on Eligibility of Employee's Transfer from Position in Which One Look-Back Measurement Period Applies to Position in Which a Different Look-Back Measurement Period Applies. This Section addresses changes in measurement methods under circumstances in which an Employee, who has been employed by the Employer in a position (referred to as the "first position") for which the Employer uses the Look-Back Measurement Method, transfers to another position (referred to as the "second position") for the same Employer for which the Employer also uses the Look-Back Measurement Method, but with a measurement period that is different from the measurement period applicable to the first position. For this purpose, two measurement periods are different if they are of different durations and/or if they start on different dates.

(a) A transfer that may result in a change in the applicable measurement method includes a transfer of the Employee (1) between employers that are part of the same "applicable large employer" group or (2) from one category of Employees identified in Section 2.01(b) through (e) to another.

(b) For purposes of this Section, following an Employee's transfer, the Employer will include hours of service earned in the first position as hours of service earned in the second position, either by (1) counting the hours of service using the counting method applied to the Employee in the first position (e.g., using a weekly equivalency method for non-hourly Employees), or (2) recalculating the hours of service earned in the first position using the hours of service counting method applied to the Employee in the second position (e.g., using a monthly equivalency method for non-hourly Employees), provided that the Employer treats all similarly situated Employees consistently.

(c) Beginning with the date on which an Employee transfers from the first position to the second position, the Look-Back Measurement Method will be applied as follows:

(i) *Employees in Initial Stability Period, Stability Period, or Administrative Period.* If the Employee is in an Initial Stability Period or a Stability Period applicable to the first position as of the date of transfer, his/her status as a Full-Time Employee or a Non-Full-Time Employee remains in effect until the end of the applicable Initial Stability Period or Stability Period. For this purpose, an Employee will be deemed to be in an Initial Stability Period or Stability Period (as applicable) if, as of the date of transfer, the Employee has been assigned a status as a Full-Time Employee or a Non-Full-Time Employee for the particular Initial Stability Period or Stability Period based on his/her having been employed by the Employer for a full Initial Measurement Period or full Standard Measurement Period (as applicable).

If, as of the date of transfer, a New Employee is in an Administrative Period immediately following the end of the Initial Measurement Period, his/her status as a Full-Time Employee or Non-Full-Time Employee (which is based on his/her hours of service in the Initial Measurement Period under the first position) will apply from the start of the associated Initial Stability Period following the end of that Administrative Period through the end of such Initial Stability Period.

At the end of the Initial Stability Period or Stability Period (as applicable) during which the transfer occurs (or, if the Employee was in an Administrative Period at the date of transfer, the end of the immediately following Initial Stability Period or Stability Period (as applicable)), the Employee will assume the full-time or non-full-time status that would have applied under the Look-Back Measurement Method applicable to the second position, but the calculation of hours under the Look-Back Measurement Method for the second position shall include any hours of service that the Employee accrued in the first position. For this purpose, if an Employee's status in the second position cannot be determined under the measurement method applicable to the second position because, for example, the Employee is a Variable Hour Employee and, even including service performed in the first position, has not yet been employed for a full Initial Measurement Period for the second position (and the Administrative Period immediately following that measurement period for the second position), then the rule in Subparagraph (ii) below shall apply to the Employee in the second position.

(ii) *Employees Not in a Stability Period*. If an Employee is not in an Initial Stability Period or an Administrative Period immediately following the end of the Initial Measurement Period under the Look-Back Measurement Method applicable to the first position as of the date of transfer, the Employee's status as a Full-Time Employee or Non-Full-Time Employee will be determined solely under the Look-Back Measurement Method applicable to the second position as of the date of transfer, including all hours of service in the first position. In all other respects, the rules generally applicable to the Look-Back Measurement Method under Treas. Reg. § 54.4980H-3(d) continue to apply. However, a transfer of a New Employee (who may be classified as a Part-Time Employee, Variable Hour Employee, or Seasonal Employee) from the first position to the second position may be a change in employment status described in Section 3.06 if, after the transfer, the Employee is reasonably expected to average at least the number of hours per week in the second position as is required for eligibility to participate in the Covered Component Benefit Plan(s) pursuant to the terms of Welfare Benefit Plan.

Until a New Employee who is neither a Part-Time Employee, Variable Hour Employee, nor Seasonal Employee has been employed for a full Standard Measurement Period applicable to the second position (including service in the first position), the status of such Employee as a Full-Time Employee or a Non-Full-Time Employee will continue to be determined on the basis of hours of service in each calendar month. If such Employee has been employed for a full Standard Measurement Period applicable to the second position but not the first position as of the date of transfer, his/her status as full-time or non-full-time will be

determined on the basis of his/her average hours of service during that Standard Measurement Period for the second position (but counting the hours of service accumulated during the Standard Measurement Period for the first position), applied starting on the first day of the first month following the date of transfer and continuing through the end of the associated Stability Period.

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PART V
ADDITIONAL ADMINISTRATIVE PROVISIONS

Section 5.01 Use of Payroll Periods in Calculating Employees' Hours of Service for Purposes of the Initial Measurement Period or Standard Measurement Period. For payroll periods that are one week, bi-weekly, or semi-monthly in duration, the Employer may treat as a Standard Measurement Period a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the Standard Measurement Period, provided that the Standard Measurement Period begins on the first day of the payroll period that includes the date that would otherwise be the first day of the Standard Measurement Period. The Employer may also treat as a Standard Measurement Period a period that begins on the first day of the payroll period that follows the payroll period that includes the date that would otherwise be the first day of the Standard Measurement Period, provided that the Standard Measurement Period ends on the last day of the payroll period that includes the date that would otherwise be the last day of the Standard Measurement Period.

For example, if the Employer uses a calendar year as the Standard Measurement Period, the Employer could exclude the entire payroll period that included January 1 (the beginning of the year) if it included the entire payroll period that included December 31 (the end of that same year). Alternatively, it could exclude the entire payroll period that included December 31 of a calendar year if it included the entire payroll period that included January 1 of that calendar year.

Section 5.02 Eligibility of Employees Rehired After Termination of Employment or Other Extended Absence. An Employee who resumes employment with the Employer after a period during which the Employee was not credited with any hours of service will be treated as having terminated employment and having been rehired, and thus treated as a New Employee upon his/her resumption of service, if either of the following is true:

(a) *Significant Break-In-Service*. The Employee did not work at least one hour of service for the Employer during the 13-consecutive-week period immediately preceding the Employee's resumption of services with the Employer (unless the Employer is an educational organization, in which case it is the 26-consecutive-week period immediately preceding the Employee's resumption of services with the Employer); or

(b) *Rule of Parity*. The period of time during which the Employee did not work at least one hour of service is less than thirteen (13) weeks (or, if the Employer is an educational organization, twenty-six (26) weeks), but is at least four (4) weeks long and is longer than the Employee's period of employment immediately preceding that period with no credited hours of service. (Example: If an Employee works for three weeks for the Employer, terminates employment, and is later rehired by the Employer ten weeks after terminating employment, the rehired Employee will be treated as a New Employee because the ten-week period with no credited hours of service is longer than the immediately preceding three-week period of employment.)

If neither Subsection (a) nor Subsection (b) is satisfied, the rehired Employee will be treated as a continuing Employee upon resuming active employment. For an Employee who is treated as a continuing Employee, the measurement and stability period that would have applied to the

Employee had he/she not experienced the period of no credited hours of service would continue to apply upon the Employee's resumption of service. (*Example*: If a continuing Employee returns during a Stability Period in which he/she is treated as being eligible to participate in the Plan because he/she had averaged at least 30 hours of service during a prior Standard Measurement Period, then the Employee will be treated as eligible to participate in the Plan upon resuming active employment and will remain in that status through the end of that Stability Period.) In such circumstances, the Employee must be offered coverage as of the first day that he/she is credited with an hour of service, or, if later, as soon as administratively practicable.

Section 5.03 Applicability of Addendum to Plan Years in Which Employer is Not an Applicable Large Employer. The eligibility provision in this Addendum shall apply:

[X] (a) Only during a Plan Year in which the Employer is deemed to be an "applicable large employer" within the meaning of PPACA.

[ ] (b) During all Plan Years.

Section 5.04 Addendum Supersedes Contrary Provisions in Welfare Benefit Plan Document. To the extent the provisions of this Addendum are inconsistent with the terms and conditions set forth in the Welfare Benefit Plan document, the terms of this Addendum shall control.

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APPENDIX A
GROUP HEALTH PLANS
(other than the Health FSA)

This Appendix A contains the terms and conditions specific to both the fully-insured Group Health Plans and the self-funded Group Health Plans, other than the Health FSA, which is addressed in Appendix C, that may be elected under Section 4.01 of the Plan. Unless otherwise altered by the terms of this Appendix A, the terms and conditions of the Plan are incorporated into, and made applicable to, the Group Health Plans.

Section A1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the entry dates for the Group Health Plans are the same as those for the Plan.

Section A1.02 Benefits. Benefits under the Group Health Plans Plan are identical to those described in, and shall be paid pursuant to the terms of, one or more group contracts (for the fully-insured Group Health Plan(s)) between the Employer and the applicable insurance carrier and one or more benefits description(s) (for the self-funded Group Health Plan(s)) between the Employer and the third party administrator.

The Employer maintains the following Group Health Plans, some of which are fully-insured through the insurance companies specified below and some of which are self-funded and administered by the company specified below:

(a) A self-funded Medical Plan that pays benefits pursuant to the terms and conditions of the Benefit Description (Group No. 18122) prepared for the Employer and administered by Meritain;

(b) A fully-insured Dental Plan that pays benefits pursuant to the terms and conditions of a group contract, the Delta Dental of Kansas Group Contract (Group No. 027050000000100000), between Delta Dental of Kansas and the Employer; and

(c) A fully-insured Vision Plan that pays benefits pursuant to the terms and conditions of a group contract, the EyeMed Vision Care Group Contract (Group No. 1011732), between EyeMed Vision Care and the Employer.

The provisions of the above Benefit Description(s), as they may be amended from time to time, are incorporated herein by reference and the rights and conditions with respect to the benefits payable under the Medical Plan shall be determined from the Benefit Description; provided, however, that should there be any contradictions between the Benefit Description and this document, this document will control.

The provisions of the above fully-insured group contract(s), as they may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by the applicable insurance company. The Employer makes no promise and shall have no obligation to provide or pay such benefits from its own assets. The rights and conditions with respect to the benefits payable under the fully-insured Group Health Plan(s) shall be determined from the applicable group contract. The Participant shall bear fully any and all risk of applicable insurance company's insolvency.

Section A1.03 Cost of Coverage.

(a) *Self-Funded Group Health Plan(s).* The Participant's monthly premiums for the self-funded Group Health Plan(s) are determined by the Employer. The Employer may change the premiums from time to time. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant.

(b) *Fully-Insured Group Health Plan(s).* The Participant's monthly premiums are determined pursuant to the group contract(s) listed in Section A1.02 between the insurance company and the Employer. Under the terms of the group contract(s), the applicable insurance company may change the premiums from time to time. The Employer will designate for each Plan Year the portion of the monthly premium for which the responsibility for payment will fall upon the Participant. If money is returned in any form by the insurance company, including but not limited to a rebate or proceeds from demutualization, the Plan Administrator shall apply such amounts to the payment of Plan expenses and/or the reduction of premiums.

Section A1.04 Election to Participate. A Participant who desires to receive coverage under one or more of the above-listed Group Health Plans must elect to participate in the Group Health Plans must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to receive coverage under one or more of the Group Health Plans, the Employer will not provide him/her with the applicable coverage.

Section A1.05 Payment of Premium(s). A Participant who has elected to participate in the Medical Plan, the Dental Plan, and the Vision Plan may pay the applicable premium on a pre-tax basis by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. Notwithstanding provisions in this Section A1.05 to the contrary, Participants who are (a) exercising their right to continuation coverage pursuant to Section A1.06 below, (b) exercising their right to continue coverage during a qualifying unpaid leave pursuant to Section 3.03, or (c) eligible pursuant to Section 2.14(b), must pay their premiums through after-tax payroll deductions.

Section A1.06 Continuation of Coverage. An individual who will lose coverage under the Group Health Plans may have the right to continue coverage under the Group Health Plans as described in Article VIII.

Section A1.07 Children Subject to a QMCSO. Children who are the subject of a Qualified Medical Child Support Order ("QMCSO") shall become "alternate recipients" of benefits under the Group Health Plans in accordance with Section 609 of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan Administrator shall establish reasonable procedures to determine the qualified status of a medical child support order. Upon receiving a medical child support order, the Plan Administrator shall promptly notify in writing all involved parties of its receipt and shall inform such parties of the Plan's procedures for determining if the order is a QMCSO. Within a reasonable period of time, the Plan Administrator shall determine the qualified status of the order and notify all parties of its decision. Notwithstanding anything to the contrary in the document for the Group Health Plans, the Group Health Plans shall provide coverage for "alternate recipients" in accordance with the terms of a properly issued and properly recognized QMCSO and the requirements of ERISA and applicable DOL regulations.

Section A1.08 Claims Administration.

(a) *Self-Funded Group Health Plan(s).* The claims administrator(s) listed in Section A1.02 above will act as Claims Administrator(s) with respect to any claim for benefits under the applicable self-funded Group Health Plan(s). The Claims Administrator for the Medical Plan is acting on behalf of the Employer in a ministerial and administrative capacity. The Employer retains full discretionary authority to make all determinations regarding the administration and payment of benefit claims.

(b) *Fully-Insured Group Health Plan(s).* The insurance company(s) listed in Section A1.02 above will act as Claims Administrator(s) with respect to any claim for benefits under the applicable fully-insured Group Health Plan(s). Each insurance company has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the applicable group contract. Except as provided by law, all decisions of the Claims Administrator shall be final and binding.

Section A1.09 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) For fully-insured Group Health Plans, the last effective date of coverage as specified by the insurance Group Contract;

(b) For self-funded Group Health Plans, the date on which the Participant terminates employment with the Employer;

(c) The date on which the Participant's election to participate expires;

(d) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;

(e) The last day of the month in which the Participant ceases to be an Eligible Employee; or

(f) The date on which the applicable Group Health Plan terminates.

Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in the Group Health Plans if and to the extent such individual elects continuation of benefits under the rules in Section A1.06.

Section A1.10 Character of Benefits Provided. The Group Health Plans do not provide medical, dental, or vision treatment or advice. They merely pay for the cost of selected benefits as described in, and in accordance with, the provisions of the group contract(s) or Benefit Description(s), as applicable. The fact that a particular medical, dental, or vision service may not be eligible for reimbursement under the Group Health Plan does not mean that a Participant or other person who is covered under the Group Health Plan should not receive that service.

Section A1.11 Subrogation/Reimbursement Rights of the Self-Funded Group Health Plans.

(a) *Self-Funded Group Health Plans' Right to Subrogation.* The self-funded Group Health Plan(s) shall be subrogated to all rights that a Participant, covered dependent, or his/her assignee has against any person, firm, corporation, insurer (including, but not limited to, workers compensation or any other occupational disease, act, or law, uninsured motorist coverage, and business/homeowners medical liability insurance coverage or payments) or other entity with respect to *any and all benefits* previously paid by the self-funded Group Health Plan(s), or on behalf of the self-funded Group Health Plan(s), to such individual for any injuries, expenses, or loss which may be caused by the negligence or wrongful act of a third party.

(b) *Self-Funded Group Health Plans' Right to Reimbursement.* A Participant, covered dependent, or assignee agrees to include the amounts of any and all benefits paid by the self-funded Group Health Plan(s) (or any amount considered to be for future medical expenses) in any claim such individual brings against any person, firm, corporation, insurer, or other entity. Upon any recovery made by a Participant, covered dependent, or assignee from any source of compensation, whether by judgment, settlement, compromise, or otherwise, the self-funded Group Health Plan(s) shall have first lien upon such recovery and be entitled to immediate reimbursement to the extent of any and all benefits paid by the self-funded Group Health Plan(s). The self-funded Group Health Plan(s) shall also have the right to reimbursement from any Participant, covered dependent, or assignee for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which the Participant, covered dependent, or assignee was not entitled.

Section A1.12 Amount of Recovery. The self-funded Group Health Plan(s) have the right to recovery, whether by subrogation or reimbursement, for any and all benefits paid by the self-funded Group Health Plan(s). The amount due shall not be reduced due to attorney's fees and/or costs incurred in pursuing a claim or reimbursement. In addition, these rights take priority over a Participant's, covered individual's, or assignee's right to be made whole.

Section A1.13 Condition of Payment. By accepting benefits from the self-funded Group Health Plan(s), a Participant, covered dependent, or his/her assignee agrees to the following:

(a) The self-funded Group Health Plan(s) may require a Participant, covered dependent, assignee, or someone legally qualified and authorized to act for such person, to agree to the provisions in this Appendix A, Sections A1.12 through A1.13 in writing, and execute any and all other instruments reasonably necessary for the self-funded Group Health Plan(s) to assert their rights under these Sections;

(b) Any amounts recovered by such individual or by the self-funded Group Health Plan(s) by judgment, settlement, or otherwise will be applied first to reimburse the self-funded Group Health Plan(s);

(c) The self-funded Group Health Plan(s) shall be subrogated to all claims, demands, actions, and rights of recovery against a third party to the extent of any and all payments made by the self-funded Group Health Plan(s); and

(d) At the self-funded Group Health Plan's request, a Participant, covered dependent, or assignee must take any action, give information, and/or execute instruments required by the self-funded Group Health Plan(s), in its discretion, in order to aid the self-funded Group Health Plan(s) in its enforcement of its rights of recovery, reimbursement, and subrogation. If such individual fails to comply with such requests, the self-funded Group Health Plan(s) may withhold benefits, services, payments, or credits due under the self-funded Group Health Plan(s).

Section A1.14 Funding Policy and Method. The benefits under the self-funded Group Health Plan(s) are funded by the Employer. The cost of providing these benefits is paid for by Employer and Employee contributions. The Employer, in its sole discretion, may purchase a group insurance policy to fund some or all of the benefits under the self-funded Group Health Plan(s).

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Four County Mental Health Center Health and Welfare Plan

Group No.: 18122

Medical Benefit Description

Effective: July 1, 2021

P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272
www.meritain.com

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ESTABLISHMENT OF THE PLAN

Four County Mental Health Center, Inc. (the "Employer" or the "Plan Sponsor") has adopted this Medical Benefit Description effective as of July 1, 2021 for the Four County Mental Health Center Health and Welfare Plan (hereinafter referred to as the "Plan" or "Medical Benefit Description"), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents.

Purpose of the Plan
The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Medical Benefit Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

Adoption of this Medical Benefit Description
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Medical Benefit Description as the written description of the Plan. This Plan represents the Medical Benefit Description, which is required by the Employee Retirement Income Security Act of 1974, as amended from time to time. This Medical Benefit Description amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Medical Benefit Description to be executed as of the date set forth below.

Four County Mental Health Center, Inc.

Dated:_____

By:_____

Name:_____

Title:_____

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #2
TO THE
FOUR COUNTY MENTAL HEALTH CENTER
HEALTH AND WELFARE PLAN
GROUP NO. 18122

This Summary of Material Modification and Amendment describes changes to the Four County Mental Health Center Health and Welfare Plan effective July 1, 2021. These changes are effective as of **July 1, 2021** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Four County Mental Health Center, Inc. (the "Plan Sponsor") is amending the Four County Mental Health Center Health and Welfare Plan (the "Plan") as follows:

*In the **Prescription Drug Schedule of Benefits – HDHP 2**, the **Specialty Pharmacy Program: 30-day supply** subsection is hereby deleted and replaced as shown below:*

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP 2

BENEFIT DESCRIPTION	BENEFIT
Specialty Pharmacy Program: 30-day supply	
Specialty Drug	100% after Deductible
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Four County Mental Health Center, Inc. has caused this Amendment to take effect, be attached to, and form a part of their Health and Welfare Plan.

Authorized Signature — 6-28-22 Date — EXECUTIVE DIRECTOR Title

Witness — 6-28-22 Date — HR Director Title

GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement that provides access to one or more networks of Participating Providers called “Networks”. Available Networks are identified on the Employee identification card. These Networks offer you health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you. You are also not required to designate a Primary Care Physician (PCP), but the Plan encourages you to designate a PCP to help manage your care.

Non-Participating Provider Exceptions
Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level subject to the Usual and Customary provision of the Plan when a:

(1) Covered Person has an Emergency Medical Condition requiring immediate care.

(2) Covered Person receives services by a Non-Participating Provider (anesthesiologists, radiologists, pathologists) who is under agreement with a Network facility.

(3) Participating Provider submits a specimen to a Non-Participating Provider laboratory.

(4) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon.

(5) Participating Provider is not available within a 75-mile radius of the Covered Person’s residence.

Not all providers based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at www.meritain.com. If you do not have access to a computer at your home, you may contact your Employer or the Network at the phone number on the Employee identification card.

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. Participating Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Participating Provider.

Transitional Care
Certain Covered Expenses may be paid at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan if the Covered Person is currently under a treatment plan by a Physician or other health care provider or facility that was a member of this Plan’s previous Network but who is not a member of this Plan’s current Network. In order to ensure continuity of care for certain medical conditions already under treatment, the Participating Provider benefit level may continue for 365 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

(1) Cancer if under active treatment with chemotherapy and/or radiation therapy.

(2) Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).

(3) If the Covered Person is Inpatient in a Hospital on the effective date.

(4) Post-acute Injury or Surgery within the past 3 months.

(5) Pregnancy in the second or third trimester and up to 8 weeks postpartum.

(6) Behavioral Health – any previous treatment.

You or your Dependent must call the Plan Administrator prior to the effective date or within 4 weeks after the effective date to see if you or your Dependents are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective Surgical Procedures will not be covered by transitional level benefits.

Costs
You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

Coinsurance
Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Medical Schedule of Benefits.

Copay
A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductible
A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Plan Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Medical Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Plan Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

Conventional Plan only: If the Deductible is satisfied in whole or in part by eligible expenses Incurred during April, May or June, those expenses will apply to the Deductible applicable in the next Plan Year.

Out-of-Pocket Maximum
An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Plan Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Plan Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by covered family members during a Plan Year. The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of Covered Expenses for any Covered Person in the family during the remainder of that Plan Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Charges over Usual and Customary Charges for Non-Participating Providers.

(2) Charges this Plan does not cover.

Reimbursement for any eligible non-accumulating expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Plan Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

Integration of Deductibles and Out-of-Pocket Maximums
If you use a combination of Participating Providers and Non-Participating Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid will not exceed the amount shown for Non-Participating Providers. In other words, the amount of the Deductible expense and Out-of-Pocket Maximum you pay for both Participating Providers and Non-Participating Providers will be combined, and the total will not exceed the amount shown for Non-Participating Providers during a single Plan Year.

MEDICAL MANAGEMENT PROGRAM

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. 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 healthcare provider. The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Plan Information page of this Plan.

Precertification
Before you or your eligible Dependents are admitted to a medical facility or receive items or services from the list below, the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies, procedures and guidelines. Once an Inpatient setting has been precertified, working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses. The Medical Management Program Administrator will also assist and coordinate the initial implementation of any services you will need post hospitalization (called discharge planning) with the attending Physician and the facility. This could include registering you for specialized programs or case management when appropriate.

Your provider may precertify your treatment for you; however, you should verify prior to incurring Covered Expenses that your provider has obtained precertification. If your treatment is not precertified by you or your provider within the time periods described below a retrospective review may be performed. A retrospective review (as directed by the Plan) will determine if the services were Medically Necessary and would have been approved had the required phone call been made, provided the Covered Expenses meets all other Plan provisions and requirements. However, any charges not deemed Medically Necessary will be denied.

Case Management
Depending on the level of care needed, 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. All parties involved (e.g., the Plan, attending Physician, and patient) must all agree to the alternate individually tailored treatment plan. Each treatment plan is specific to that patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. Case management is a voluntary service. There are no reductions of benefits or penalties if you or your eligible Dependents choose not to participate.

Important Timeframes to Know
You, your Physician, the Facility or someone acting on your behalf, should call the Medical Management Program Administrator (at the number listed on your Employee identification card or the General Plan Information page of this Plan) within the following time frames for a:

Non-emergency admission	48 hours before the scheduled admission
Non-emergency services	48 hours before you are scheduled to receive the services
Emergency admission	Within 48 hours or if later, the next business day after you are admitted

If the attending Physician feels that it is Medically Necessary for a patient to receive services for a greater length of time than initially precertified, the attending Physician or the medical facility should request the additional service or days as soon as reasonably possible, but no later than the final authorized day.

List of Items and/or Services that require Precertification
The below items and/or services, if Covered Expenses under the Plan, should be precertified (except as otherwise specifically stated within the Plan) before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of your Plan.

All Inpatient Admissions:

- Acute
- Long-Term Acute Care
- Rehabilitation Facility
- Mental Disorder / Substance Use Disorder
- Residential Treatment Facility
- Transplant
- Skilled Nursing Facility

Diagnostic Services (Outpatient and Physician):

- CT for non-orthopedic
- MRI for non-orthopedic
- PET
- Capsule endoscopy
- Genetic testing, including BRCA
- Sleep study

Surgery (including in a Physician's office):

- Breast and bone marrow biopsy
- Biopsies (excluding skin)
- Vascular Access Devices for the infusion of chemotherapy (including, but not limited to, PICC and Central Lines)
- Thyroidectomy, partial or complete
- Open prostatectomy
- Creation and revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for dialysis
- Oophorectomy, unilateral and bilateral
- Back Surgeries and hardware related to Surgery
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Sleep apnea related Surgeries, limited to:
  - Radiofrequency ablation (Coblation, Somnoplasty)
  - Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures

Continuing Care Services (Outpatient and Physician):

- Chemotherapy (including oral)
- Radiation therapy
- Oncology and transplant related injections, infusions and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Dialysis
- Hyperbaric oxygen
- Home health care
- Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices

Monthly High Cost Drugs that are $2,000 or more and are:

- Injectables
- Infusion therapies

Important Notes:

❖ Precertification is recommended if a procedure could be considered Experimental and/or Investigational or potentially Cosmetic in nature (such as, but not limited to: abdominoplasty, cervicoplasty, liposuction/lipectomy, mammoplasty (augmentation and reduction - includes removal of implant), Morbid Obesity procedures, septoplasty, etc.).

❖ Precertification is NOT REQUIRED for a maternity delivery admission, unless the stay extends past 48 hours for vaginal delivery or 96 hours for a cesarean section. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified, the confinement should be precertified with the Medical Management Program Administrator.

❖ High Cost Drugs are drugs that are covered under the medical benefits section of the Plan. This requirement does not apply to drugs covered under the Prescription Drug Card Program.

Precertification Does Not Guarantee Payment

Precertification of the above benefits ensures the service being rendered is Medically Necessary and appropriate. All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered a Covered Expense and are subject to all other provisions of the Plan.

To File a Complaint or Request an Appeal to a Non-Certification

If it is determined that the item and/or services are not Medically Necessary, the notification you receive will explain why. Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Plan Information page of this Plan.

High Cost Drug Management
The primary objective of the High Cost Drug Management program is to provide assistance when you or eligible Dependents have been prescribed a high cost drug that exceeds $2,000 per month and is covered under the medical benefits section of the Plan.

The High Cost Drug Management program helps coordinate the most effective way to reduce expenses associated with the high cost drug. Specially trained case managers will make recommendations based on the terms of the Plan to ensure the medication is being obtained through the most cost effective method.

If you or your eligible Dependents are not currently utilizing the most cost effective method, the case manager will make a recommendation to how to obtain the medication from the most cost efficient Participating Provider. The program includes 1-on-1 coaching based on Plan provisions, support and education to improve adherence and avoid complications.

This is a voluntary service. There are no reductions of benefits or penalties if the Covered Person and family choose not to participate or comply with recommendations or suggestion provided by case managers.

MEDICAL SCHEDULE OF BENEFITS – CONVENTIONAL

CONVENTIONAL	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE		
Single	$2,000	$4,000
Family	$4,000	$8,000
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Coinsurance only)		
Single	$2,500	$8,700
Family	$5,000	$17,400
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	$6,350	$12,700
Family	$12,700	$25,400
MEDICAL BENEFITS		
Ambulance Services	80% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance Services	80% after Deductible	Paid at Participating Provider level of benefits Up to 300% of Medicare Allowable Rates
Chiropractic Care/Spinal Manipulation	80% after Deductible	60% after Deductible
Plan Year Maximum Benefit	15 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	100%; Deductible waived 1st $350 per Plan Year, then 80% after Deductible	60% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	100%; Deductible waived 1st $350 per Plan Year, then 80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	60% after Deductible
Emergency Services/Emergency Room Services	$150 Copay, then 80% after Deductible	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Home Health Care	100%; Deductible waived	100%; Deductible waived
Hospice Care	100%; Deductible waived	100%; Deductible waived
Hospice Bereavement Counseling	100%; Deductible waived	100%; Deductible waived

CONVENTIONAL	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	60% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Keep It Simple Surgery (KISx) Program Outpatient surgical and non-surgical treatment provided by KISx providers*	100%; Deductible waived	N/A
*Please refer to the KISx Program section of this Plan for a more detailed description of this benefit. Covered Expenses include facility and professional fees, supplies and equipment Incurred at a KISx contracted facility. If treatment is received from providers outside of the KISx Program, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	60% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	60% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	80% after Deductible	60% after Deductible
Outpatient		
Office Visits	$25 Copay, then 100%; Deductible waived	60% after Deductible
All Other Outpatient Care	80% after Deductible	60% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Occupational Therapy (OT) (Outpatient)	80% after Deductible	60% after Deductible
Physical Therapy (PT) (Outpatient)	80% after Deductible	60% after Deductible

CONVENTIONAL	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	60% after Deductible
Office Visits	$25 Copay*, then 100%; Deductible waived	60% after Deductible
Physician Office Surgery	$25 Copay*, then 100%; Deductible waived	60% after Deductible
Telemedicine July 1, 2021 – December 31, 2021)	100%; Deductible waived	60% after Deductible
Teladoc	100%; Deductible waived	N/A
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	60% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	60% after Deductible
Routine Eye Examination	100%; Deductible waived	60% after Deductible
Plan Year Maximum Benefit	1 exam	
Prosthetics	80% after Deductible	60% after Deductible
Post Mastectomy Bras	80% after Deductible	60% after Deductible
Plan Year Maximum Benefit	2 bras	
Skilled Nursing Facility and Rehabilitation Facility	100%; Deductible waived	100%; Deductible waived
Speech Therapy (ST) (Outpatient)	80% after Deductible	60% after Deductible
Plan Year Maximum Benefit	90 visits	
Transplants	80% after Deductible (Aetna IOE Program)* 60% after Deductible (All Other Network Providers)	60% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	$25 Copay*, then 100%; Deductible waived	60% after Deductible
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
All Other Eligible Medical Expenses	80% after Deductible	60% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CONVENTIONAL

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Copays – combined with major medical Out-of-Pocket) Single Family	 $6,350 $12,700
Retail Pharmacy: 34-day supply	
Generic Drug	$15 Copay
Preferred Drug	$50 Copay
Non-Preferred Drug	$75 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)
Specialty Pharmacy Program: 30-day supply	
Generic Drug	$15 Copay
Preferred Drug	$50 Copay
Non-Preferred Drug	$75 Copay
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
Mail Order Pharmacy: 90-day supply	
Generic Drug	$37.50 Copay
Preferred Drug	$125 Copay
Non-Preferred Drug	$187.50 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid)

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

MEDICAL SCHEDULE OF BENEFITS – HDHP 1

HDHP 1	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE (combined with Prescription Drug Card)		
Single	$3,000*	$6,000
Family	$6,000**	$12,000
***For Employees with single coverage only, a reduced individual Deductible amount of $1,400 must be met before the Plan starts to pay for services rendered through the KISx Program. **For Employees with family coverage, a reduced single Deductible amount of $2,800 must be met before the Plan starts to pay for services rendered through the KISx Program.		
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance – combined with Prescription Drug Card)		
Single	$4,000	$8,000
Family	$8,000	$16,000
MEDICAL BENEFITS		
Ambulance Services	90% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance Services	90% after Deductible	Paid at Participating Provider level of benefits Up to 300% of Medicare Allowable Rates
Chiropractic Care/Spinal Manipulation	90% after Deductible	70% after Deductible
Plan Year Maximum Benefit	15 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	90% after Deductible	70% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	90% after Deductible	70% after Deductible
Durable Medical Equipment (DME)	90% after Deductible	70% after Deductible
Emergency Services/Emergency Room Services	90% after Deductible	Paid at the Participating Provider level of benefits
Home Health Care	90% after Deductible	70% after Deductible
Hospice Care	90% after Deductible	70% after Deductible
Hospice Bereavement Counseling	90% after Deductible	70% after Deductible

HDHP 1	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	90% after Deductible	70% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	90% after Deductible	70% after Deductible
Outpatient	90% after Deductible	70% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Keep It Simple Surgery (KISx) Program Outpatient surgical and non-surgical treatment provided by KISx providers*	100% after Deductible	N/A
* See Calendar Year Deductible section for modified Deductible amounts related to KISx. **NOTE:** Please refer to the KISx Program section of this Plan for a more detailed description of this benefit. Covered Expenses include facility and professional fees, supplies and equipment Incurred at a KISx contracted facility. If treatment is received from providers outside of the KISx Program, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	70% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	90% after Deductible	70% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	90% after Deductible	70% after Deductible
Outpatient	90% after Deductible	70% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Occupational Therapy (OT) (Outpatient)	90% after Deductible	70% after Deductible
Physical Therapy (PT) (Outpatient)	90% after Deductible	70% after Deductible
Physician's Services		
Inpatient/Outpatient Services	90% after Deductible	70% after Deductible
Office Visits	90% after Deductible	70% after Deductible
Physician Office Surgery	90% after Deductible	70% after Deductible
Telemedicine July 1, 2021 – December 31, 2021)	90% after Deductible	70% after Deductible
Teladoc	90% after Deductible	N/A
NOTE: Your consult fee to use a Teladoc provider applies to your Deductible and Out-of-Pocket Maximum. Once your Deductible is met, you will be reimbursed 90% of the consult fee. Once your Out-of-Pocket Maximum is met, you will be reimbursed the entire consult fee.		

HDHP 1	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	70% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	70% after Deductible
Routine Eye Examination	100%; Deductible waived	70% after Deductible
Plan Year Maximum Benefit	1 exam	
Prosthetics	90% after Deductible	70% after Deductible
Post Mastectomy Bras	90% after Deductible	70% after Deductible
Plan Year Maximum Benefit	2 bras	
Skilled Nursing Facility and Rehabilitation Facility	90% after Deductible	70% after Deductible
Speech Therapy (ST) (Outpatient)	90% after Deductible	70% after Deductible
Plan Year Maximum Benefit	90 visits	
Transplants	90% after Deductible (Aetna IOE Program)* 70% after Deductible (All Other Network Providers)	70% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% after Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	90% after Deductible	70% after Deductible
All Other Eligible Medical Expenses	90% after Deductible	70% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP 1

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
PLAN YEAR DEDUCTIBLE (combined with major medical Deductible) Single Family	 $3,000 $6,000
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance – combined with major medical Out-of-Pocket) Single Family	 $4,000 $8,000
Retail Pharmacy: 34-day supply	
Generic Drug	90% after Deductible
Preferred Drug	90% after Deductible
Non-Preferred Drug	90% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)
Specialty Pharmacy Program: 30-day supply	
Specialty Drug	90% after Deductible
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
Mail Order Pharmacy: 90-day supply	
Generic Drug	90% after Deductible
Preferred Drug	90% after Deductible
Non-Preferred Drug	90% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician’s office, infusion center or other clinical setting, or the Covered Person’s home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

MEDICAL SCHEDULE OF BENEFITS – HDHP 2

HDHP 2	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN YEAR DEDUCTIBLE (combined with Prescription Drug Card)		
Single	$5,000*	$10,000
Family	$10,000*	$20,000
***For Employees with single coverage only, a reduced individual Deductible amount of $1,400 must be met before the Plan starts to pay for services rendered through the KISx Program. **For Employees with family coverage, a reduced single Deductible amount of $2,800 must be met before the Plan starts to pay for services rendered through the KISx Program.		
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance – combined with Prescription Drug Card)		
Single	$5,000	$10,000
Family	$10,000	$20,000
MEDICAL BENEFITS		
Ambulance Services	100% after Deductible	Paid at Participating Provider level of benefits
Air Ambulance Services	100% after Deductible	Paid at Participating Provider level of benefits Up to 300% of Medicare Allowable Rates
Chiropractic Care/Spinal Manipulation	100% after Deductible	80% after Deductible
Plan Year Maximum Benefit	15 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	100% after Deductible	80% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy)	100% after Deductible	80% after Deductible
Durable Medical Equipment (DME)	100% after Deductible	80% after Deductible
Emergency Services/Emergency Room Services	100% after Deductible	Paid at the Participating Provider level of benefits
Home Health Care	100% after Deductible	80% after Deductible
Hospice Care	100% after Deductible	80% after Deductible
Hospice Bereavement Counseling	100% after Deductible	80% after Deductible

HDHP 2	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	100% after Deductible	80% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	100% after Deductible	80% after Deductible
Outpatient	100% after Deductible	80% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Keep It Simple Surgery (KISx) Program Outpatient surgical and non-surgical treatment provided by KISx providers*	100% after Deductible	N/A
* See Calendar Year Deductible section for modified Deductible amounts related to KISx. **NOTE:** Please refer to the KISx Program section of this Plan for a more detailed description of this benefit. Covered Expenses include facility and professional fees, supplies and equipment Incurred at a KISx contracted facility. If treatment is received from providers outside of the KISx Program, standard Plan benefits will apply as outlined in the Medical Schedule of Benefits.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	80% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	100% after Deductible	80% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	100% after Deductible	80% after Deductible
Outpatient	100% after Deductible	80% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Occupational Therapy (OT) (Outpatient)	100% after Deductible	80% after Deductible
Physical Therapy (PT) (Outpatient)	100% after Deductible	80% after Deductible
Physician's Services		
Inpatient/Outpatient Services	100% after Deductible	80% after Deductible
Office Visits	100% after Deductible	80% after Deductible
Physician Office Surgery	100% after Deductible	80% after Deductible
Telemedicine July 1, 2021 – December 31, 2021)	100% after Deductible	80% after Deductible
Teladoc	100% after Deductible	N/A
NOTE: Your consult fee to use a Teladoc provider applies to your Deductible. Once your Deductible is met, you will be reimbursed the entire consult fee.		

HDHP 2	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	80% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	80% after Deductible
Routine Eye Examination	100%; Deductible waived	80% after Deductible
Plan Year Maximum Benefit	1 exam	
Prosthetics	100% after Deductible	80% after Deductible
Post Mastectomy Bras	100% after Deductible	80% after Deductible
Plan Year Maximum Benefit	2 bras	
Skilled Nursing Facility and Rehabilitation Facility	100% after Deductible	80% after Deductible
Speech Therapy (ST) (Outpatient)	100% after Deductible	80% after Deductible
Plan Year Maximum Benefit	90 visits	
Transplants	100% after Deductible (Aetna IOE Program)* 80% after Deductible (All Other Network Providers)	80% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% after Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	100% after Deductible	80% after Deductible
All Other Eligible Medical Expenses	100% after Deductible	80% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – HDHP 2

BENEFIT DESCRIPTION	BENEFIT
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.	
PLAN YEAR DEDUCTIBLE (combined with major medical Deductible) Single Family	 $5,000 $10,000
PLAN YEAR OUT-OF-POCKET MAXIMUM (includes Deductible– combined with major medical Out-of-Pocket) Single Family	 $5,000 $10,000
Retail Pharmacy: 34-day supply	
Generic Drug	100% after Deductible
Preferred Drug	100% after Deductible
Non-Preferred Drug	100% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)
Specialty Pharmacy Program: 30-day supply	
Specialty Drug	10% after Deductible
NOTE: Specialty Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at retail or mail order pharmacies and there are no grace fills provided to Covered Persons.	
Mail Order Pharmacy: 90-day supply	
Generic Drug	100% after Deductible
Preferred Drug	100% after Deductible
Non-Preferred Drug	100% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived)

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

(1) Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or

(2) Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

(1) **Allergy Services:** Allergy testing, serum and injections. Allergy serum and injections will be payable under the Physician office visit benefit.

(2) **Ambulance Service:** Professional ambulance service to transport the Covered Person:

(a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or

(b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or

(c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or

(d) From the Hospital to the patient's home or to a Skilled Nursing Facility, Rehabilitation Facility or any other type of convalescent facility nearest to the patient's home when there is documentation the patient required ambulance transportation.

Professional ambulance charges for convenience are not covered.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(3) **Ambulatory Surgical Center:** Services and supplies provided by an Ambulatory Surgical Center.

(4) **Anesthetics:** Anesthetics and their professional administration.

(5) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced.

(6) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(7) **Chemotherapy:** Services and supplies related to chemotherapy.

(8) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(9) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

(10) **Cleft Palate and Cleft Lip:** Services and supplies related to cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close. Eligible expenses include the following when provided by a Physician, or other professional provider:

(a) Oral and facial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.

(b) Habilitative speech therapy.

(c) Otolaryngology treatment.

(d) Audiological assessments and treatment.

(e) Orthodontic treatment.

(f) Prosthodontic treatment.

(g) Prosthetic treatment such as obturators, speech appliances and feeding appliances.

(11) **Cochlear Implants and Implanted Bone Anchored Hearing Aids:** Services and supplies related to cochlear implants and implanted bone anchored hearing aids when Medically Necessary, and the related maintenance and adjustments. Benefits include post-aural cochlear implant therapy under the recommendation of a Physician.

(12) **Contraceptives:** Contraceptive procedures and medications other than those considered preventive services, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the Prescription Drug Card Program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service).

(13) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(a) For the correction of a Congenital Anomaly for a Dependent Child.

(b) Birthmarks on head or neck.

(c) Webbed fingers or toes.

(d) Supernumery fingers or toes.

(e) Any other Medically Necessary Surgery related to an Illness or Injury.

(f) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

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

(ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and

(iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

(14) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(a) Surgical procedures of the jaw and gums.

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

(c) Emergency repair due to Injury to sound natural teeth, including the emergency replacement of sound natural teeth.

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

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

(f) External incision and drainage of cellulitis.

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

(h) Removal of impacted teeth.

(i) Intraoral imaging services in connection with a covered oral Surgery.

(j) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliance when provided because of an Accidental Injury.

(k) Cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants and the associated fixed and/or removable prosthetic appliances following Surgical resection of either benign or malignant lesions (not including inflammatory lesions).

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital for a patient 5 years of age and under, a patient who is severely disabled or to monitor the patient due to a behavioral condition or a serious underlying medical condition, such as heart condition, blood disorder, etc. or is necessary due to Accidental Injury to sound natural teeth.

(15) **Developmental Delay:** Testing and Medically Necessary treatment of developmental delay, including therapy.

(16) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.

(17) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card Program.

(18) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, and services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(19) **Dialysis:** Treatment of a kidney disorder by dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient 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 pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person’s home as shown under the Durable Medical Equipment benefit.

(20) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary; and

(b) The equipment will be provided on a rental basis; however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and

(c) Benefits will be limited to standard models as determined by the Plan; and

(d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair or motorized scooter; and

(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; and

(f) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(21) **Emergency Services:** The Plan will pay the greater of the following amounts for Emergency Services received from Non-Participating Providers (as required by law):

(a) The amount negotiated with Participating Providers for Emergency Services provided, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider. If there is more than one amount negotiated with Participating Providers for the Emergency Services provided the amount paid shall be the median of the negotiated amounts, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or

(b) The amount for the Emergency Services calculated using the same method the Plan generally uses to determine payments for services provided by a Non-Participating Provider (such as Usual and Customary Charge), excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or

(c) The amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Services, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(22) **Gender Reassignment Surgery:** Reconstructive Surgery for sex reassignment Surgery including mastectomy, gonadectomy, and/or genital reconstructive Surgery.

(23) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(24) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

(a) Home nursing care;

(b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Visits provided by a medical social worker (MSW);

(d) Physical, occupational, speech, or respiratory therapy if provided by the Home Health Care Agency;

(e) Medical supplies, drugs and medications prescribed by a Physician;

(f) Laboratory services; and

(g) Nutritional counseling by a licensed dietician.

In no event will the services of a Close Relative, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(25) **Hospice Care:** Hospice care on either an Inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.).

(d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:

(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical and speech therapy.

(e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

(f) Nutritional counseling by a licensed dietician.

(g) Respite care.

(h) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family after the patient's death. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's spouse, parents of a Dependent Child and/or Dependent Children who are covered under the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(26) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(27) **Infertility:** Diagnosis and testing of infertility (the inability to conceive) and the correction of an underlying medical condition. All other treatment, drugs or procedures for the promotion of conception will not be considered eligible (e.g., invitro fertilization, GIFT, artificial insemination, etc.).

(28) **Infusion Therapy:** Services, supplies and equipment necessary for infusion therapy provided:

(a) By a free-standing facility;

(b) By an outpatient department of a Hospital;

(c) By a Physician in his/her office; or

(d) In your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient infusion therapy services and supplies are Covered Expenses:

(a) The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;

(b) Professional services;

(c) Total parenteral nutrition (TPN);

(d) Chemotherapy;

(e) Drug therapy (includes antibiotic and antivirals);

(f) Pain management (narcotics); and

(g) Hydration therapy (includes fluids, electrolytes and other additives).

(29) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(30) **Maternity:** Expenses Incurred by all Covered Persons for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center.

(d) Amniocentesis testing when Medically Necessary.

(e) Up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary).

(f) Elective induced abortions only when carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performance of any abortion for any Covered Person, any expenses Incurred to treat those complications will be eligible, whether the abortion was eligible or not.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(31) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, ostomy supplies, orthotics (excluding foot orthotics), prescribed compression garments, Surgical dressings and other Medically Necessary supplies ordered by a Physician.

(32) **Mental Disorders:** Care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism, ADD and ADHD and family counseling. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(33) **Nutritional Counseling:** Services related to nutritional counseling for a covered medical condition. Nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(34) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life for Covered Persons who are or will become malnourished or suffer from disorders, which left untreated will cause chronic disability or intellectual disability. Covered Expenses include rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation, and special dietary treatment when prescribed by a Physician for Covered Persons with inherited metabolic diseases, such as phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(35) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(36) **Off-Label Drug Use:** Services and supplies related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(a) The named drug is not specifically excluded under the General Exclusions and Limitations section of the Plan; and

(b) The named drug has been approved by the FDA; and

(c) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

(d) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

(37) **Outpatient Pre-Admission Testing:** Outpatient pre-admission testing performed prior to a scheduled Inpatient hospitalization or Surgery.

(38) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. This includes Medically Necessary aquatic therapy (hydrotherapy or pool therapy) for musculoskeletal conditions when provided by a physical therapist or other recognized, licensed provider. Eligible expenses include the professional charges for physical therapy modalities administered in a pool, which require direct one-on-one patient contact. Charges for aquatic exercise programs or separate charges for use of a pool are not covered. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(39) **Physician’s Services:** Services of a Physician for medical care or Surgery.

(a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, allergy shots, x-ray and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery. If more than one Physician is seen in the same clinic on the same day, only one Copay will apply.

(b) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.

(c) For surgical assistance by an Assistant Surgeon, the charge will be 25% of the corresponding Surgery.

(d) Telemedicine: Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

(e) Teladoc: Teladoc provides 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. Teladoc services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

For any questions with respect to Teladoc, please contact the Plan Administrator. Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in the Teladoc program. To learn more about Teladoc, see the Teladoc contact information under General Plan Information section of the Plan.

Teladoc benefits include:

- 24/7/365 access to a Physician online or by phone.
- Fast treatment.
- Talk to a Teladoc Physician from anywhere at home, work, or while traveling.
- Save money by avoiding expensive urgent care or emergency room visits.

Call your Teladoc provider:

- When you need care now.
- If you’re considering the emergency room or urgent care center for non-emergency issues.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

Teladoc providers treat conditions such as:

- Cold and flu
- Bronchitis
- Respiratory infection
- Sinus problems
- Allergies
- Urinary tract infection
- Pediatric care
- Poison ivy
- Pink eye
- Ear infections

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(40) **Podiatry:** Treatment for the following foot conditions: (a) bunions, when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed or treatment of ingrown toenails; (d) any Medically Necessary Surgical Procedure required for a foot condition. In addition, orthopedic shoes when an integral part of a leg brace will also be covered.

(41) **Prescription Drugs:** Prescription Drugs, injectables or supplies used for the treatment of a covered Illness or Injury, which are dispensed through the Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, and take-home Prescription Drugs from a Hospital are covered under the major medical benefits of this Plan and separate from the Prescription Drug Card Program benefits. If the Plan has a Specialty Drug program in place, Specialty Drugs will only be eligible under this provision if those drugs fall outside the Specialty Pharmacy Program (as noted in the Prescription Drug Card Program section). Benefits will be paid as billed by provider.

(42) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(iii) Prevention for Children

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(iv) Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include Inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

(B) Screening for gestational diabetes. A maximum of 5 screenings for gestational diabetes shall be covered in pregnant women.

(C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to 1 screening every 3 Plan Years.

(D) Counseling annually for sexually transmitted infections (including for the human immunodeficiency virus (HIV)) and screening annually for HIV for all sexually active women. Limited to 2 counseling sessions per Plan Year.

(E) Screening and counseling annually for interpersonal and domestic violence.

(F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include sterilization implant (Essure) and surgical sterilization (Sterilization) either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense.

(G) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.

(2) Breastfeeding equipment will be covered, subject to the following:

(i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

(ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last 3 Plan Years and provided the Covered Person remains continuously enrolled in the Plan.

(3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.hrsa.gov/womens-guidelines. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

(v) Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

(b) Routine Care

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or immunizations (including flu vaccines), well child care, pap smears, mammograms, routine eye exams (including refraction), colon exams and PSA testing. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

(43) **Prosthetic Devices:** Artificial limbs, eyes, post mastectomy bras or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis 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. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(44) **Qualified Clinical Trial Expenses:** Please refer to the CancerCARE Program section of the Plan for information related to Qualified Clinical Trial Expenses for cancer.

For all other Qualified Clinical Trials, eligible expenses are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a “life threatening condition” means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a “qualifying individual” means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

(a) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments; or

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(45) **Radiation Therapy:** Radium and radioactive isotope therapy treatment.

(46) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.

(47) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(48) **Respiratory/Pulmonary Therapy:** Respiratory/pulmonary therapy under the recommendation of a Physician.

(49) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the newborn's expense.

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 eligible expense.

(50) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

(51) **Skilled Nursing Facility:** Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(52) **Sleep Disorders:** Sleep disorder treatment and sleep studies that are Medically Necessary.

(53) **Speech Therapy:** Restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury or Surgery or therapy to correct a Congenital Anomaly. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(54) **Sterilization:** Elective sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan.

(55) **Substance Use Disorders:** Care, supplies and treatment of a Substance Use Disorder, including family counseling. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(56) **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves and other tissues related to the temporomandibular joint. Treatment shall include:

(a) Only one of the following:

(i) A clinical evaluation, to include examination, history, ordering of necessary diagnostic procedures, such as radiographs, study models if necessary, muscle testing, evaluation of results and consultation with the patient.

(ii) A total diagnostic evaluation including, but not limited to history, examination, radiographs, study models and a patient consultation.

(b) Diagnostic services, including but not limited to:

(i) Panoramic radiographs

(ii) Cephalometric radiographs with tracing

(iii) Temporomandibular joint tomography

(iv) Temporomandibular joint arthrography

(v) Skull series; computerized tomography of temporomandibular joint

(vi) Manual muscle testing procedures

And one of the following:

(i) Electromyography of cranial supplied nerves

(ii) Electronic computerized neuromuscular testing

(iii) Oscilloscopic neuromuscular testing

The maximum benefit payment, after application of any payment provisions, will be the allowable amount for conventional electromyography, or neuromuscular-type test.

(c) Non-Surgical initial treatment procedures (reversible Phase 1) limited to:

(i) Orthopedic repositioning appliances (maxillary or mandibular).

(ii) Orthopedic (orthotic) splints (such as nite-guards, bite blocks, bite openers, bite plates, muscle de-programmer).

(iii) Physical therapy procedures (limited to transcutaneous electrical nerve stimulators, Galvanic stimulation, ultrasound, diathermy).

(iv) Trigger point injections.

Exclusions:

(i) Equilibration of occlusion

(ii) Massage, either manual or by machine

(iii) Coronoplasty

(iv) Acupuncture or dry needling

(v) Occlusal adjustment

(vi) Cold packs

(vii) Slides and/or photographs

(viii) Range of motion treatments

(ix) Non-Prescription Drugs

(x) Diet survey

(xi) Vitamins

(xii) Nutrition counseling

(xiii) Nutrition supplements

(xiv) Office visits

(xv) Stretching and other exercises

(xvi) Hot packs

(xvii) Coolant sprays

(xviii) Moist heat therapy

(xix) Orthodontic treatment, including both fixed and removable appliances used for the purpose of moving teeth

(xx) Rental or purchase of transcutaneous electrical nerve stimulators

(xxi) Periapical, bitewing and full-mouth radiographs

(d) Surgical procedures

Final stabilization non-Surgical (irreversible Phase II) treatment.

(57) **Transplants (other than those received through the Aetna IOE Program):** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures.

(a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

(b) If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

(c) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.

(d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

See the Aetna Institute of Excellence (IOE) Program section of the Plan with respect to coverage for transplants received through the Aetna IOE Program.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Exclusions:

(a) Non-human and artificial organ transplants.

(b) The purchase price of bone marrow, any organ, tissue or any similar items which are sold rather than donated.

(c) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

(d) Lodging expenses, including meals.

(e) Expenses related to the Covered Person's travel.

(58) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

AETNA INSTITUTE OF EXCELLENCE (IOE) PROGRAM

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses
Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you or your Physician should call the Medical Management Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility or that is an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility or that is not an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna, even if the facility is considered a Participating Provider for other types of services, will be covered at the Non-Participating Provider level. Please read each section below carefully.

Covered Transplant Expenses
Covered transplant expenses include the following:

(1) Charges for activating the donor search process with national registries.

(2) Compatibility testing of prospective organ donors that are immediate family members. For purposes of this section an “immediate” family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.

(3) Inpatient and outpatient expenses directly related to a transplant.

(4) Charges made by a Physician or a transplant team.

(5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

(6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically Incurred during the 4 phases of transplant care described below. Expenses Incurred for one transplant during these 4 phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The 4 phases of one transplant occurrence and a summary of covered transplant expense during each phase are as follows:

(1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program.

(2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.

(3) Transplant event. A transplant event includes Inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more Surgical Procedures or medical therapies for a transplant; Prescription Drugs provided during your Inpatient stay or outpatient visits, including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or outpatient visits; cadaveric and live donor procurement.

(4) Follow-up care. Follow-up care includes all covered transplant expenses; home health care services; home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

One Transplant Occurrence
The following are considered one transplant occurrence:

(1) Heart.

(2) Lung.

(3) Heart/Lung.

(4) Simultaneous Pancreas Kidney (SPK).

(5) Pancreas.

(6) Kidney.

(7) Liver.

(8) Intestine.

(9) Bone marrow/stem cell transplant.

(10) Multiple organs replaced during one transplant Surgery.

(11) Tandem transplants (stem cell).

(12) Sequential transplants.

(13) Re-transplant of same organ type within 180 days of first transplant.

(14) Any other single organ transplant, unless otherwise excluded under the Plan.

More Than One Transplant Occurrence
The following are considered more than one transplant occurrence:

(1) Autologous blood/bone marrow transplant followed by allogeneic blood/bone marrow transplant (when not part of a tandem transplant).

(2) Allogeneic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).

(3) Re-transplant after 180 days of the first transplant.

(4) Pancreas transplant following a kidney transplant.

(5) A transplant necessitated by an additional organ failure during the original transplant Surgery/process.

(6) More than one transplant when not performed as part of a planned tandem or sequential transplant (i.e. a liver transplant with subsequent heart transplant).

Limitations
Transplant coverage does not include charges for the following:

(1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

(2) Services and supplies furnished to a donor when recipient is not a Covered Person.

(3) Home infusion therapy after the transplant occurrence.

(4) Harvesting or storage of organs without the expectation of immediate transplant for an existing Illness.

(5) Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing Illness.

(6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Travel and Lodging Expenses
Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

(1) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence.

(2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed per IRS guidelines.

(3) Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, to a maximum of $100 per night.

(4) Overall maximum. Travel and lodging reimbursements are limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion and donor.

(5) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

CANCERCARE PROGRAM COVERAGE

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

CancerCARE Benefits	
Participating Providers	
Compliant Benefit	**Non-Compliant Benefit**
• Standard Plan Benefits apply as outlined within the Medical Schedule of Benefits • Certain Course of Care Certification requirements waived for services included in a confirmed Value Pathway • Covered Persons choosing not to travel to a COE Network Provider for complex care, but receiving care in concordance to a Value Pathway • Clinical Trials as defined below • Navigator or Compass Covered Persons receiving cancer care when a Value Pathway does not exist if Clear Value Participation has been achieved with NCCN Guideline® concordance or Plan-approved deviation • CancerCARE Second Opinion Benefits at 100% of CancerCARE Allowable, Conventional Deductible does not apply; HDHP 1 and HDHP 2 Deductible applies • Travel Benefits at 100%, Conventional Deductible does not apply; HDHP 1 and HDHP 2 Deductible applies	• Standard Plan Benefits apply as outlined within the Medical Schedule of Benefits

DEFINITIONS

CancerCARE Allowable: For Inpatient and outpatient Hospital and professional services, CancerCARE Allowable means billed charges for covered services provided in compliance with the CancerCARE Program, minus non-covered services and supplies, negotiated price concessions, discounts and professional charges beyond Usual and Customary fees for such services. Once treatment is precertified by the Plan for services from a COE Network Provider, payment to the provider will be paid at the applicable benefit reimbursement percentage based on the applicable contract allowable.

For covered cancer pharmacy products and supplies, CancerCARE Allowable means pharmacy products dispensed in concordance with the NCCN Guidelines and Drugs & Biologics Compendium®, with Category 1, 2a or 2b level of evidence, which are then payable at a Plan maximum benefit of AWP plus 40% unless provided at a Participating Provider. Pharmacy and dosing instructions are included in the evidence-based NCCN Guidelines®. Non-covered cancer pharmacy products are not included in the CancerCARE Allowable.

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

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

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

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

Risk Management Group: Covered Person groups based upon diagnosis or staging. The three groups are Explorer, Navigator and Compass. CancerCARE will notify the Covered Person to which group he/she has been assigned.

COE Network Provider: A cancer center, hospital or other institution, Physician or ancillary provider that has been designated by the CancerCARE Program to provide complex cancer care services. COE Network Providers must have their designation as a National Cancer Institute (NCI) Cancer Center or NCCN® member institution and be a member of the Aetna Network.

Pathology/DiagnosticCOE: A Network of highly specialized pathology labs identified by CancerCARE's Medical Advisory Board to affirm diagnoses for commonly misdiagnosed cancer types. Pathology/DiagnosticCOE access is arranged by the CancerCARE Triage Center based on Covered Person-reported diagnosis during the triage center registration. The Pathology/DiagnosticCOE is comprised of only COE Network Providers in the Aetna Network.

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

Non-Compliant Benefit: If the Covered Person does not comply with the requirements of the CancerCARE Program, achieve a Compliant Benefit Level, or attend a Participating Provider, the Plan's standard benefits apply as outlined within the Medical Schedule of Benefits.

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

Course of Care Certification Waiver: Precertification for CancerCARE confirmed Value Pathway courses of treatment is required, but precertification for services and products included in each Value Pathway is waived if 1) the Covered Person has enrolled in the CancerCARE Program, and 2) the Covered Person has obtained a Compliant Benefit Level status. Course of Care Certification Waiver for courses of treatment shall apply to COE Network Providers if they achieve Clear Value Participation.

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

ADDITIONAL PROVISIONS

Registration Requirement: Upon diagnosis of cancer of any type, Covered Persons shall call the CancerCARE Program at (877) 640-9610 for registration into the Program. Failure to register with the CancerCARE Program will reduce benefits to the Non-Compliant Benefit Level as outlined above.

COE Travel Benefits: The Plan provides a maximum travel and lodging benefit up to $10,000 per Covered Person per lifetime. Travel benefits will only apply for Covered Persons with cancer diagnoses or conditions as described within the COE Referral provision that have been directed to a COE Network Provider by the CancerCARE Program. The COE Network Provider location must be at least 50 miles from the Covered Person's home. Travel and lodging assistance shall be coordinated by the CancerCARE Program. While receiving care at a COE Network Provider, the Plan will reimburse lodging, meals and incidentals. The Plan covers travel costs (coach air, train or mileage at Internal Revenue Service "IRS" Standard Mileage Rate for travel by car) for the Covered Persons plus one companion if the Covered Person is an adult (18 or older), or up to 2 companions if the Covered Person is less than 18. The benefit is subject to INTERLINK's CancerCARE Program coordination and approval guidelines.

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

Clinical Trial Benefits: The Plan provides Clinical Trial coverage for Routine Patient Costs consistent with applicable law. Routine Patient Costs will not be considered Experimental and/or Investigational for Covered Persons accepted into an Approved Clinical Trial (as defined by Section 2709(d) of the Public Health Services Act). Routine Patient Costs are limited to: (1) covered health services for which benefits are typically provided in the absence of a Clinical Trial; (2) covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects or item of service, or the prevention of complications; and (3) covered health services needed for reasonable and necessary care arising for the provision of an investigational item or service.

Routine Patient Costs for a Clinical Trial do not include: (1) the investigational item, device, or service itself; (2) 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; and (3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. These items shall be considered Experimental and/or Investigational and are excluded.

Routine Patient Costs shall be reimbursed at the Compliant Benefit level, provided that the Clinical Trial: (1) is provided at a COE Network Provider; and (2) is a Phase 1-4 Clinical Trial, that has been approved and coordinated by a CancerCARE Program Nurse. Otherwise, Routine Patient Costs shall be reimbursed per standard Plan benefits as outlined in the Medical Schedule of Benefits section.

Covered Persons will be reimbursed at the Non-Compliant Benefit level for participation at a Non-Participating Provider only if Non-Participating Provider benefits are otherwise provided by the Plan.

Covered Persons are encouraged to contact CancerCARE at (877) 640-9610 for further information on clinical trial coverage.

Questions: If there are any questions regarding coverage or a specific provision of the CancerCARE Program, please contact the Plan Administrator or the CancerCARE Program at (877) 640-9610.

KEEP IT SIMPLE SURGERY (KISX) PROGRAM

The Keep It Simple Surgery (KISx) Program includes services and supplies rendered for certain outpatient surgical and non-surgical treatment for a medical condition. Expenses include a bundled cost for facility and professional charges, supplies and equipment Incurred at a KISx-contracted facility. Selecting a KISx provider for non-emergency procedures and services may result in a lower cost to the Plan as well as a lower cost to you. The choice of provider is entirely up to you.

You and your eligible Dependents may seek services through the KISx Program and receive care and treatment at no cost. If you are required to satisfy a Deductible amount, prior to receiving services through this Plan, you may be eligible for a cash incentive distributed through the KISx Program.

Expenses Incurred by a KISx provider are considered eligible expenses when such services are Medically Necessary and not otherwise excluded under the Plan.

Outpatient procedures and services available through the KISx Program include, but are not limited to:

- Colonoscopies
- Orthopedic Surgeries
- General Surgeries
- MRIs, CT and PET Scans

You may access a complete list of eligible services and providers under the KISx Program by visiting the KISx website at www.getkisx.com or call (877) 438-5479. KISx advocates can provide details regarding medical procedures and services offered through the program.

The KISx Program does not offer:

- Pediatric services
- Travel and lodging reimbursement

ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

(1) **Abortions:** Expenses related to elective abortions will not be considered eligible, except as specified under the Maternity benefit under Eligible Medical Expenses.

(2) **Acupuncture or Dry Needling:** Expenses for acupuncture or dry needling will not be considered eligible.

(3) **Administrative Services:** Expenses for completion of claim forms and shipping and handling will not be considered eligible.

(4) **Adoption:** Expenses related to adoption will not be considered eligible.

(5) **After Termination Date:** Expenses which are Incurred after the termination date of your coverage under the Plan will not be considered eligible.

(6) **Assessments:** Expenses for any assessment to attend an alcohol and drug safety action program by a diversion agreement or by court order will not be considered eligible.

(7) **Automatic External Defibrillators:** Expenses for automatic external defibrillators will not be considered eligible.

(8) **Autopsies:** Expenses for autopsies will not be considered eligible.

(9) **Biofeedback:** Expenses related to biofeedback will not be considered eligible, except for urinary incontinence in Covered Persons age 18 and older.

(10) **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(11) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

(12) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

(13) **Cognitive Therapy:** Expenses for cognitive therapy will not be considered eligible. Cognitive therapy is a service provided to retain or enhance information processing due to brain damage or brain dysfunction which alters the way in which a person perceives or responds. These therapies include, but are not limited to treatment of memory loss, problem solving difficulties, short attention span, or inability to scan visually. Cognitive therapy services may also be known as multi-sensory programs, educational therapies, perceptual therapies, sensory integration, auditory integrative training, augmentative/alternative communication, discrete training trials, or similar therapies. Cognitive therapy services do not apply to neuropsychological testing. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD or autism.

(14) **Communication Devices:** Expenses for any device used for enhancing or enabling communication will not be considered eligible, except for an electrolarynx.

(15) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible. This exclusion does not apply to complications from abortions as specified under Eligible Medical Expenses.

(16) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible.

(17) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.

(18) **Counseling:** Expenses for religious, marital, family, bereavement or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

(19) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(20) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses.

(21) **Exercise Programs:** Expenses for exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(22) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational, including any related complications will not be considered eligible, except for Off-Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses.

(23) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible, unless for metabolic or peripheral vascular disease.

(24) **Foot Orthotics:** Expenses for foot only orthotics, orthopedic shoes (except those that are an integral part of a leg brace), arch supports or for the exam, prescription or fitting thereof will not be considered eligible.

(25) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(26) **Hair Loss:** Expenses for hair loss, hair transplants, wigs or any drug that promises hair growth, whether or not prescribed by a Physician, will not be considered eligible. This exclusion does not apply to the Medically Necessary treatment of alopecia areata.

(27) **Hearing Exams/Aids:** Expenses for routine hearing examinations, hearing aids (including the fitting thereof) and supplies will not be considered eligible. This exclusion does not apply to a cochlear implant and implanted bone anchored hearing aids. This exclusion does not apply to any expenses otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(28) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(29) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.

(30) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(31) **Infertility:** Expenses for confinement, treatment or services related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible, except diagnosis and testing of infertility and the correction of an underlying medical condition as specified under Eligible Medical Expenses.

Nothing in this section is intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).

(32) **Legal Proceedings:** Expenses for diagnostic tests and evaluations ordered, requested or performed solely for the purpose of resolving issues in the context of legal proceedings, including those concerning custody, visitation, termination of parental rights, civil damages or criminal actions will not be considered eligible.

(33) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(34) **Massage Therapy:** Expenses for massage therapy or Rolfing will not be considered eligible.

(35) Mass Screenings: Expenses for services associated with any mass screening type of physical or health examination, except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services, will not be considered eligible. Examples of mass screenings are mobile vans and school testing programs.

(36) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(37) **Missed Appointments:** Expenses for missed appointments will not be considered eligible.

(38) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's Plan to be primary.

(39) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(40) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(41) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(42) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(43) **Obesity:** Expenses for surgical and non-surgical care and treatment of obesity including weight loss, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

Additionally, expenses for surgical and non-surgical treatment of Morbid Obesity will not be considered eligible.

(44) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

(45) **Operated by the Government:** 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.

(46) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.

(47) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(48) **Plan Maximums:** Expenses for charges in excess of Plan maximums will not be considered eligible.

(49) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(50) **Private Duty Nursing:** Expenses for private duty nursing will not be considered eligible, except those nursing services which are considered eligible under the Home Health Care and Hospice Care benefits.

(51) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(52) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.

(53) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

(54) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(55) **Rest Cures:** Expenses for rest cures will not be considered eligible.

(56) **Riot/Revolt:** Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(57) **Schools:** Expenses for any service provided through a district pursuant to an Individual Education Plan (IEP) as required under any federal or state law will not be considered eligible. This exclusion applies whether or not you choose to waive your rights to these services.

(58) **Sexual Dysfunction/Impotence:** Expenses for services, supplies or drugs related to sexual dysfunction/ impotence will not be considered eligible, except as specified under the Prescription Drug Card Program. Expenses for sex therapy will not be considered eligible. This exclusion does not apply to penile prosthesis required for physiological impotence (not psychological) due to trauma, radical pelvic Surgery, diabetes, Peyronie's Disease, vascular or neurological diseases.

(59) **Smoking Cessation:** Expenses for smoking cessation programs, including smoking deterrents will not be considered eligible, unless otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(60) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

(61) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(62) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to preventive services for any Covered Person as described under the Eligible Medical Expenses section of the Plan.

(63) **Travel:** Expenses for travel will not be considered eligible, except as specified under the CancerCARE Program and under the Eligible Medical Expenses section of the Plan.

(64) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(65) **Vision Care:** Expenses for vision care, including professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible, except routine eye exams as specified under Eligible Medical Expenses. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages.

(66) **Vision Therapy:** Expenses for vision therapy/orthoptic therapy will not be considered eligible.

(67) **War:** Expenses for the treatment of Illness or Injury resulting from actively participating in a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(68) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Emergency Medical Condition admissions on a Friday, Saturday or Sunday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(69) **Workers' Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Plan.

PRESCRIPTION DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed by a Physician or authorized prescriber and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician; diabetic supplies; sexual dysfunction/impotence medication; growth hormones and contraceptives (regardless of intended use). See the Prescription Drug Schedule of Benefits for any cost-sharing provisions, if applicable.

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 34-day supply.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for certain medications that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under the medical benefits section of the Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for certain medications that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician must be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician’s office, infusion center or other clinical setting, or the Covered Person’s home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Brand Name Drug: Means a trade name medication.

Generic Drug: 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.

Non-Preferred Drug: Any Brand Name drugs that do not appear on the list of Preferred Drugs.

Preferred Drug: A list of Brand Name drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. The list of Brand Name drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Prescription Drug Card Program Administrator will have a list of Preferred Drugs available.

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

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Specialty Drug means those Prescription Drugs, medicines, agents, substances and other therapeutic products that include one or more of the following particular characteristics:

(1) Address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis);

(2) Require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste;

(3) Limited pharmaceutical supply chain distribution as determined by the applicable drug's manufacturer; and/or

(4) Relative expense.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

Qualified Beneficiary
In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

If the qualifying event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, a covered Retiree and his or her covered spouse, surviving spouse or Dependent child of such retiree will also be considered qualified beneficiaries provided the bankruptcy results in the loss of their coverage under the Plan.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event
If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

(1) Your spouse/parent-Employee dies;

(2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or

(3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of; (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Extension of 18-Month Continuation Coverage Period

If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Notice Requirement

The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

(1) Name and address of the covered Employee or former Employee;

(2) Name and address of your Spouse, former Spouse and any Dependent Children;

(3) Description of the qualifying event; and

(4) Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

(1) Name of person deemed disabled;

(2) Date of disability determination; and

(3) Copy of SSA determination letter.

If you cannot provide a copy of the SSA's determination by the deadline, complete and provide the notice as instructed and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage will be available until the copy of the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

WEX Health Inc., a WEX Company
700 26th Ave., E.
West Fargo, ND 58078
(877) 765-8810 or (701) 239-6420

Termination of COBRA Continuation Coverage
COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

(1) The date the Plan Sponsor ceases to provide any group health plan coverage;

(2) The date on which the qualified beneficiary fails to pay the required contribution;

(3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first); or

(4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage
Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you may be required to pay up to 150% of the actual cost of coverage you elect for the 11-month extension period.

Additional Information
Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified on the General Plan Information page of this Plan.

Current Addresses
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

(1) The date of service;

(2) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges (including Network repricing information);

(6) The name of the Plan;

(7) The name of the covered Employee; and

(8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a "claim" since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Third Party Administrator within one year following the date services were Incurred. Claims filed after this time period will be denied.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination
If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the denial;

(2) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim;

(4) An explanation of why the additional material or information is necessary;

(5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a);

(7) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and

(8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

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

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initial Adverse Benefit Determination
If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

(2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

(4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initial adverse benefit determinations (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

Deadline for Internal Review of Initial Adverse Benefit Determinations

(1) Urgent Care Claims. The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(2) Pre-Service Claims. The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(3) Post-Service Claims. The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initial Adverse Benefit Determinations

Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

(1) A description of the Plan’s decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a);

(6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;

(7) If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request; and

(8) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your state insurance regulatory agency."

Any notice of adverse determination will include the following information:

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

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Calculation of Time Periods
For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination
For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Adverse Benefit Determinations
If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with federal law.

Note that the federal external review process (including the expedited external review process described later in these procedures) is not available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

(1) An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

(2) A rescission of coverage.

For any adverse determination for which external review is available, the federal external review requirements are as follows:

(1) You have 4 months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

(2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review
You may request an expedited external review if you have received:

(1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received Emergency Services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this Plan.

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

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

(1) Any primary payer besides the Plan;

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

(3) Any policy of insurance from any insurance company or guarantor of a third-party;

(4) Workers' Compensation or other liability insurance company; or

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

Vehicle Limitation
When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses
"Allowable expenses" shall mean any Medically Necessary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

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

Other Plan
"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

(1) Group, blanket or franchise insurance coverage;

(2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

(3) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;

(4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

(5) Coverage under any Health Maintenance Organization (HMO); or

(6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

Order of Benefit Determination
For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

(1) A plan without a coordinating provision will always be the primary plan.

(2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.

(3) Active/laid-off employees or retirees: The plan which covers a person as an active employee (or as that employee’s dependent) determines its benefits before the plan which covers a person as a laid-off or retired employee (or as that employee’s dependent). If the plan which covers that person has not adopted this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

(4) Dependent Children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent 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.

(5) Dependent Children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

(a) The plan of the parent with custody pays first;

(b) The plan of the spouse of the parent with custody (the step-parent) pays next;

(c) The plan of the parent without custody pays next; and

(d) The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the Child’s health care expenses, the benefits of the plan that covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

(6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery
Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

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

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

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

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

(1) In error;

(2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

(3) Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences;

(4) With respect to an ineligible person;

(5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or

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

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage
You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid
In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you or your Dependents(s) are enrolled in the Plan due to your Retiree coverage, and you and/or your Dependent(s) did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over and rules concerning working disabled individuals (as discussed below).

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

(1) The Working Aged Rule: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

    If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your Incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

(2) The Working Disabled Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your Dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.

(3) End-Stage Renal Disease Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a 3-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to 3 months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

Medicare and COBRA
For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan’s Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE
The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

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

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

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

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

Subrogation

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

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

(4) The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:

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

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

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

(d) Workers' Compensation or other liability insurance company; or

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

The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

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

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

Covered Person is a Trustee Over Plan Assets

(1) Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

(a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

(b) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

(c) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

(d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

(3) No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

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

The Plan's benefits shall be excess to any of the following:

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

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

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

(4) Workers' Compensation or other liability insurance company; or

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

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

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

Obligations

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

(a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and cooperating in trial to preserve the Plan's rights;

(b) To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;

(f) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

(g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;

(h) To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;

(i) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

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

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

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

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

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

Language Interpretation
The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

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

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable state subrogation laws.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have 1 or 2 Assistant Surgeons. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's spouse, children, parents (including step-parents), sibling or legal guardian of the person receiving the service.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Expense means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

(2) For Prescription Drug expenses, any Prescription Drugs or medicines eligible for coverage under the Prescription Drug Card Program.

Covered Person means, individually, a covered employee or retiree and each of his or her Dependents who are covered under the Plan.

Custodial Care means care, or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the employee or retiree**,** who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

Durable Medical Equipment means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an Illness or Injury; and

(4) Is appropriate for use in the home.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

(2) Serious impairment to bodily functions; or

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

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

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

(2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

Employer means the Four County Mental Health Center, Inc. , or any successor thereto.

ERISA means the Employee Retirement Income Security Act of 1974, as may be amended from time to time.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

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

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or

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

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

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

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

Illness means a non-occupational bodily disorder, disease, physical sickness, pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

Incurred means the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special lifesaving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

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

Medically Necessary/Medical Necessity means treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

(1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

(2) "Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.

(3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

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

Morbid Obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Out-of-Pocket Maximum has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Physician means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Nurse Practitioner, Physician's Assistant, Speech Therapist, Speech Pathologist and Licensed Midwife (if covered by the Plan). An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the Four County Mental Health Center Health and Welfare Plan.

Plan Administrator means the administrator of the Plan in accordance with ERISA.

Plan Sponsor means Four County Mental Health Center, Inc. or any successor thereto.

Plan Year means the period from July 1 - June 30 each year.

Prescription Drug is defined in the "Prescription Drug Card Program" section of the Plan.

Primary Care Physician means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

Qualified Clinical Trial Please refer to the CancerCARE Program section of the Plan for information related to Qualified Clinical Trial Expenses for cancer.

For all others, Qualified Clinical Trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening condition and is described in (1), (2) or (3) below:

(1) The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   (a) The National Institutes of Health;

   (b) The Centers for Disease Control and Prevention;

   (c) The Agency for Health Care Research and Quality;

   (d) The Centers for Medicare & Medicaid Services;

   (e) A cooperative group or center of one of the entities described in (a) through (d) above;

   (f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or

   (g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly 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. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) nursing services are available 24 hours a day; and (8) the confinement is not for Custodial Care or maintenance care.

Residential Treatment Facility means a facility that provides 24-hour treatment for Mental Disorders or Substance Use Disorders on an Inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services. A Residential Treatment Facility is recognized if it is accredited for its stated purpose by the Joint Commission and carries out its stated purpose in compliance with all relevant state and local laws.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by 2 or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

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

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

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

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

(5) It has an effective utilization review plan.

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

(7) It is approved and licensed by Medicare.

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

Specialist means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g. cardiologist, neurologist, etc.).

Specialty Drug is defined in the "Prescription Drug Card Program" section of the Plan.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Surgery or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

Third Party Administrator means Meritain Health, Inc., P.O. Box 853921, Richardson, TX 75085-3921.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan's Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

(1) The duration and complexity of a service;

(2) Whether multiple procedures are billed at the same time, but no additional overhead is required;

(3) Whether an Assistant Surgeon is involved and necessary for the service;

(4) If follow up care is included;

(5) Whether there are any other characteristics that may modify or make a particular service unique; and

(6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

PLAN ADMINISTRATION

Delegation of Responsibility
The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions
The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

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

(2) To determine all questions of eligibility, status and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise a Third Party Administrator to pay claims;

(9) To perform all necessary reporting as required by federal or state law;

(10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;

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

(12) To perform each and every function necessary for or related to the Plan's administration.

Amendment or Termination of Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Assignment of Benefits
No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

Clerical Error
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Employer's general assets. If applicable, a biometric evaluation to determine health risk factors associated with a wellness program will be paid from the general assets of the Employer. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document
The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

Minimum Essential Coverage
Refer to the Employer's Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides "minimum essential coverage" within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides "minimum value" within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).

No Contract of Employment
This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of, the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Workers' Compensation
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

(1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you and your Dependents are entitled to certain rights and protections under ERISA. ERISA provides that you and your eligible Dependents are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) and updated Medical Benefit Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Medical Benefit Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your Employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you a daily penalty up to the statutory maximum amount until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(2) Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

(2) Ensure that any agents , to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for 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 PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

(a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

(1) The Plan documents have been amended to incorporate the above provisions; and

(2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose Genetic Information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include Genetic Information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA's standards for security (the "security standards"), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

(3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.

(4) Report to the Plan any Security Incident of which it becomes aware.

(5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

GENERAL PLAN INFORMATION

Name of Plan:	Four County Mental Health Center Health and Welfare Plan
Plan Sponsor: **(Named Fiduciary)**	Four County Mental Health Center, Inc. 3751 West Main Street Independence, KS 67301 (620) 331-1748
Plan Administrator:	Four County Mental Health Center, Inc. 3751 West Main Street Independence, KS 67301 (620) 331-1748
Plan Sponsor EIN:	40-0697159
Plan Year:	July 1 - June 30
Plan Number:	501
Meritain Health, Inc. Group Number:	18122
Plan Type:	Welfare benefit plan providing medical and Prescription Drug benefits.
Plan Funding:	All benefits are paid from the general assets of the Employer.
Contributions:	The cost of coverage under the Plan is funded in part by Employer contributions and in part by Employee contributions.
Third Party Administrator:	Meritain Health, Inc. P.O. Box 853921 Richardson, TX 75085-3921 (800) 925-2272
COBRA Administrator:	WEX Health Inc., a WEX Company 700 26th Ave., E. West Fargo, ND 58078 (877) 765-8810 or (701) 239-6420
Medical Management Program Administrator:	Meritain Health Medical Management 7400 West Campus Road, F-510 New Albany, OH 43054-8725 (800) 242-1199
Teladoc Program Administrator:	Teladoc, Inc. 1945 Lakepointe Drive Lewisville, TX 75057 (800) 835-2362 www.teladoc.com
Prescription Drug Card Program Administrator:	ESI (800) 334-8134 express-scripts.com

Agent for Service of Legal Process:	Four County Mental Health Center, Inc. 3751 West Main Street Independence, KS 67301 (620) 331-1748

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.

INSERT DENTAL PLAN POLICY HERE

INSERT VISION PLAN POLICY HERE

APPENDIX B
AFLAC PLAN

This Appendix B contains the terms and conditions specific to the Four County Mental Health Center AFLAC Plan that may be elected under Sections 4.01 and 4.02 of the Plan. Unless otherwise altered by the terms of this Appendix B, the terms and conditions of the Plan are incorporated into, and made applicable to, the AFLAC Plan.

Section B1.01 Eligibility/Plan Entry Dates. The eligibility conditions and the entry dates for the AFLAC Plan are the same as those for the Plan.

Section B1.02 Benefits Provided under Individual Policies or Group Contracts. Under the AFLAC Plan, the Participant may choose to receive benefits under one or more of the following policies of insurance:

(a) *Cancer Plan.* Benefits under this Cancer Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance or group contract, as applicable, issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.

(b) *Accident Plan.* Benefits under this Accident Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance or group contract, as applicable, issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.

(c) *Hospital Plan.* Benefits under this Hospital Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance or group contract, as applicable, issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.

(d) *Short Term Disability Plan.* Benefits under this Short Term Disability Plan are identical to those described in, and shall be paid pursuant to the terms of, the individual policy of insurance or group contract, as applicable, issued by AFLAC to the Participant. The provisions of that policy, as it may be amended from time to time, are incorporated herein by reference, solely as a description of the benefits provided by AFLAC.

Section B1.03 Obligation to Pay Benefits. The Employer makes no promise and shall have no obligation to provide or pay benefits under these individual policies or group contracts, as applicable, from its own assets. The rights and conditions with respect to the benefits payable under this AFLAC Plan shall be determined from each AFLAC policy. The Participant shall bear fully any and all risk of AFLAC's insolvency.

Section B1.04 Cost of Coverage. The Participant's monthly premiums are determined by AFLAC pursuant to the terms of the policy or policies issued by AFLAC to the Participant. Under the terms of those policies, AFLAC may have the right to change the amount of the applicable premium from time to time. The Participant must pay the entire cost of the monthly premium for coverage on a pre-tax or after-tax basis, as applicable.

Section B1.05 Election to Participate. A Participant who desires to receive benefits under one or more of the individual policies or group contracts, as applicable, listed in Section B1.02 above must elect to participate in this AFLAC Plan and must make arrangements to pay his/her share of the applicable premium. If a Participant does not elect to participate, the Employer will not provide him/her with any benefits under this Plan.

Section B1.06 Payment of Premium. A Participant who has elected to participate in this AFLAC Plan must pay the applicable premium for the benefits listed in Section B1.02(a)-(c) on a pre-tax basis (to the extent the benefit is payable on a pre-tax basis and the participant has so elected) by entering into a salary reduction agreement pursuant to the terms and provisions of the Plan. A Participant who has elected to participate in this AFLAC Plan must pay the applicable premium for the benefit listed in Section B1.02(d) on an after-tax basis by authorizing a payroll deduction in the amount of the applicable premium.

Section B1.07 Claims Administration. AFLAC will act as Claims Administrator with respect to any Claim for benefits under this AFLAC Plan. AFLAC has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims, in accordance with the terms of the individual policy or group contract, as applicable. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section B1.08 Termination of Participation. A Participant ceases to be a Participant as of the earliest of the following:

(a) The last effective date of coverage as specified by the individual policies or group contract;

(b) The date on which the Participant's election to participate expires;

(c) The end of a period for which a required contribution by the Participant was last paid, taking into account any grace periods required by law;

(d) The last day of the month in which the Participant ceases to be an Eligible Employee; or

(e) The date on which the AFLAC Plan terminates.

INSERT AFLAC PLAN POLICY HERE

APPENDIX C
HEALTH FLEXIBLE SPENDING ACCOUNT

This Appendix C contains the terms and conditions specific to the Four County Mental Health Center Health Flexible Spending Account benefit that may be elected under Section 4.01 of the Plan. Under this benefit, a Participant may be reimbursed, on a pre-tax basis, for Qualified Medical Expenses incurred during a Plan Year. Unless otherwise altered by the terms of this Appendix C, the terms and conditions of the Plan are incorporated into, and made applicable to, the Health FSA.

ARTICLE C-I
PARTICIPATION IN THE HEALTH FLEXIBLE SPENDING ACCOUNT

Section C1.01 Eligibility/Plan Entry Dates. The eligibility conditions and plan entry dates are the same as those for the Plan.

Section C1.02 Election to Participate. To become a Participant in this Health FSA, an Eligible Employee must make an election under the Plan to participate in this Health FSA. Such an election must be made pursuant to the terms and provisions of the Plan.

Section C1.03 Effective Date of Election. An election to participate in this Health FSA shall take effect as follows:

(a) If an Eligible Employee's election was made during the Annual Enrollment Period under the Plan, the election shall take effect as of the first day of the next Plan Year;

(b) If the Eligible Employee's election was made (and the completed election form was received by the Plan Administrator) on or before the date the Eligible Employee becomes a Participant in the Plan, the election shall take effect as of the date the Eligible Employee becomes a Participant; or

(c) If the Eligible Employee's election was made within 30 days after an event that would allow an election change to be made under the terms of the Plan, the election shall take effect as of the first day of the month on or after the date that the completed election form is received by the Plan Administrator; provided, however, that this Section C1.03(c) shall apply if and only if the Eligible Employee had not previously been a Participant in this Health FSA at any time during the Plan Year.

Section C1.04 Election Changes. Once an Eligible Employee has become a Participant in this Health FSA, he/she may make an election change after the beginning of a Plan Year in accordance with, and as permitted by, Article V.

Section C1.05 FMLA Leave. A Participant who is taking or returning from FMLA leave shall have the following options with respect to his/her participation in this Health FSA:

(a) *Taking FMLA Leave.* Upon commencement of FMLA leave, a Participant may continue his/her coverage under this Health FSA by continuing to pay the applicable premium during the period of the FMLA leave or by making such other arrangements as may be permitted under the provisions of the Plan. Alternatively,

upon commencement of FMLA leave, a Participant may revoke his/her participation in this Health FSA, in which event the Participant will no longer be covered under this Health FSA as of the date that his/her FMLA leave commenced.

(b) *Returning from FMLA Leave.* If a Participant's participation in this Health FSA was terminated when the Participant began his/her FMLA leave, the former Participant may, upon returning to work from an FMLA leave, elect to resume his/her participation in this Health FSA as of the date that he/she returns to work.

(i) Such a Participant may elect to resume coverage at the prior coverage level, in which event the Participant will be required to make up the premiums that would have been due during the period the Participant was on FMLA leave.

(ii) In lieu of making up the missed premiums, such a Participant may instead choose to resume coverage at a reduced level. In such an event, the Participant's coverage for the Plan Year shall be reduced on a pro rata basis by the portion of the Plan Year that the Participant was absent from work due to his/her FMLA leave.

ARTICLE C-II
MEDICAL REIMBURSEMENT

Section C2.01 Definition of a Dependent. The term "Dependent," for purposes of participation in this Health FSA, means the following:

(a) *Children Through Age 26.* The Participant's natural child, lawfully adopted child (including a child placed with the Participant for adoption but for whom the adoption is not yet final), stepchild, or other child for whom the Participant has obtained legal guardianship pursuant to a court order, until such child attains age 26 (or until such child attains age 18 in the case of a legal guardianship). Children placed with a Participant for adoption and Children who are the subject of a Qualified Medical Child Support Order will also be considered Dependents.

(b) *Disabled Children Above Age 26.* The Participant's natural child, lawfully adopted child (including a child placed with the Participant for adoption but for whom the adoption is not yet final), stepchild, or other child for whom the Participant has obtained legal guardianship pursuant to a court order, who is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical disability and for whom the Participant is the major source of financial support, from the end of the calendar month in which the Child attains age 26.

(c) *Non-Children Dependents.* Any relatives of the Participant who reside in the Participant's home, are claimed by the Participant as a tax dependent, and meet the definition of a tax dependent under Code § 152. This includes "any qualifying relative within the meaning of Code § 152(a)(2), without regard to Subsections (b)(1), (b)(2) or (d)(1)(B)."

Section C2.02 Qualified Medical Expense. The term "Qualified Medical Expense" means an expense incurred by the Participant, or by the Spouse or Dependent (as defined in Section C2.01 above) of a Participant, for medical care as defined in Code § 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. The term includes reimbursable Qualified Medical Expenses described under Section C2.06. It does not include premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer).

Section C2.03 [Reserved]

Section C2.04 Run-Out Period. The Run-Out Period means the period following the end of the Plan Year during which the prior Plan Year Claims may be submitted to the Employer for reimbursement. The Run-Out Period under this Health FSA ends 90 days from the last day of the Plan Year.

Section C2.05 Reimbursement.

(a) *General Rule*. The Employer will reimburse the Participant in the Plan Year for Qualified Medical Expenses incurred by the Participant during the Plan Year subject to the other limitations of this Health FSA.

(b) *Electronic Payments.* If the Employer permits the use of an electronic payment card, such as a debit card, such card may be used to pay for Qualified Medical Expenses at merchants and service providers which are authorized by the Employer.

The Employer will not make any reimbursement to a Participant if the Participant receives reimbursement for the expense through insurance or under any other means. The Employer will only reimburse for Qualified Medical Expenses incurred while the employee participates in the Health FSA. An expense is incurred when the Participant is provided with the medical care that gives rise to the Qualified Medical Expenses, and not when the Participant is formally billed or charged for, or pays for the medical care.

Section C2.06 Reimbursable Qualified Medical Expenses. The following expenses constitute Qualified Medical Expenses, as defined in C2.02, that may be reimbursed under this Health FSA:

(a) Deductibles and copayment amounts the Participant pays under his/her medical and/or dental and/or vision care coverage, which includes amounts paid for hospital bills, and doctor and dental bills;

(b) Medical and/or dental and/or vision care expenses in excess of usual, reasonable and customary rates; and

(c) Any Code § 213(d) medical, dental, or vision care expenses not reimbursed by insurance or otherwise, including medicine and drugs (whether purchased over-the-counter or with a prescription), and certain menstrual products (as defined in Code § 223(d)(2)(D)).

The Plan Administrator has discretion to construe and apply what may be reimbursable under this Plan in accordance with such final or informal guidance as the IRS might provide.

Section C2.07 Maximum Amount of Reimbursement. The maximum amount of reimbursement for any Plan Year is the dollar amount that the Participant elected to contribute to his/her Health FSA for that Plan Year, plus the amount, if any, of the contributions made by the Employer to the Participant's Health FSA for that Plan Year. The Employer will reimburse the Participant throughout the coverage period for Qualified Medical Expenses up to the maximum amount of reimbursement, as set forth in this Section, without regard to the actual amount that the Participant has contributed to his/her Health FSA as of the date a claim for reimbursement was submitted.

(a) *Limit on Amounts Elected by the Participant.* The dollar amount elected by the Participant may not exceed the dollar limit established by the Employer for that Plan Year.

(b) *Dollar Limit Established by the Employer.* The dollar limit established by the Employer for a Plan Year will be equal to the dollar limit set forth in the Code (as indexed annually for cost-of-living adjustments by the IRS); provided, however, that the Employer may elect to establish a lower dollar limit for a Plan Year.

(c) *Communication to Eligible Employees.* The dollar limit established by the Employer for a Plan Year must be communicated by the Plan Administrator to Eligible Employees in the enrollment materials for the Health FSA.

(d) *No Carryovers of Unused Amounts.* A Participant may not carry over an unused amount to a succeeding year.

Section C2.08 Withholding - Accounting. The Employer will establish and maintain a Health FSA for each Participant who has elected to receive the Health FSA benefit under this Health FSA. The Employer will credit to the Participant's Health FSA an amount of the Participant's Compensation which he/she elects to reduce. The amounts credited to the Participant's Health FSA are the property of the Employer until the Employer actually makes reimbursement to the Participant. The Employer will debit a Participant's Health FSA for the amount of the reimbursement made for the Participant. A Participant's Health FSA will never exceed the dollar amount specified in Section C2.07 above of this Health FSA.

Section C2.09 Year End Accounting - Forfeitures. The Employer will use the amount credited to a Participant's Health FSA for any Plan Year to reimburse the Participant for Qualified Medical Expenses or to make a "qualified reservist distribution" in accordance with Article C-IV, Sections C4.01 through C4.06 of this Appendix C. If any balance remains in the Participant's Health FSA for any Plan Year after the Employer has made the reimbursements and/or "qualified reservist distribution" for the Plan Year, the Participant will forfeit the unused amount. Within a given Plan Year, if the total forfeitures from all Participants exceed the total reimbursement amount, then the Health FSA will have a surplus. The amount of the surplus, if any, will be determined after the end of the Claims Run-Out Period, defined in C2.04, and after all pending Claims have been processed. Any surplus will be used to offset reasonable administrative costs.

Any excess still remaining after such costs are paid will be used to reduce the required premiums under the Health FSA for all Employees participating in the Health FSA in the Plan Year following the Year in which the surplus was created. Participants for this purpose will be determined on the date of the first payroll following the date on which the amount of surplus has been determined.

Section C2.10 Termination of Health FSA by the Employer - Forfeitures. If the Health FSA is terminated by the Employer either before or at the end of the Plan Year and the total contributions from all Participants exceed the total Health FSA reimbursements, then the Employer will use the surplus to offset reasonable administrative costs. Any surplus remaining after reasonable administrative costs have been paid shall be distributed *per capita* to all Participants who participated in the Health FSA in the year in which the surplus was gained. In no case will the surplus be allocated to a Participant based directly or indirectly on his/her Claims experience. The administrative costs will not be offset and the surplus, if any, will not be distributed until the Claims Run-Out period has expired and all pending Claims have been processed.

Section C2.11 Recoupment of Underwithheld Amounts. In the event that the amount withheld from a Participant's salary for his/her Health FSA contribution is less than the amount that should have been withheld pursuant to the Participant's election, whether by fault of the Participant or the Employer, the Employer shall seek recoupment of the amount of the insufficient withholding.

Section C2.12 Minimum Election Amount. The dollar amount elected by the Participant may not be less than the dollar amount established by the Employer for that Plan Year.

ARTICLE C-III
CLAIMS PROCEDURE

Section C3.01 Submission of Claims. A Participant desiring to be reimbursed for medical expenses must apply for reimbursement by completing the application form provided by the Claims Administrator. A Participant may also access his/her Health FSA through the use of an electronic payment card, provided that the Claim is properly adjudicated, as set forth in Section C3.03.

Subject to Section C5.01 of this Plan, a Participant must submit the application for reimbursement for expenses incurred during a Plan Year before the end of the Run-Out Period, defined in Section C2.04. The Claims Administrator may require the Participant to provide such information as may reasonably be required to process the Claims, including, but not limited to, the following:

(a) The amount, date incurred, and nature of each expense;

(b) The name of the person, organization, or entity with whom the expense was incurred;

(c) The name of the person for whom the expense was incurred;

(d) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and

(e) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

Such application shall be accompanied by a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense, and by such other bills, invoices, receipts, or other statements or documents that the Claims Administrator may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

Section C3.02 Claims Administration. Paylocity will act as Claims Administrator with respect to any claim for benefits under this Health FSA. Paylocity has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims.

Section C3.03 Electronic Payment Card Reimbursements. If the funds in a Health FSA are accessible by electronic debit card a Participant must comply with the substantiation and correction procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. A debit card that is presented as payment for a medical expense and denied at the point-of-sale (i.e., when the service or item is provided) does not constitute an initial Claim denial under these procedures.

Section C3.04 Limitation on Reimbursements With Respect to Certain Participants. Notwithstanding any other provision of this Health FSA, the Plan Administrator may limit the amounts reimbursed with respect to any Participant who is a highly compensated individual (within the meaning of Code §105(h)(5) or §125(e)) to the extent the Claims Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section C2.09 of this Health FSA.

Section C3.05 Time Frame for Deciding Claims. If any Claim for benefits under this Health FSA is denied, in whole or in part, then the Claims Administrator shall promptly furnish to the Claimant, within 30 days of receipt of the Claim, written notice:

(a) Setting forth the reason for the denial;

(b) Making reference to pertinent Health FSA provisions upon which the denial is based;

(c) Describing any additional material or information from the Claimant which is necessary and why;

(d) Referencing any internal rule, guideline, protocol, or similar criterion relied upon in making the adverse determination (if applicable); and

(e) Explaining the Claim review procedure set forth herein, including applicable time limits and a statement of the Claimant's right to bring a civil action under ERISA § 502(a) following an adverse determination upon review.

Section C3.06 Extension of Time Frame for Deciding Claims. The Claims Administrator may seek one extension of up to 15 days in order to make the benefit determination. The extension must be sought due to matters beyond the control of the Plan and the Claimant must be notified of the extension prior to the expiration of the initial 30 day period. If the extension is due to the

failure of the Claimant to submit information necessary to decide the Claim, the notice of extension shall specifically describe the required information and the Claimant shall have at least 45 days from receipt of the notice to provide the specified information. The period for making the benefit determination shall be tolled from the time the notification of extension is sent until the date on which the Claimant responds to the request for information.

Section C3.07 Appealing a Claim Denial. Any Claimant seeking review hereunder has 180 days to submit the Appeal. The Claimant may, upon request and free of charge, examine all pertinent documents and may submit issues and comments in writing.

Section C3.08 Time Frame for Deciding Appeal. The Plan Administrator shall render a decision on review no later than 60 days after receipt of the request for review hereunder.

Section C3.09 Decision on Appeal. In conducting the review, no deference shall be given to the initial adverse determination, and a plan fiduciary, other than the one who originally decided the Claim (or the person's subordinate), shall make the determination upon Appeal. The decision on review shall be in writing. If the Claim is once again denied, in whole or in part, then the notification shall (a) state the reason for the decision, (b) refer to the Health FSA provisions upon which it is based, (c) state that the Claimant is entitled to receive (upon request and free of charge) reasonable access to, and copies of, all relevant information, (d) describe any voluntary Appeals procedures, and (e) state the Claimant's right to bring an action under ERISA § 502(a).

ARTICLE C-IV
QUALIFIED RESERVIST DISTRIBUTIONS

Section C4.01 Qualified Reservist Distributions ("QRD"). A "qualified reservist distribution" is a distribution of all or a portion of the account balance of a Participant who is called to active military service, provided the call to active military service is for a period of 180 or more days or for an indefinite period of time.

Section C4.02 Amount of the QRD. Unless a lesser amount is specifically requested, the QRD will be the total of the Participant's contributions as of the date of the approval of the QRD request minus the amount of any Qualified Medical Expense reimbursements received as of the date of the request for the QRD.

Section C4.03 Time Frame for Requesting a QRD. A Participant must request a QRD on or after the date the Participant is called to active military service and prior to the end of the Run-Out Period immediately following the Plan Year in which the Participant is called to such service.

Section C4.04 Time Frame for Plan Administrator to Respond to a Request for a QRD. The Claims Administrator shall respond to any timely request for a QRD within 60 days of the date it receives the request, including providing payment of the distribution within such time frame if the request is approved. If the request is denied, the Claims Administrator shall follow the claims procedures set forth in Article C-III of this Appendix C, except that the time frame set forth in Section C3.05 shall be 60 days instead of 30 days.

Section C4.05 Eligible Claims. A Participant who requests a QRD forfeits the right to receive reimbursements for Qualified Medical Expenses incurred after the date of his/her last day of active employment. Such Participant shall be reimbursed for Qualified Medical Expenses properly submitted for reimbursement prior to the end of the Run-Out Period immediately following the end of the Plan Year and incurred on or prior to the last day of active employment, provided that the total dollar amount of such claims does not exceed the amount of the Participant's election minus the sum of his/her QRD and prior reimbursements received for the Plan Year.

Section C4.06 No Penalty on QRD. The QRD will not be subject to a distribution penalty. The amount of the QRD, however, will be included in the Participant's gross wages for the Plan Year in which the distribution is made, as required by the Internal Revenue Code and applicable IRS guidance.

ARTICLE C-V
TERMINATION OF PARTICIPATION IN THE HEALTH FLEXIBLE SPENDING ACCOUNT AND CONTINUATION OF COVERAGE

Section C5.01 Termination of Participation.

(a) *General Rule.* A Participant will cease participation in this Health FSA on the earlier of the following dates:

(i) The date on which this Health FSA terminates; or

(ii) The date on which the Participant ceases to be an Eligible Employee.

(b) *Effect of Ceasing to be a Participant*. If a Participant ceases to be a Participant in this Health FSA for any reason, the Participant's election to receive reimbursements for Qualified Medical Expenses terminates on that date. The Participant may only receive reimbursement for Qualified Medical Expenses incurred within the same Plan Year and prior to the first day after the day the Participant terminates participation in this Health FSA.

(c) *Continuation Coverage*. Notwithstanding anything in this Section to the contrary, an individual who would normally be required to terminate participation may continue to be a Participant in this Health FSA if and to the extent such an individual elects continuation of benefits under the rules in Section C5.02 below.

(d) *Reimbursement.* If a Participant ceases participation under this Health FSA, the Participant must apply for reimbursement in accordance with Article C-III within the 90-day period following the date the Participant ceases to be a Participant.

(e) *Electronic Payment Card.* A Participant will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in his/her Health FSA, effective the date of his/her termination from employment. Any claim submitted following a Participant's termination must be submitted in paper form.

Section C5.02 Continuation of Coverage. A Participant who will lose coverage under this Health FSA may have the right to continue coverage under this Health FSA if permitted under the terms and conditions of Article VIII except that (a) COBRA continuation coverage will not be offered if the Participant has overspent his/her account and (b) the maximum period of COBRA coverage described in Section 8.01(e) is limited to the remainder of the Plan Year.

Section C5.03 Limits on Continuation Coverage. Reimbursements under Section C5.02 above shall be made for expenses incurred in any Plan Year only if the Participant applies for such reimbursement in accordance with Article C-III within the Run-Out Period following the close of the Plan Year. In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements pursuant to Article C-III above. No reimbursement shall exceed the remaining balance, if any, in the Participant's health flexible spending account for the Plan Year in which the expenses were incurred.

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APPENDIX D
DEPENDENT CARE ASSISTANCE PLAN

This Appendix D contains the terms and conditions specific to the Four County Mental Health Center Dependent Care Assistance Plan that may be elected under Section 4.01 of the Plan. Under this DCAP, a Participant may be reimbursed, on a pre-tax basis, for Qualified Dependent Care Expenses incurred during a Plan Year. Unless otherwise altered by the terms of this Appendix D, the terms and conditions of the Plan are incorporated into, and made applicable to, this DCAP.

ARTICLE D-I
PARTICIPATION IN THE DEPENDENT CARE PLAN

Section D1.01 Eligibility/Plan Entry Dates. The eligibility conditions and plan entry dates are the same as those for the Plan.

Section D1.02 Election to Participate. To become a Participant in this DCAP, an Eligible Employee must make an election under the Plan to participate in this DCAP. Such an election must be made pursuant to the terms and provisions of the Plan.

Section D1.03 Effective Date of Election. An election to participate in this DCAP shall take effect as follows:

(a) If an Eligible Employee's election was made during the Annual Enrollment Period under the Plan, the election shall take effect as of the first day of the next Plan Year;

(b) If the Eligible Employee's election was made (and the completed election form was received by the Plan Administrator) on or before the date the Eligible Employee becomes a Participant in the Plan, the election shall take effect as of the date the Eligible Employee becomes a Participant; or

(c) If the Eligible Employee's election was made within 30 days after an event that would allow an election change to be made under the terms of the Plan, the election shall take effect as of the first day of the month on, or coincident with, the date that the completed election form is received by the Plan Administrator.

Section D1.04 Election Changes. A Participant in this DCAP may change his/her election during the middle of a Plan Year, either as to participation in this DCAP or as to the dollar amount of the benefit elected, if and only if such an election change is permitted under the terms of the Plan.

Section D1.05 Not An ERISA Plan. The DCAP is not an employer-sponsored employee benefits plan under ERISA.

ARTICLE D-II
DEPENDENT CARE REIMBURSEMENT

Section D2.01 Qualified Dependent Care Expense. The term "Qualified Dependent Care Expense" means an amount paid by the Participant for care of a Dependent, including related household services, which enables the Participant to be gainfully employed.

(a) *Dependent Care Expenses That Are Not "Qualified."* Qualified Dependent Care Expenses do not include the following:

(i) Amounts paid to a child of the Participant who is under age nineteen (19);

(ii) Amounts paid to an individual for whom the Participant or the Participant's Spouse is entitled to an exemption under Code § 151(c); and

(iii) Amounts paid to a dependent care center that is not a Dependent Care Center as defined in Section (d) below.

(b) *Special Rule for Services Performed Outside the Home.* Amounts paid for services performed outside the Participant's household are not Qualified Dependent Care Expenses unless the expenses are for a Dependent as defined in Section (c)(i) below or a Dependent as defined in Section (c)(ii) below who spends at least eight hours each day in the Participant's home.

(c) *Dependent.* For purposes of this DCAP benefit, the term "Dependent" means an individual meeting the conditions under subparagraphs (i), (ii), or (iii) below as follows:

(i) A tax dependent of the Participant as defined in Code § 152 who is:

(A) Under the age of thirteen (13); and

(B) The Participant's qualifying child as defined in Code § 152(a)(1).

or

(ii) A tax dependent of the Participant as defined in Code § 152, but determined without regard to Code § 152(b)(1), (b)(2) and (d)(1)(B), who:

(A) Is physically or mentally incapable of caring for himself/herself; and

(B) Has the same principal place of abode of the Participant for more than one-half of the calendar year;

or

(iii) A Participant's Spouse who:

(A) Is physically or mentally incapable of caring for himself/herself; and

(B) Has the same principal place of abode of the Participant for more than one-half of the calendar year.

Notwithstanding the foregoing, and in accordance with Code § 21(e)(5), in the case of divorced or legally separated parents, a Dependent who is a child shall be treated as a Dependent of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Dependent of the non-custodial parent.

(d) *Dependent Care Center.* The term "Dependent Care Center" means a facility, organized and operated in compliance with all applicable laws and regulations, for care of more than six persons, including one or more Dependents of the Participant, other than persons who reside there and which facility receives a fee, payment, or grant for providing services for any of the six individuals regardless of whether the facility operates at a profit.

Section D2.02 [Reserved]

Section D2.03 Run-Out Period. The Run-Out Period means the period following the end of the Plan Year during which the prior Plan Year Claims may be submitted to the Employer for reimbursement. The Run-Out Period under this DCAP ends 90 days from the last day of the Plan Year.

Section D2.04 Reimbursement. The Employer will reimburse a Participant for his/her Qualified Dependent Care Expenses incurred by the Participant during the Plan Year subject to the other limitations of this DCAP. The Employer will only reimburse for Qualified Dependent Care Expenses incurred while the Employee participated in the DCAP benefit under the Plan. An expense is incurred when the Participant is provided with the care that gives rise to the Qualified Dependent Care Expense, and not when the Participant is formally billed or charged for, or pays for the care.

(a) *Electronic Payments.* If the Employer permits the use of an electronic payment card, such as a debit card, such card may be used to pay for Qualified Dependent Care Expenses at merchants and service providers which are authorized by the Employer.

Section D2.05 Reimbursable Qualified Dependent Care Expenses. Reimbursable Qualified Dependent Care Expenses do not include:

(a) Education expenses for a child in kindergarten or any higher grade;

(b) Overnight care at a convalescent nursing home for a Dependent;

(c) Overnight camp;

(d) Expenses for lessons, tutoring, or certain types of transportation expenses;

(e) Expenses paid through another policy or DCAP of the Participant or the Participant's Spouse;

(f) Forfeited deposits, but may include application fees, agency fees, and deposits if the Participant is required to pay the expenses to obtain dependent care; or

(g) Expenses incurred before the Participant elected to participate in the DCAP benefit.

Section D2.06 Maximum Amount of Reimbursement. The maximum amount that a Participant may be reimbursed for Qualified Dependent Care Expenses that are incurred during a Plan Year is limited to the dollar amount that the Participant elected to contribute to the Participant's DCAP for that Plan Year.

(a) *Amount Elected by Participant for the Plan Year.* The dollar amount of the election that is made by a Participant for a Plan Year is subject to the following limitations:

(i) *Limitation on Elections to Comply with the Exclusion Limit Under Code § 129(a)(2).* A Participant's election must be limited so that, on a calendar year basis, the Participant does not exceed the exclusion limit set forth in Code § 129(a)(2). The exclusion limit for a calendar year is $5,000 or, in the case of a married Participant who is filing a separate return, $2,500.

(ii) *Earned Income Limitation.* As required by Code § 129(b), a Participant's election must further be limited so that, on a calendar year basis, the amount elected by the Participant does not exceed the earned income of that Participant or, for a Participant who is married as of the last day of a calendar year, the lesser of the earned income of the Participant or the earned income of the Participant's Spouse. The Claims Administrator will determine earned income pursuant to Code § 32(c)(2).

(iii) *Limit Announced by the Plan Administrator.* The dollar amount of a Participant's election for a Plan Year may not exceed the dollar limit, if any, that is announced by the Plan Administrator for that Plan Year.

(b) *Reimbursements Limited to Dollar Amounts Actually Credited to DCAP.* In no event will the reimbursements to a Participant exceed the dollar amount actually credited to the Participant's DCAP for the Plan Year minus amounts previously reimbursed for the Plan Year.

Section D2.07 Withholding - Accounting. The Employer will establish and maintain a DCAP for each Participant who has elected to receive the DCAP benefit under the Plan. The Employer will credit to the Participant's DCAP an amount of the Participant's Compensation which he/she elects to reduce. The amounts credited to the Participant's DCAP are the property of the Employer until the Employer actually makes reimbursement. The Employer will debit a Participant's DCAP for the amount of the reimbursement made to the Participant. A Participant's DCAP will never exceed the maximum amount specified in Section D2.06 above.

Section D2.08 Year End Accounting - Forfeitures. The Employer will use the amount credited to a Participant's DCAP for any Plan Year to reimburse the Participant for Qualified Dependent Care Expenses. If any balance remains in the Participant's DCAP for any Plan Year after the Employer has made all reimbursements for the Plan Year, the Participant will forfeit the unused amount. Within a given Plan Year, if the total forfeitures from all Participants exceed the total reimbursement amount, then the DCAP will have a surplus. The amount of the surplus, if any, will be determined after the end of the Claims Run-Out Period, defined in D2.03, and after all pending Claims have been processed. Any surplus will be used to offset reasonable administrative costs. Any

excess still remaining after such costs are paid will be used to reduce the required premiums under the DCAP for all Employees participating in the DCAP in the Plan Year following the Year in which the surplus was created. Participants for this purpose will be determined on the date of the first payroll following the date on which the amount of surplus has been determined.

Section D2.09 Minimum Election Amount. The dollar amount elected by the Participant may not be less than the dollar amount established by the Employer for that Plan Year.

ARTICLE D-III
CLAIMS PROCEDURES

Section D3.01 When to File a Claim. Subject to Section D4.01 of this Appendix D, the Participant must submit the application for reimbursement for expenses for a Plan Year no later than the end of the Run-Out Period.

Section D3.02 How to Submit Claims. A Participant desiring to be reimbursed for Qualified Dependent Care Expenses must make a Claim for reimbursement by completing the application form provided by the Claims Administrator. A Participant may also access his/her DCAP through the use of an electronic payment card, provided that the Claim is properly adjudicated, as set forth in Section D3.03.

The Claims Administrator may require the Participant to provide such information as may reasonably be required to process the Claims, including, but not limited to, the following:

(a) The amount and date of services rendered and the nature of each expense with respect to which a benefit is requested;

(b) The name of the person, organization, or entity to which the expense was, or is, to be paid;

(c) The signature of the daycare provider; and

(d) Such other information as the Claims Administrator may, from time to time, require.

Such application shall be accompanied by bills, invoices, receipts, or other statements or certifications showing the amounts of such expenses, together with any additional documentation which the Employer may request. Such application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense.

Claims may be filed by the Participant or by the Participant's duly authorized representative. Prior to recognizing any such appointment of an authorized representative, the Claims Administrator may require proof that the representative has been duly appointed.

Section D3.03 Claims Decisions. Paylocity will act as Claims Administrator with respect to any Claims for benefits under this DCAP. Paylocity has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit Claims. Except as otherwise provided by law, all decisions of the Claims Administrator shall be final and binding.

Section D3.04 Electronic Payment Card Reimbursements. If the funds in a DCAP are accessible by electronic debit card, a Participant must comply with the substantiation and correction procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. A debit card that is presented as payment for a dependent care expense and denied at the point-of-sale (i.e., when the service is provided) does not constitute an initial Claim denial under these procedures.

Section D3.05 Limitation on Reimbursements with Respect to Certain Participants. No more than twenty-five percent of the total amounts reimbursed from all dependent care assistance accounts maintained by all Participants under this DCAP during any Plan Year may be reimbursed with respect to the class of individuals who own more than five percent of the stock of the Employer (or their Spouses or dependents). Notwithstanding any other provision of this DCAP, the Claims Administrator may limit the amounts reimbursed with respect to any Participant who is a highly compensated employee (within the meaning of Code § 414(q)) to the extent the Claims Administrator deems such limitation to be advisable to assure compliance with the restriction described in the preceding sentence or with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section D2.08 above.

Section D3.06 Time Frame for Deciding Claims. The Claim for reimbursement shall be approved or denied within a reasonable period (but no later than 90 days) after receipt of the Claim by the Claims Administrator. The initial 90-day period begins at the time the Claim is filed, whether or not all the necessary information for determining the Claim is provided at that time.

Section D3.07 Extension of Time Frame for Deciding Claims. Notwithstanding Section D3.06 above, if the Claims Administrator determines that special circumstances require an extension of time (up to 90 days from the end of the initial 90-day period) for processing the Claim for reimbursement, written notice of the extension shall be furnished to the Participant before the end of the initial 90-day period. The written notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

Section D3.08 Notification Regarding the Claim Decision. If any Claim for reimbursement of expenses under this DCAP is denied, in whole or in part, then the Claims Administrator shall furnish the Participant written notice within the applicable time periods described in D3.06 or D3.07 above:

(a) Setting forth the reason for the denial;

(b) Making reference to pertinent DCAP provisions upon which the denial is based;

(c) Describing any additional material or information from the Participant which is necessary and why; and

(d) Explaining the Claim review procedure and the applicable time frames set forth herein.

Section D3.09 Right to Appeal the Decision. Within 60 days after receipt of the notification of the denial to reimburse an expense, the Participant may request, in writing, a review of the denial by the Claims Administrator.

Section D3.10 Time Frame for Deciding Appeal. Subject to D3.11 below, the Claims Administrator shall render a decision on review of a denied Claim within a reasonable period of time, but no later than 60 days after receipt of the request for review hereunder unless special circumstances require an extension of time.

This 60-day period begins at the time an Appeal is filed without regard to whether all the information necessary to determine on review whether an expense is reimbursable accompanies the filing. However, if an extension is required, as described below, due to the Participant's failure to submit necessary information, the period of time for making the determination shall be tolled from the date on which the notification of extension is sent to the Participant until the date on which the Participant responds to the request.

Section D3.11 60-Day Extension of Time. If the Claims Administrator determines that special circumstances require an extension of time (up to 60 days from the end of the initial 60-day period) for processing the Claim, written notice shall be furnished to the Participant before the end of the initial 60-day period. The written notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on Appeal.

Section D3.12 Decision on Appeal. In the case of an adverse decision on Appeal, the Claims Administrator shall send the Participant a notification:

(a) Setting forth the reason for the denial;

(b) Making reference to pertinent DCAP provisions upon which the denial is based;

(c) Stating the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and

(d) Explaining any voluntary Appeals procedures and the Participant's right to information regarding these procedures, if any.

ARTICLE D-IV
TERMINATION OF DEPENDENT CARE ASSISTANCE PLAN

Section D4.01 Termination of Participation.

(a) *General Rule.* A Participant will cease participation in this DCAP on the earlier of the following dates:

(i) The date on which this DCAP terminates; or

(ii) The date on which the Participant ceases to be an Eligible Employee, except that the individual may continue to participate for purposes of incurring Reimbursable Qualified Dependent Care Expenses through the end of the Plan Year and be reimbursed for such Expenses from any money remaining in his/her account.

Although a Participant's participation under this DCAP terminates on the above date, coverage or benefits under the Pre-Tax Benefits may continue if, and to the extent, provided by such Pre-Tax Benefits.

(b) *Deadline for Incurring Claims Following Cessation of Participation*. If a Participant ceases to participate in this DCAP for any reason, the Participant's salary reductions and election to participate will terminate on that date. The Participant will not be able to receive reimbursements for Qualified Dependent Care Expenses incurred after the end of the last day of the Plan Year.

(c) *Deadline for Seeking Reimbursement of Claims Following Cessation of Participation*. To the extent Participants seek reimbursement for expenses incurred, they must do so in the following timeframes:

(i) Except as provided otherwise by Subsection (ii) below, if the Participant terminates employment or otherwise ceases to be an Eligible Employee, the Participant (or the Participant's estate) must apply for reimbursement of Qualified Dependent Care Expenses by submitting a claim in accordance with Article D-III no later than the last day of the Plan Year.

(ii) If this DCAP is terminated, the Participant (or the Participant's estate) must submit any claim for reimbursement of Qualified Dependent Care Expenses in accordance with Article D-III within the 90-day period following the date the DCAP terminates.

(d) *Electronic Payment Card.* A Participant will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in his/her DCAP, effective the date of his/her termination from employment. Any claim submitted following a Participant's termination must be submitted in paper form.

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APPENDIX E
HEALTH SAVINGS ACCOUNT

This Appendix E contains the terms and conditions specific to enabling a Participant to contribute to an HSA pursuant to Section 4.01 of the Plan. Under this provision, a Participant covered by a high deductible health plan ("HDHP") may contribute, on a pre-tax basis, to an individual HSA. Unless otherwise altered by this Appendix E, the terms and conditions of the Plan are incorporated into, and made applicable to, the HSA contribution option.

Section E1.01 Eligibility. The eligibility conditions are the same as those for the Plan. In addition, in order to contribute to an HSA, the Participant must meet each of the following conditions:

(a) Must have enrolled in employee-only or family coverage (i.e., any coverage which is not employee-only coverage) under the HDHP coverage option of the Four County Mental Health Center Medical Plan;

(b) Cannot be claimed as another person's tax dependent;

(c) Is not entitled to (i.e., eligible for and enrolled in) Medicare benefits;

(d) If he/she has any other health coverage *other than* coverage under the Four County Mental Health Center Medical Plan, that coverage is either: (i) HDHP coverage; or (ii) permitted non-HDHP insurance or coverage; and

(e) If married and covering the Spouse, the Spouse of the Participant does not have any non-HDHP family health coverage.

Section E1.02 High Deductible Health Plan Coverage. HDHP Coverage means the high deductible health coverage option offered by the Employer that is intended to qualify as HDHP coverage under Code § 223(c)(2).

Section E1.03 Effective Date of Election. An election to participate in an HSA shall take effect as described in Article V of this Plan.

Section E1.04 HSA Benefits. An Eligible Employee can contribute on a pre-tax basis to an HSA by completing the salary reduction agreement provided by the Plan Administrator. The Participant's HSA is established and maintained outside the Plan by a trustee-custodian to which the Employer will forward the contributions to be deposited. This funding feature constitutes the HSA benefits offered under this Plan.

Section E1.05 Carryover of Unused Amounts. Any amounts remaining in a Participant's HSA account at the end of the Plan Year may be carried forward to the following Plan Year.

Section E1.06 Funding of HSA. Each Plan Year, the Employer shall determine whether or not each Participant who opens an HSA with Health Equity or Paylocity and elects to make pre-tax contributions for the Plan Year through the Plan will receive a contribution to his/her HSA from the Employer. Any additional contributions to a Participant's HSA through this Plan

shall be funded solely with the Participant's pre-tax salary reductions. The Employer shall communicate the amount of any Employer contribution during the Annual Enrollment Period. The Employer contribution is conditioned on the Participant properly establishing an HSA pursuant to policies established by the Employer.

Section E1.07 Election Changes. An election to contribute to an HSA can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next month following the date that the election change was filed.

Section E1.08 HSA and Health FSA. A Participant may not contribute to an HSA and participate in a Health FSA benefit (including that of a Spouse) during the same month.

Section E1.09 Maximum Annual Contribution Limit. The Maximum Annual Contribution Limit means the total amount that may be contributed to an HSA in a calendar year by an individual and/or on behalf of an individual (including any Employer contribution made on the Participant's behalf). The Maximum Annual Limit is subject to the provisions below:

(a) *Current Limit for Plan Year*. The HSA Maximum Annual Contribution Limit is equal to the statutory annual maximum dollar limit for HSA contributions applicable to the Participant's HDHP coverage option (i.e., single or family), as adjusted annually by the IRS pursuant to Code Section 223(g) to reflect changes in the cost of living.

(b) *No Proration for Less Than Full Year Participation*. The Maximum Annual Contribution Limit applies regardless of when the Participant first becomes eligible to contribute to the HSA during the Plan Year, provided that the Participant satisfies the "testing period." The "testing period" begins the last month of the Participant's tax year (generally, December 1) and ends on the last day of the 12th month following that month (generally, December 31 of the following year). Failure to complete the "testing period" will result in a ten percent penalty tax on the amount of the contributions and such contributions shall be included in the Participant's gross income. An exception applies if the Participant fails the "testing period" due to death or disability.

(c) *Catch-Up Contributions*. Individuals who are or will be age fifty-five (55) or older on December 31 of the Plan Year may make an additional catch-up contribution for that Plan Year. For Plan Years beginning on or after January 1, 2009, the amount of the additional catch-up contribution may not exceed $1,000. A catch-up contribution shall not be taken into account for purposes of applying the Maximum Annual Contribution Limit.

Section E1.10 Recording Contributions for HSA. The Plan Administrator will maintain records to keep track of HSA contributions a Participant makes through the pre-tax salary reduction agreement. The Plan Administrator will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

Section E1.11 HSA Providers. The qualified HSA trustee/custodian, not the Employer, will establish and maintain the HSA. In order to make pre-tax contributions to an HSA and receive the annual funding amount from the Employer, the Participant must choose Equity Bank or Paylocity as its qualified HSA trustee/custodian.

Section E1.12 Trust/Custodial Agreement. The HSA benefit consists solely of the ability to make contributions to the HSA on a pre-tax basis pursuant to a salary reduction agreement. The terms and conditions of coverage and benefits (e.g. eligible medical expenses, claims procedures, etc.) will be provided by, and are set forth in, the HSA documents provided by the custodian/trustee. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

Section E1.13 Tax Treatment of HSA Contributions and Distributions. The tax treatment of the HSA (including contributions and distributions) is governed by Code § 223.

Section E1.14 Not An ERISA Plan. The HSA is not an employer-sponsored employee benefits plan under ERISA. It is a savings account that is established and maintained by a qualified HSA trustee/custodian outside this Plan, to be used primarily for reimbursement of "qualified eligible medical expenses," as set forth in Code § 223(d)(2).

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FOUR COUNTY MENTAL HEALTH CENTER

WELFARE BENEFIT PLAN

Summary Plan Description

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SUMMARY PLAN DESCRIPTION
FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN

Four County Mental Health Center, Inc. ("Employer") maintains the Four County Mental Health Center Welfare Benefit Plan ("Plan") for the exclusive benefit of, and to provide benefits to, its Eligible Employees, their legal Spouses, and their eligible dependents.

This Summary Plan Description ("SPD") describes the basic features of the Plan, how the Plan operates, and the benefits that can be purchased through the Plan. This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant. It is not a part of the official plan documents. ***If there is a conflict between the plan documents and this SPD, the plan documents will control.***

(1) General Information

(a) *Type of Plan.* The Plan is a cafeteria plan. The Employer has assigned number 501 as the Plan Number for the Plan.

(b) *Pre-Tax Benefits.* Participants in the Plan may reduce their salary on a pre-tax basis to pay for the cost of benefits (or a portion of the cost of benefits if partially paid by the Employer) provided by one or more of the following plans maintained by the Employer:

(i) Four County Mental Health Center Medical Plan ("Medical Plan");

(ii) Four County Mental Health Center Dental Plan ("Dental Plan");

(iii) Four County Mental Health Center Health Flexible Spending Account ("Health FSA");

(iv) Four County Mental Health Center Dependent Care Assistance Plan ("DCAP");

(v) Four County Mental Health Center Vision Plan ("Vision Plan"); and

(vi) Certain benefit options under the Four County Mental Health Center AFLAC Plan ("AFLAC Plan").

Each of the above Pre-Tax Benefits is governed by a plan document. Please refer to such document for information regarding specific terms and conditions associated with each plan. This SPD serves as the summary plan description for each of these Pre-Tax Benefits. A summary of each of these plans is provided later in this SPD.

The amount by which your salary is reduced to purchase benefits, and any benefits paid to you under these Pre-Tax Benefits, will not be included in your taxable income for federal income tax purposes and is not subject to FICA taxes.

In addition, the Pre-Tax Benefits also include contributions by a Participant to a Health Savings Account ("HSA"). The terms and conditions of coverage and benefits under the HSA will be provided by, and are set forth in documents provided by, the qualified custodian or trustee of the account. A summary of the HSA account is provided later in this SPD.

(c) *After-Tax Benefits.* Participants in the Plan may reduce their salary on an after-tax basis to pay for the cost of benefits provided by certain benefit options under the Four County Mental Health Center AFLAC Plan ("AFLAC Plan"), which is maintained by the Employer.

This SPD serves as the summary plan description for this plan. A summary of this plan is provided later in this SPD.

(d) *Employer-Paid Benefits.* The Employer-Paid Benefits include contributions by the Employer to a HSA. The terms and conditions of coverage and benefits under the HSA will be provided by, and are set forth in documents provided by, the qualified custodian or trustee of the account. A summary of the HSA account is provided later in this SPD.

(e) *Group Health Plans.* Certain special rules apply to benefits that are considered to be "group health plans." Therefore, whenever you see the term "group health plan" in this SPD, it is referring to the following benefits under the Plan:

(i) Four County Mental Health Center Medical Plan;

(ii) Four County Mental Health Center Dental Plan;

(iii) Four County Mental Health Center Health Flexible Spending Account; and

(iv) Four County Mental Health Center Vision Plan.

The term does not include an HSA.

(f) *Employer.* The name, address, telephone number, and federal tax identification number of the Employer are:

Four County Mental Health Center, Inc.
3751 W. Main
P.O. Box 688
Independence, Kansas 67301
(620) 332-1940
EIN: 48-0697159

(g) *Plan Administrator.* The Employer is the Plan Administrator. The Plan Administrator is responsible for providing you and other Participants with information regarding your rights and benefits under the Plan. The Plan Administrator must also file various reports, forms, and returns with the Department of Labor ("DOL") and the Internal Revenue Service ("IRS"). The Plan Administrator is vested with full discretionary authority to interpret, construe, and carry out the provisions of the Plan, and to render decisions on the administration of the Plan, including any factual and legal determinations as to whether an individual is eligible to be enrolled in and/or receive any benefit under the terms of the Plan. The Plan Administrator has the authority to take such corrective action as it might consider to be appropriate in the event that an error in administering the Plan has taken place. For example, if there is a failure to

deduct the correct amount of a Participant's election, the Plan Administrator has the authority to deduct an overpayment from future compensation payable to the Participant and/or otherwise recover the amount that is owed.

(h) *Service of Process.* The name of the person designated as the Agent for Service of Legal Process is Greg Hennen, whose address is the same as the Employer's address. Service of Legal Process may also be made upon the Plan Administrator.

(i) *Plan Year*. The Plan Year is or the 12-month period beginning every July 1 and ending the subsequent June 30.

(j) *Spouse.* When the word "Spouse" is used in this SPD, it means a person of the same or opposite sex to whom you are legally married under the laws of the jurisdiction in which the marriage was entered into (as such laws existed at the time of marriage), regardless of whether the marriage would be recognized by the jurisdiction in which you currently reside. A common law marriage shall be considered to be a legal marriage if the common law marriage was validly entered into in a state that recognizes common law marriage. The Plan Administrator shall have the authority to determine whether a person is a Spouse, including the authority to request such documents as may be necessary, in its discretion, to establish the existence of a legal marriage (including the existence of a common law marriage). An individual will not be considered a "Spouse" for purposes of the Plan if (i) his/her marriage to you has been terminated by a court having jurisdiction over you or the individual or (ii) either party to the marriage is also lawfully married to another (third) person under the laws recognized by any state.

(k) *Dependent.* When the word "Dependent" is used in this SPD, it means, for purposes of the Health FSA only, the following:

(i) *Children Through Age 26.* Your natural child, lawfully adopted child (including a child placed with you for adoption but for whom the adoption is not yet final), stepchild, or other child for whom you have obtained legal guardianship pursuant to a court order, until such child attains age 26 (or until such child attains age 18 in the case of a legal guardianship). Children placed with you for adoption and children who are the subject of a Qualified Medical Child Support Order will also be considered Dependents.

(ii) *Disabled Children Above Age 26.* Your natural child, lawfully adopted child (including a child placed with you for adoption but for whom the adoption is not yet final), stepchild, or other child for whom you have obtained legal guardianship pursuant to a court order, who is unmarried and incapable of self-sustaining employment by reason of mental retardation or physical disability and for whom you are the major source of financial support, from the end of the calendar month in which the child attains age 26.

(iii) *Non-Children Dependents.* Any of your relatives who reside in your home, are claimed by you as a tax dependent, and meet the definition of a tax dependent under Code § 152.

(2) Participation in the Plan

You will automatically become a Participant in the Plan on your plan entry date if you satisfy the eligibility conditions for the Plan. Once you become a Participant, you will continue to be a Participant until the eligibility conditions are no longer met. These requirements are explained in more detail below.

(a) *Eligibility Conditions.* To be eligible to participate in the Plan (i.e., to be an "Eligible Employee"), the following conditions must be met:

(i) *Employee.* You must be an individual employed by the Employer;

(ii) *Regularly Scheduled Hours per Week.* Your regularly scheduled workweek must ordinarily equal or exceed thirty (30) hours per week. For purposes of the Plan, this is considered to be "full-time"; and

(iii) *Not Excluded from Participation.* You must not be excluded from participation. You are excluded from participation if you are (A) covered under a collective bargaining agreement; (B) classified on the Employer's payroll records as a "leased" employee; or (C) for purposes of participating in the Plan (but not, unless otherwise provided, for purposes of participating on an after-tax basis in any underlying Benefit Package Option), an individual who is, with respect to the Employer, self-employed within the meaning of Section 401(c)(1) of the Code or is treated as a partner under Section 1372 of the Code.

(b) *Plan Entry Date – General Rule.* If you are an Eligible Employee, you will become a Participant on the first day of the month following or coincident with thirty (30) days of continuous, active employment as an Eligible Employee, even if you do not choose to purchase benefits under one or more of the Pre-Tax Benefits and/or After-Tax Benefits.

(c) *Termination of Participation.* Once you become a Participant, you will continue to be a Participant as long as you continue to satisfy the conditions for being an Eligible Employee, as summarized above. If one or more of these conditions is not met, you will cease to be a Participant, unless a special rule applies. The special rules that might apply are summarized below.

(i) *Special Rule for Leaves of Absence.* If the number of hours that you are regularly scheduled to work each week falls below the minimum number required for you to participate in the Plan, you may still continue to participate in the Plan if you are on:

(A) A paid leave approved by the Employer (including a paid leave of absence while on active service in the armed forces (within the meaning of USERRA));

(B) An unpaid leave approved by the Employer (including an unpaid leave of absence while on active service in the armed forces (within the meaning of USERRA), subject to Subsection (D)) of up to six weeks;

(C) An unpaid leave under the Family and Medical Leave Act ("FMLA") if the FMLA is applicable to the Employer; or

(D) During a paid or unpaid leave of absence of less than 31 days while on active service in the armed forces (within the meaning of USERRA). To the extent the length of the leave of absence in Subsection (B) exceeds the length of the leave of absence in this Subsection (D), Subsection (B) shall control.

Note: Any period of unpaid leave shall run concurrently with any FMLA leave.

(ii) *All Disability Leave.* Whether treated as unpaid or paid (i.e., taxable or non-taxable compensation) – all disability leave shall be treated as "unpaid leave" for purposes of plan eligibility. However, nothing in this Subsection shall preclude you, if you are on FMLA leave from maintaining eligibility during such FMLA leave.

(iii) *Special Rule for Military Service.* If you enter active service in the armed forces of any country, you will not be eligible to participate in the Plan unless your service is temporary active service of two weeks or less.

(iv) *Special Rule for Certain Pre-Tax Benefits.* If you are participating in a Pre-Tax Benefit and your employment is terminated before the end of a pay period or the end of the month, your participation in the Plan may continue through the end of the pay period and/or the month (depending on the underlying Pre-Tax Benefit).

(3) Pre-Tax Benefit Options – Participant Elections

To purchase benefits on a pre-tax basis through the Plan, you must make what is known as an "Election." Once you have made an Election, you will not be able to change that Election until the next Plan Year, unless an exception applies. These rules are discussed in more detail below.

(a) *How to make an Election.* To make an Election, you must complete a salary reduction agreement and return the completed salary reduction agreement to the Plan Administrator. If you are changing an Election in the middle of a Plan Year, you may also be required to complete and return an Election change form. The Plan Administrator may require the salary reduction agreement or the Election change form to be completed and submitted in electronic form through the use of the Internet, an Intranet, a telephone system, or such other system as the Plan Administrator may prescribe.

(b) *When to make an Election.*

(i) *General Rule.* An Election for the next Plan Year must be made during the Annual Enrollment Period for that Plan Year. The Annual Enrollment Period will be announced by the Plan Administrator each year.

(ii) *Initial Election by New Participants.* If you are a newly Eligible Employee, an Election will normally need to be made on or prior to the date you enter the Plan as a Participant. However, if you are newly eligible because you are a newly hired

employee, you may have thirty (30) days (or such longer period as may be specified in the group insurance contract/policy or, in the case of a self-funded plan, the separate plan document or benefit description, as applicable) from your date of hire to make your elections.

(iii) *Election Changes.* Any election change made as a result of an event qualifying as an Election change event must be made no later than 30 days (or such longer period as may be specified in the group insurance contract/policy or, in the case of a self-funded plan, the separate plan document or benefit description, as applicable) after the event. An Election change made in connection with certain HIPAA special enrollment rights may be made within sixty (60) days after the event as further described in (3)(d)(ii) below.

(c) *Failure to make an Election.*

(i) *Failure to Make an Initial Election.* If you have never made an Election, you will not be able to purchase any benefits through the Plan on a pre-tax basis.

(ii) *Failure to Change Existing Election.* Once you have made an Election, a failure to complete a new salary reduction agreement for a subsequent Plan Year will be treated as a decision on your part to retain your existing Elections for the new Plan Year. However, if you have elected to put money into the Health FSA or DCAP, your Election for those plans will be reduced to zero dollars for any subsequent Plan Years.

(d) *Election Changes.* An Election may not be changed in the middle of a Plan Year unless you qualify for one of the exceptions listed below. All Election changes must be approved by the Plan Administrator. In approving or denying an Election change, the Plan Administrator may rely on the terms of the Plan, IRS regulations, and informal guidance from the IRS.

You may change an Election in the middle of a Plan Year in the following circumstances (and subject to the other rules of the Plan):

(i) *Change in Status.* If there is a "change in status" and the Election change is consistent with the "change in status," then the following events may constitute a "change in status":

(A) A change in your marital status;

(B) A change in the number of your dependents;

(C) A change in the employment status of yourself, your Spouse, or your dependent. This may include starting a new job, leaving an old job, taking an unpaid leave of absence, or returning from an unpaid leave of absence. It may also include a change in the number of hours that you, your Spouse, or your dependent are regularly scheduled to work, but only if the change

in hours affects your eligibility for benefits under the Plan, or any of the other Benefit Plans, or your Spouse's or dependent's eligibility under a benefit plan of their employer;

(D) A reduction in your hours such that you will no longer average at least thirty (30) hours per week, even though that reduction in hours does not affect your eligibility for benefits under a Group Health Plan (other than a Health FSA). However, in order to make an election change on the basis of a reduction in hours that does not affect Group Health Plan eligibility, you (and any Spouse and/or dependents who are covered through you) must enroll in another group health plan that provides "minimum essential coverage" no later than the first day of the second month following the month in which your coverage under the Group Health Plan was revoked;

(E) One of your dependents satisfies, or ceases to satisfy, the eligibility requirements for a dependent under a Benefit Plan;

(F) A change in residence for yourself, your Spouse, or your dependent if it affects that person's eligibility for benefits;

(G) You enroll in a Qualified Health Plan through an Exchange/Health Insurance Marketplace (the "Marketplace") established pursuant to the Patient Protection & Affordable Care Act by virtue of having become eligible for a special enrollment period in the Marketplace or during the Marketplace's annual open enrollment period. However, in order to make an Election change on this basis, you (and any Spouse and/or dependents who are covered through you) must enroll in the Qualified Health Plan and have such coverage take effect no later than the day immediately following the day that your coverage under the Medical Plan is terminated; and/or

(H) Your Spouse and/or dependent(s) enroll in a Qualified Health Plan through the Marketplace by virtue of having become eligible for a special enrollment period in the Marketplace or during the Marketplace's annual open enrollment period, in which case you may revoke your prior election for other-than-self-only coverage (referred to as "Family Coverage" for purposes of this Subsection). If you revoke your prior election for Family Coverage under this Subsection, and you do not enroll in a Qualified Health Plan through the Marketplace, you must elect individual coverage under the Medical Plan (or Family Coverage that includes coverage for one or more individuals already covered by your prior election).

Whether an Election change is consistent with the "change in status" will be determined by the Plan Administrator in accordance with IRS regulations and prevailing IRS guidance.

(ii) *HIPAA Special Enrollment Rights.* Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), certain group health plans must provide a "special enrollment" period for certain individuals. These individuals include individuals who were eligible for coverage but who did not enroll due to other coverage and individuals who have become dependents through marriage, birth, or adoption. These individuals also include individuals who become eligible for a state premium assistance subsidy under a Group Health Plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP). Similarly, individuals who lose eligibility for Medicaid or SCHIP coverage have special enrollment rights in the Plan. If you exercise your "special enrollment" rights under HIPAA, you may make an Election change to pay the cost of covering the individuals you enrolled. Although the normal deadline to make an election change is 30 days after the election change event took place, you have 60 days to enroll an individual using HIPAA special enrollment rights (and, if they are not already enrolled, other family members, including yourself) if the election change event is related to the individual becoming eligible for a state premium assistance subsidy or a loss of eligibility for Medicaid or SCHIP.

(iii) *Change in Coverage of Your Spouse or Dependent*. If there is a change in the coverage of your Spouse or your dependent and that coverage is obtained through the cafeteria plan of another employer, you may make a "corresponding" Election change. For this exception to apply, one of the following conditions must be met: (A) The plan year of the other employer's cafeteria plan is different than the Plan Year of the Plan; or (B) the cafeteria plan of the other employer permits only those Election changes that are authorized under IRS regulations. The Plan Administrator will decide in its discretion and in accordance with prevailing IRS guidance whether a requested change is on account of, and corresponds with, the change made under the plan of the other employer.

EXAMPLE: You have elected to provide medical coverage for your family under the Employer's Medical Plan. Your Spouse is employed by a different employer. During open enrollment for the cafeteria plan of that employer, your Spouse elects "family coverage" under the medical plan of that employer. The plan year of that employer is different than the Plan Year of your Employer. Under this exception, you may discontinue your Election to pay for family coverage on a pre-tax basis through the Plan.

(iv) *Loss of Governmental/Educational Institution Group Health Coverage (Does not apply to the Health FSA or DCAP).* If you, your Spouse, or your dependent loses group health coverage and the coverage was sponsored by a governmental or educational institution, you may make an Election change to add coverage for the persons who are losing coverage. For purposes of this provision, group health coverage sponsored by a governmental or educational institution includes a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government or a tribal organization, a state health benefits risk pool, or a foreign government health plan.

(v) *"Significant" Curtailment in Coverage (Does not apply to the Health FSA).*

(A) *Without Loss of Coverage.* If coverage under a plan is "significantly curtailed," but not lost, you may change your Election to elect coverage under another benefit option that provides similar coverage. Coverage under a plan is "significantly curtailed" only if there is an overall reduction in the coverage provided to participants in the plan.

(B) *With Loss of Coverage.* If coverage under a plan is "significantly curtailed" and that curtailment constitutes a "loss of coverage" for you, your Spouse, or your dependent, you may change your Election to elect coverage under another benefit option that provides similar coverage. If no similar benefit option is available, you may elect to drop coverage. For purposes of this provision, a "loss of coverage" means a complete loss of coverage under the benefit option. This includes the elimination of a benefit option, the loss of coverage under an option due to an individual reaching an overall lifetime or annual coverage limit, a substantial decrease in the medical care providers available under the option, or a reduction in the benefits for a specific type of medical condition or treatment for which you, your Spouse, or your dependent is currently receiving treatment.

(C) *Determinations to be Made by the Plan Administrator.* The Plan Administrator will decide in its discretion, and in accordance with prevailing IRS guidance, whether a curtailment is "significant," whether a curtailment represents a "loss of coverage" with respect to a particular individual, and whether a substitute benefit option provides "similar coverage."

(vi) *Addition or Improvement of a Benefit Option (Does not apply to the Health FSA).* If a benefit option is added in the middle of a Plan Year or if coverage under an existing benefit option is significantly improved, you may make an Election change to add that option.

(vii) *FMLA Leave.* If you take a leave of absence under the FMLA, you may change your Election for coverage under a plan. You may also be able to change your Election under the "change in status" exception discussed above.

(viii) *To Comply with a Judgment, Decree, or Order.* If you are required to provide medical coverage for a dependent child pursuant to a judgment, decree, or order, you may change your Election to pay for the increased cost of the coverage. If you are already providing coverage and a judgment, decree, or order requires someone else to provide coverage, you may change your Election to reflect the decreased cost of coverage. *However*, before you are allowed to drop coverage, you may be required to provide proof that other coverage for the child is actually being provided.

(ix) *Entitlement to Medicare/Medicaid.* If you, your Spouse, or your dependent becomes entitled to Medicare or Medicaid, you may change your Election to reflect the decreased cost of coverage under the Employer's Group Health Plan. If you, your

Spouse, or your dependent loses your/their entitlement to Medicare or Medicaid, you may increase your Election to reflect the increased cost of coverage under the Employer's Group Health Plan.

(x) *Significant Change in Cost of Coverage (Does not apply to the Health FSA).* If your share of the premium for coverage under a benefit option increases by a significant amount, you may increase your Election to reflect the increased cost or you may elect to be covered under another benefit option (if any) providing similar coverage. If similar coverage is not available, you may drop your coverage all together.

If your share of the premium for coverage under a benefit option decreases by a significant amount, you may decrease your Election by a corresponding amount or, if you are not currently enrolled in that benefit option, you may elect to become covered under that benefit option.

Whether there has been a "significant" change in cost and whether another benefit option provides "similar coverage" will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

(xi) *Special Rule for Eligible Individuals Contributing to an HSA*. If you are eligible to contribute to an HSA, you may change your HSA contribution election at any time during the Plan Year for any reason. If you are eligible and contributing to an HSA, you may increase, decrease or revoke your HSA contribution election at any time during the Plan Year for any reason by submitting a new salary reduction form to the Plan Administrator. This means that you can begin making HSA contributions, if you are not already making them. If you are already making HSA contributions, this means that you can increase or decrease the amount of those HSA contributions or you may stop making them all together. The new Election will be effective prospectively on the first day of the next month following the date on which the Election change was properly submitted.

In addition to the Election changes, which you may make in the middle of a Plan Year, as summarized above, the Plan Administrator may automatically change the amount of your Election in the middle of a Plan Year if there is an "insignificant" change in the cost of the coverage you have elected. Whether there has been an "insignificant" change in cost will be decided by the Plan Administrator in its discretion and in accordance with prevailing IRS guidance.

(e) *Effective Date of Elections.*

(i) *Election Made During Annual Enrollment Period.* An Election made during the Annual Enrollment Period will be given effect as of the first day of the next Plan Year.

(ii) *Election Made in the Middle of a Plan Year.* An Election made in the middle of a Plan Year will be given effect as of the earliest administratively practicable date after a completed Election change form and salary reduction agreement are received by the Plan Administrator. This includes both Election changes and the initial

Elections made by new Participants. Under IRS regulations, Elections cannot be given retroactive effect. For example, although you can use pre-tax dollars to pay for future coverage, you cannot use pre-tax dollars to pay for coverage that has already been provided.

(iii) *Special Rule for HIPAA Special Enrollment Rights.* The only exception to the prohibition against retroactive election changes is for newborn children and newly adopted dependents who are enrolled in a Group Health Plan pursuant to HIPAA "special enrollment" rights. Coverage that is retroactive to the date of their birth or adoption may be paid for on a pre-tax basis.

(f) *Special Rule for Health FSAs.* You may *not* change your Election under the Health FSA in the middle of a Plan Year except as follows:

(i) You may begin to participate in the Health FSA if you are eligible, provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above;

(ii) You may increase your Election as long as you do not exceed the maximum Election amount permitted under the Health FSA and provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above; or

(iii) You may decrease your Election, provided you are permitted to make an Election change under the rules summarized in Section (3)(d) above; however, you may not reduce your Election amount below the total amount you have already been reimbursed.

EXAMPLE: During the Annual Enrollment Period, you make an Election of $1,200 for your Health FSA for the Plan Year. To pay for this benefit, your salary is reduced by $100 per month. Suppose that after three months, you have contributed a total of $300 into your Health FSA, you have been reimbursed $400, and you experience a qualifying Election change event. You may change your Election for the Plan Year to any amount equal to or greater than $400.

Continuing with the above example, suppose you change your Election amount for the Plan Year to $600 instead of $1,200. Because you have already been reimbursed $400, only $200 will be available to you for reimbursement through the end of the Plan Year.

Except as set forth above, an Election with respect to the Health FSA may not be changed during the Plan Year once it has been made.

(g) *Special Election Change Rule for Health Savings Accounts*. To the extent you are eligible to contribute to an HSA, you may increase or decrease your HSA contribution Election at any time during the Plan Year for any reason by submitting an Election change form to the Plan Administrator. In addition, you may revoke your contribution Election at any

time by submitting an Election change form to the Plan Administrator. The Election change will be effective prospectively on the first day of the next month following the date on which the Election change was properly submitted.

(4) After-Tax Benefit Option - Participant Elections

You may make and/or change your Elections with respect to an After-Tax Benefit at any time in accordance with the rules and procedures established by the Plan Administrator. Any such Election change will take effect on the earliest administratively practicable date after the request to change an after-tax Election is received by the Plan Administrator.

(5) Coverage Under the Group Health Plans

The Employer maintains the following Group Health Plans, some of which are fully-insured through the insurance companies specified below and some of which are self-funded and administered by the company specified below:

(1) A self-funded Medical Plan that pays benefits pursuant to the terms and conditions of a benefit description administered by Meritain, P.O. Box 853921, Richardson, TX 75085-3921;

(2) A fully-insured Dental Plan that pays benefits pursuant to the terms and conditions of a group contract with Delta Dental of Kansas, P.O. Box 789769, Wichita, KS 67278; and

(3) A fully-insured Vision Plan that pays benefits pursuant to the terms and conditions of a group contract with EyeMed Vision Care, 4000 Luxottica Place, Mason, Ohio 45040.

(a) *Type of Plans.* The above plans are Group Health Plans. The fully-insured Group Health plans are administered by the Employer; however, benefit claims for the fully-insured Group Health Plans are processed and paid by the applicable insurance company, who is referred to as the Claims Administrator. The self-funded Group Health Plan is funded and administered by the Employer; however, benefit claims for the self-funded Group Health Plan is processed by the third party administrator, who is also referred to as the Claims Administrator.

(b) *Eligibility/Plan Entry Dates.* The eligibility conditions and the Group Health Plan entry dates are the same as those for the Plan, as described in Section (2) above.

(c) *Enrollment in the Plan.* **To become a Participant in the Group Health Plans, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your entry date into the applicable Group Health Plan. **If you do not elect to participate in one or more of the Group Health Plans, you will not receive any benefits under such Group Health Plans.**

(i) *Failure to Enroll When First Eligible.* If you fail to enroll when you are first eligible to do so, you will not be allowed to enroll in the applicable Group Health Plan until the next open enrollment period and your enrollment will not take effect until the anniversary date of the applicable group contract or benefits description. The same rule applies if you fail to enroll your dependents (including your Spouse) when you are first eligible to do so. This rule does not apply, however, if you are entitled to HIPAA "Special Enrollment" rights.

(ii) *HIPAA "Special Enrollment" Rights.* If you are declining enrollment in a Group Health Plan for yourself or your dependents because of other health insurance coverage and that other coverage is subsequently lost, you may be able to enroll yourself and/or your dependents in the Group Health Plan if you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you become eligible for a state premium assistance subsidy under a Group Health Plan of the Employer from either Medicaid or a state's children's health insurance program (SCHIP), you may be able to enroll yourself and/or your dependents in the Group Health Plan if you request enrollment within 60 days after you or your dependents become eligible for such assistance. Similarly, if you lose eligibility for Medicaid or SCHIP coverage, you have special enrollment rights in a Group Health Plan, provided you request enrollment within 60 days after you or your dependents lose eligibility for Medicaid or SCHIP coverage.

(d) *Plan Benefits.* If you elect to participate in one or more of the Group Health Plans, benefits will be provided by the Employer pursuant to the terms and conditions of one or more group contracts (for the fully-insured Group Health Plan(s)) and one or more benefits description(s) (for the self-funded Group Health Plan(s)) between the Employer and the applicable insurance carrier and/or third party administrator. These Group Health Plans provide you and/or your dependents with comprehensive medical, dental, and/or vision coverage, as applicable. The applicable insurance carrier and/or third party administrator has prepared materials which explain the benefits under these Group Health Plans in detail. If you have not received these materials from the applicable insurance company or third party administrator, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Medical, Dental, and Vision Treatment.* The above-listed Group Health Plans do not provide medical, dental, or vision treatment or advice. **It is your responsibility, in consultation with the doctors and dentists of your choice, to get appropriate treatment**. The fact that some expense may not be eligible for reimbursement by the Group Health Plans does not mean that you or your dependents should not have that treatment.

(f) *Explanation of Benefits*. You will receive an explanation of benefits (EOB) under the appropriate Group Health Plan(s) in which you are enrolled at your primary residence (as provided to the Claims Administrator, i.e., the insurance company for fully-insured

plans or third-party administrator for self-funded plans). If your covered Spouse or dependent does not wish for an EOB to be provided at this address, he/she will need to contact the claims administrator and provide an alternate address.

Self-Funded Group Health Plan

(g) *Obligation to Pay Benefits for the Self-Funded Group Health Plan.* The Employer is obligated to pay all benefits provided by the self-funded Group Health Plan listed at the beginning of this Section of the SPD.

(h) *Premiums for the Self-Funded Group Health Plan.* The monthly premiums for coverage under the self-funded Group Health Plan are determined by the Employer, and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period. Premiums may be paid on a pre-tax basis through the Plan.

(i) *Claims Procedures for the Self-Funded Group Health Plan.* The third-party administrator named at the beginning of this Section of the SPD will act as Claims Administrator with respect to any claim for benefits under the Medical Plan. In the event you have a claim for benefits under the Medical Plan, you should follow the procedures outlined in the materials prepared by the third-party administrator, and the claims procedures in Section (13) of this SPD. The Plan Administrator, upon your request, will assist you in making these claims. The Claims Administrator for the Medical Plan is acting on behalf of the Employer in a ministerial and administrative capacity. The Employer retains full discretionary authority to make all determinations regarding the administration and payment of benefit claims.

Fully-Insured Group Health Plans

(j) *Obligation to Pay Benefits for the Fully-Insured Group Health Plans.* The applicable insurance carrier is solely obligated to pay for the benefits provided under its group contract for the applicable Group Health Plan. The Employer makes no promise and will have no obligation to provide or pay for benefits under the applicable group contract.

(k) *Premiums for the Fully-Insured Group Health Plans.* The monthly premiums for insurance coverage under the Dental Plan and the Vision Plan are determined by the applicable insurance company and may change from time to time. Premiums may be paid on a pre-tax basis through the Plan. Premiums may be paid on an after-tax basis through the Plan. You may obtain current premium rates by contacting the Plan Administrator. The Employer will communicate the portion of the premium which you must pay each year during the Annual Enrollment Period.

(l) *Claims Procedures for the Fully-Insured Group Health Plans.* In the event you have a claim for benefits under one of the fully-insured Group Health Plans, you should follow the procedures outlined in the materials prepared by the applicable insurance company. The Plan Administrator, upon your request, will assist you in making these claims.

The insurance company has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the applicable group contract.

All Group Health Plans

(m) *Termination of Coverage.* Your participation in the above-listed Group Health Plans ends on whichever of the following dates occurs first:

(i) The last effective date of coverage as specified by the insurance Group Contract (for those Group Health Plans which are fully-insured);

(ii) The date on which you terminate employment with the Employer (for those Group Health Plans which are self-funded);

(iii) The date on which your election to participate expires;

(iv) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(v) The last day of the month in which you cease to be an Eligible Employee; or

(vi) The date the Employer terminates the applicable Group Health Plan.

If you have elected coverage, your coverage for benefits under the Group Health Plans ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a separate Section of this SPD.

(6) Health Flexible Spending Account

The Employer maintains a Health FSA that pays benefits out of the Employer's general assets.

(a) *Type of Plan.* The Health FSA is a self-funded group health plan. The Health FSA is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the Health FSA entry date are the same as those for the Plan, as described in Section (2) above.

(c) *Election to Participate in the Plan.* To become a Participant in the Health FSA, you must complete and return the form or forms provided by the Plan Administrator, as set forth in Section (3)(a) through (c) above. **If you do not elect to participate in the Health FSA, the Employer will not provide you with any benefits under the Health FSA.** However, if you experience an event that would allow an Election change under the terms of the Plan (see Section (3)(d) and (f) of this SPD), you may enroll in the Health FSA in the middle of the Plan Year.

(d) *Special Rules Relating to FMLA Leave.* If you are a Participant in the Health FSA and you are taking or returning from FMLA leave, the following special rules apply to your participation in the Health FSA:

(i) *Taking FMLA Leave.* You may continue to participate in the Health FSA after you begin your FMLA leave by continuing to pay the applicable premium while you are on leave or by making such other arrangements for the payment of the applicable premiums as may be permitted under the Plan (see Section (14)(b) of this SPD). You may also choose to discontinue your participation in the Health FSA once you begin your FMLA leave.

(ii) *Returning From FMLA Leave.* If you discontinued your participation in the Health FSA when you began your FMLA leave, you may choose to participate again once you return to work from your FMLA leave. If you want to resume your participation at the same coverage level that was in effect before your FMLA leave, you will be required to pay the premiums that would have been due while you were on FMLA leave. If you do not want to make up the missed premiums, you may instead choose to resume coverage at a reduced level. In this event, the amount of coverage that you elected will be reduced by the percentage of the Plan Year that you were on FMLA leave. For example, if you had elected $1,200 for the Plan Year and were on FMLA for two months, your annual Election would be reduced to $1,000 under this alternative.

(e) *Effective Date of Election.* If you elect to participate in the Health FSA, your Election will take effect and you will become a Participant as follows:

(i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year.

(ii) *Election Made by A Newly Eligible Employee.* If you are a newly Eligible Employee, your Election will take effect when you become a Participant in the Plan.

(iii) *Election Made Following an Election Change Event.* If you elect to participate within thirty (30) days after an event that would allow you to make an Election change under the Plan (see Section (3)(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your child is born. This is a "change in status" which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within 30 days after March 15, (that is, by April 14). If you do not elect to enter the Health FSA within 30 days after this "change in status," you will not have a second opportunity to enter the Health FSA until the first day of the next Plan Year unless you experience a second Election change event.

(f) *Plan Benefits.* If you elect to participate in the Health FSA, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. To determine how much you should reduce your salary for medical reimbursement benefits, you should estimate the amount of medical and dental expenses you expect to have for the Plan Year in which your health or dental insurance will not cover. When you incur uninsured medical or dental expenses, the Plan Administrator will reimburse you for those expenses. The amount of salary you reduce for these medical or dental expenses is not subject to income tax or FICA.

EXAMPLE: You elect to reduce your salary by $1,200 for the Plan Year. Therefore, $1,200 is your maximum reimbursement for uninsured medical expenses incurred for that Plan Year.

If you do not incur uninsured medical expenses for the Plan Year equal to the maximum reimbursement amount, you will lose the unused portion.

EXAMPLE: Assume you elect to reduce your salary by $1,200 for medical expenses, but incur only $1,000 of uninsured expenses for the Plan Year. As required by IRS regulations, you will forfeit the remaining $200. This example illustrates the importance of carefully estimating your uninsured medical expenses for the Plan Year.

If the Employer determines after the claims Run-Out Period and after processing all pending claims that the total premiums paid by all participants in the Health FSA exceed the total reimbursements paid out, the Plan will have a surplus. Such surplus will be used to offset reasonable administrative costs. Any surplus remaining after such costs are paid will be used to reduce the required premiums in the following Plan Year. If you are a participant in the Health FSA on the date of the first payroll following the date on which the amount of surplus has been determined, you will receive a reduction in the cost of your premium, known as a "premium holiday."

If the Health FSA is terminated by the Employer before or at the end of the Plan Year, then the Employer will determine whether or not there is a surplus. There is a surplus if the total contributions from all Participants exceed the total Health FSA reimbursements. This determination will not be made until after the claims Run-Out Period and after all pending claims have been processed. The Employer will use the surplus, if any, to offset reasonable administrative costs. Any surplus remaining after reasonable administrative costs have been paid shall be distributed to all individuals who were participating in the Health FSA on the date of the Plan's termination. The amount of remaining surplus will be divided by the number of participants entitled to the distribution in order to determine each person's share. In no case will the surplus be allocated to you based directly or indirectly on your claims experience or on the amount of your annual election.

(g) *Maximum Benefit Amount.* Under the Health FSA, if you or your dependents incur a "qualified medical expense" for which you submit a timely claim for reimbursement, you will receive a reimbursement for the portion of that expense that is not covered by medical or dental insurance; however, your reimbursements may not exceed the maximum reimbursement amount.

(i) *Maximum Reimbursement Amount – General Rule.* The maximum reimbursement amount for a Plan Year, plus the amount, if any, of the contributions made by the Employer to the Participant's Health FSA for that Plan Year, may not exceed the total amount that you have elected to contribute to the Health FSA for that Plan Year.

(ii) *Limits on Contributions to a Health FSA.* The amount that you elect to contribute to the Health FSA for a Plan Year may not exceed the maximum dollar limit that is established each year by the Employer nor may it be lesser than the minimum dollar limit, if any, established each year by the Employer. The maximum dollar limit, in turn, may not exceed the statutory dollar limit established in the Code, as adjusted by the IRS for periodic cost-of-living increases. The dollar limit(s) established by the Employer will be communicated in the enrollment materials for the Health FSA. The Plan Administrator will also provide information about this dollar limit upon request.

(iii) *Maximum Reimbursement Amount – Run-Out Periods.* A claim that is incurred during the previous Plan Year and which is submitted for reimbursement during the Plan's Run-Out Period will count against the maximum reimbursement amount for the previous Plan Year and not the Plan Year during which reimbursement is made.

(h) *Qualified Medical Expenses.* The "qualified medical expenses" for which you (or your Spouse or Dependent) are entitled to reimbursement under the Health FSA are generally those medical expenses that are tax deductible under Section 213(d) of the Internal Revenue Code and for which you have not otherwise been reimbursed through insurance or any other means. It also includes menstrual care products as defined in Code § 223(d)(2)(D). Typical expenses include, but are not limited to:

(i) Deductibles and copayment amounts you pay under your medical or dental or vision care coverage;

(ii) Medical, dental and/or vision care expenses that have not otherwise been reimbursed;

(iii) Certain over-the-counter drugs permitted by Code § 213(d); and

(iv) Certain menstrual care products, such as tampons and pads.

The Health FSA does not reimburse for amounts paid to obtain other health insurance coverage. The Health FSA will only reimburse you for qualified medical expenses incurred while you are a Participant in the Health FSA. Under IRS rules, a qualified medical expense is generally considered to be "incurred" when the treatment is provided and not when you are billed for the treatment or when the treatment is paid for.

Typical expenses <u>not</u> eligible for reimbursement by the Health FSA include, but are not limited to:

(i) Those reimbursed through any other policy or plan, including Medicare or other federal programs;

(ii) Those incurred before you enroll in the Health FSA;

(iii) Those incurred in any year other than the year for which Health FSA contributions are made;

(iv) Those claimed as a deduction or credit for federal income tax purposes; and

(v) Those the IRS would not allow as deductions for federal income tax purposes, except for certain over-the-counter drugs.

(i) *Run-Out Period*. "Run-Out Period" means the period that begins at the close of the Plan Year and ends 90 days following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the Run-Out Period.

(j) *Electronic Payment Card.* The Employer permits the use of an electronic payment card, such as a debit card, to pay for Qualified Medical Expenses. The electronic payment card may only be used at merchants and service providers which are authorized by the Employer.

(k) *How to Submit a Claim.*

(i) *Claims Forms.* Except as provided in (ii) below, in the event you have a claim for benefits under the Health FSA, you must submit a claim using the claims form that will be provided to you by the Plan Administrator and following the instructions on that form. The Claims Administrator may require you to provide such information as may reasonably be required to process the claims, including, but not limited to, the following:

(A) The amount, date incurred and nature of each expense;

(B) The name of the person, organization or entity with whom the expense was incurred;

(C) The name of the person for whom the expense was incurred;

(D) The amount (if any) recovered under any insurance arrangement or other plan, with respect to the expense; and

(E) A statement that the expense (or portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

(ii) *Electronic Payment Card.* If the Employer permits the use of an electronic payment card, such as a debit card, you may be able to access your Health FSA through the use of such card, provided that the claim is properly adjudicated. If your funds are accessible by an electronic payment card, you must comply with the substantiation procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. Under those procedures, some payments with your electronic payment card may be

automatically substantiated by this Health FSA; other payments may require further substantiation by you to the Health FSA. Please note that, if you present your electronic payment card as payment for a medical expense and it is denied at the point-of-sale (i.e., when the service or item is provided), that denial of payment will *not* constitute an initial claim denial under these procedures.

(l) *Claims Administrator.* Paylocity will act as Claims Administrator with respect to any claim for benefits under this Health FSA. Paylocity has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims.

(m) *Recoupment of Underwithheld Amounts.* In the event that not enough salary is withheld from your paycheck, resulting in insufficient funds in your Health FSA, the Employer will seek recoupment of the amount of the insufficient withholding.

(n) *Timing of Claims.* You may submit your claim for benefits under the Health FSA during the Plan Year in which the expenses are incurred or within the Run-Out Period following the close of the Plan Year. If you terminate your participation in the Health FSA or if the Employer terminates the Health FSA, you must submit your claim for reimbursement for that Plan Year no later than 90 days after the date of your termination or no later than 90 days after the date the Employer terminates the Health FSA, respectively. For example, if you terminate employment with the Employer on July 1 of a particular Plan Year, you must submit your claim for reimbursement no later than September 29 of that Plan Year to receive reimbursement for expenses covered by the Plan which you incurred prior to that July 1.

(o) *Time Frame for Deciding Claims.* If any claim for benefits under this Health FSA is denied, in whole or in part, then the Claims Administrator will promptly furnish you, within 30 days of receipt of the claim, written notice:

(i) Setting forth the reason for the denial;

(ii) Making reference to pertinent Health FSA provisions upon which the denial is based;

(iii) Describing any additional material or information which is necessary and why;

(iv) Referencing any internal rule, guideline, or protocol, or similar criterion relied upon in making the adverse determination (if applicable); and

(v) Explaining the claim review procedure set forth herein, including applicable time limits and a statement of your right to bring a civil action under ERISA § 502(a) following an adverse determination upon review.

(p) *Extension of Time Frame for Deciding Claims.* The Claims Administrator may seek one extension of up to 15 days in order to make the benefit determination. The extension must be sought due to matters beyond the control of the Plan. You will be notified of the extension prior to the expiration of the initial 30-day period. If the extension is due to your

failure to submit information necessary to decide the claim, the notice of extension shall specifically describe the required information and give you at least 45 days from receipt of the notice to provide the specified information. The period for making the benefit determination shall be tolled from the time the notification of extension is sent until the date on which you respond to the request for information.

(q) *Appealing a Claim Denial*. If your claim is denied, in whole or in part, you have 180 days to submit an appeal. You may, upon request and free of charge, examine all pertinent documents and may submit issues and comments in writing.

(r) *Time Frame for Deciding Appeal.* The Plan Administrator shall render a decision on review no later than 60 days after receipt of your request for review.

(s) *Decision on Appeal.* In conducting the review, no deference will be given to the initial adverse determination and a plan fiduciary, other than the one who originally decided the claim (or the person's subordinate), will make the determination upon appeal. The decision on review shall be in writing. If the claim is once again denied, in whole or in part, then the notification shall (i) state the reason for the decision, (ii) refer to the Health FSA provisions upon which it is based, (iii) state your right to receive (upon request and free of charge) reasonable access to, and copies of, all relevant information, (iv) describe any voluntary appeals procedures, and (v) state your right to bring an action under ERISA § 502(a).

(t) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services. Prior to making any payment of benefits under the Health FSA, Paylocity (or the Plan Administrator) may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. Paylocity and/or the Plan Administrator may rely upon all such information furnished to it, including your current mailing address. Furthermore, Paylocity (or the Plan Administrator), prior to making payments under the Plan, may require you to file all appropriate claims and requests for payment from any other plan or plans maintained by the Employer, including requests for payment with any insurance carrier which has the responsibility for making any benefit payments under any plans maintained by the Employer.

(u) *Termination of Coverage.* Your participation in the Health FSA ends on whichever of the following dates occurs first:

(i) The date that you terminate your employment with the Employer;

(ii) The date in which your election to participate expires;

(iii) The end of a period in which you last paid a required contribution; or

(iv) The date the Employer terminates the Health FSA.

Your coverage for benefits under the Health FSA ends with the termination of your participation. However, you may, in some circumstances, be entitled to purchase COBRA continuation coverage. COBRA continuation coverage is discussed in a

separate Section of this SPD. You will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds in your Health FSA as of the date of your termination from employment. Any claim submitted following your termination must be submitted in paper form.

(v) *Qualified Reservist Distributions (QRDs).* A "qualified reservist distribution" is a distribution of all or a portion of your account balance if you are called to active military service, provided the call to service is for a period of 180 days or more or for an indefinite period of time.

(i) *Amount of QRD*. Unless a lesser amount is specifically requested, the QRD will be the total of your contributions as of the date of the approval of the QRD request minus the amount of any Qualified Medical Expense reimbursements received as of the date of the request for the QRD.

(ii) *Timeframe for Requesting a QRD*. You must request a QRD on or after the date you are called to active military service and prior to the end of the Run-Out Period immediately following the end of the Plan Year in which you are called to service.

(iii) *Timeframe for Claims Administrator to Respond to a QRD Request*. The Claims Administrator shall respond to any timely request for a QRD within 60 days of the date it receives the request, including providing payment of the distribution within such time frame if the request is approved. If the request is denied, the Claims Administrator shall follow the claims procedures set forth above in this Health FSA Section of the SPD, except that the time frame set forth in (o) above is 60 days instead of 30 days.

(iv) *Eligible Claims*. If you request a QRD, you forfeit the right to receive reimbursements for Qualified Medical Expenses incurred after the date of your last day of active employment. You will be reimbursed for Qualified Medical Expenses properly submitted for reimbursement prior to the end of the Run-Out Period immediately following the end of the Plan Year and incurred on or prior to the last day of active employment or if later, the date of your QRD request, provided that the total dollar amount of such claims does not exceed the amount of your election minus the sum of your QRD and prior reimbursements received for the Plan Year.

(v) *No Penalty on QRD*. The QRD will not be subject to a distribution penalty. The amount of the QRD, however, will be included in your gross wages for the Plan Year in which the distribution is made, as required by the Internal Revenue Code and applicable IRS guidance.

(7) Dependent Care Assistance Plan

The Employer maintains a DCAP that pays benefits out of the Employer's general assets.

(a) *Type of Plan.* The DCAP is a Code Section 129 dependent care assistance plan. The DCAP is administered by the Employer; however, benefit claims are processed by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the plan entry date are the same as those for the Plan, as described in Section (2) above.

(c) *Election to Participate in the Plan.* To become a Participant in the DCAP, you must complete and return the form or forms provided by the Plan Administrator. **If you do not elect to participate in the DCAP, the Employer will not provide you with any benefits under the DCAP.**

(d) *Effective Date of Election.* If you elect to participate in the DCAP, your Election will take effect and you will become a Participant as follows:

(i) *Election Made During Annual Enrollment Period.* If you elect to participate during the Annual Enrollment Period for the Plan, your Election will take effect on the first day of the next Plan Year.

(ii) *Election Made by A Newly Eligible Employee.* If you are a newly eligible employee, your Election will take effect when you become a Participant in the Plan.

(e) *Election Made Following an Election Change Event.* If you elect to participate within 30 days after an event that would allow you to make an Election change under the Plan (see Section (3)(d) of this SPD), your Election will take effect on the first day of the month following the receipt of your completed Election form by the Plan Administrator. If your Election form is received on the first day of the month, you will become a Participant on that same day.

EXAMPLE: During the Annual Enrollment Period, you did not elect to participate in the Plan. On March 15, your Spouse begins a full-time job. This is a "change in status" which allows you to make an Election change under the Plan. You may elect to participate in the Plan if you do so within 30 days after March 15, (that is, by April 14). If you do not elect to enter the DCAP within 30 days after this "change in status," you will not have a second opportunity to enter the DCAP until the first day of the next Plan Year unless you experience a second Election change event.

(f) *Plan Benefits.* If you elect to participate in the DCAP, you must elect the amount by which you want the Employer to reduce your salary for the Plan Year. Under the DCAP, the maximum amount of reimbursement you may receive for a Plan Year is limited to the actual amount of your salary reduction for the Plan Year.

(g) *Maximum Benefit Amount.* The maximum amount that you may be reimbursed for Qualified Dependent Care Expenses that are incurred during a Plan Year is limited to the dollar amount that you elected to contribute to your DCAP for that Plan Year.

(i) *Amount Elected for the Plan Year.* The dollar amount of your election for a Plan Year is subject to the following limitations:

(A) *Limitation on Elections to Comply with the Exclusion Limit Under Code § 129(a)(2).* Your election must be limited so that, on a calendar year basis, you do not exceed the exclusion limit set forth in Code § 129(a)(2). The exclusion limit for a calendar year is $5,000 or, if you are married and filing a separate return, $2,500.

(B) *Earned Income Limitation.* As required by Code § 129(b), your election must further be limited so that, on a calendar year basis, the amount you elected does not exceed your earned income.

(C) *Limit Announced by the Plan Administrator.* The dollar amount of your election for a Plan Year may not exceed the dollar limit, if any, that is announced by the Plan Administrator for that Plan Year.

(ii) *Reimbursements Limited to Dollar Amounts Actually Credited to DCAP.* In no event will the reimbursements to you exceed the dollar amount actually credited to your DCAP for the Plan Year minus amounts previously reimbursed for the Plan Year.

(h) *IRS "Use It or Lose It" Requirement.* You should carefully evaluate the amount of your salary reduction for dependent care expenses. ***If your dependent care expenses are less than the amount by which you have reduced your salary for the Plan Year, you will forfeit the excess amount.*** This is an IRS requirement.

(i) *Election Changes.* Once you make an Election to participate in this DCAP, that Election may not be changed in the middle of the Plan Year, either as to your participation in the Plan or as to the dollar amount you elected, unless an Election change is permitted under the terms of the Plan (see Section (3)(d) of this SPD).

(j) *Federal Income Tax Considerations.* You may be able to claim a Dependent Care Tax Credit on your federal income tax return for your dependent care expenses. The availability of this credit depends on the number of dependents you have and your gross income. More information about the federal Dependent Care Tax Credit may be found in IRS Publication No. 503. ***You may not claim a credit on your federal income tax return for any dependent care expenses for which you have been reimbursed by the DCAP***. In many cases, you may save more money by receiving tax-free reimbursements under the Plan than by claiming the tax credit. ***Consult your own tax advisor if you are in doubt as to whether to obtain reimbursements under the Plan or to take the tax credit.***

(k) *Qualified Dependent Care Expenses.* A dependent care expense is an amount paid by you for the care of a qualified dependent, including related household services, which enables you to be gainfully employed. The "qualified" dependent care expenses for which you are entitled to reimbursement under the DCAP are generally those dependent care expenses that are permitted under Section 129 of the Internal Revenue Code.

(i) *Qualified Dependent.* A qualified dependent is:

(A) Your child (as defined in Internal Revenue Code § 152) who is under age 13 and is your "qualifying child" as defined in Code § 152(a)(1);

(B) Your tax dependent as defined in Code § 152, but determined without regard to Code § 152(b)(1), (b)(2), and (d)(1)(B), who:

(1) Is physically or mentally incapable of caring for himself/herself; and
(2) Is living with you for more than one-half of the calendar year; or

(C) Your Spouse who is physically or mentally incapable of self-care and who is living with you for more than one-half of the calendar year.

If you are divorced or separated and have a child whom you do not claim as a dependent for federal income tax purposes, the child must be in your custody for at least six months out of the year to be a qualified dependent.

(ii) *Types of Expenses Eligible For Reimbursement.* The following expenses are eligible for reimbursement:

(A) Payments for the care of a qualified dependent in your home. This includes care provided by a babysitter, nurse, or housekeeper in your home, as long as part of their service benefits the qualified dependent.

(B) Payments for the care of a qualified dependent outside your home. If such expenses are incurred for services provided by a dependent care center (i.e., a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations. If such expenses are incurred for services performed outside your home for an individual described in (k)(i)(B) above, then such individual must be living with you at least eight hours a day.

(C) Pre-school care, before- and after-school care, and day camp during school vacation.

(iii) *Types of Expenses Not Eligible For Reimbursement.* The following expenses are not eligible for reimbursement:

(A) Expenses paid through another policy or plan providing dependent care benefits to you or your Spouse.

(B) Amounts paid to your child who is age 18 or younger for babysitting or care of a qualified dependent.

(C) Expenses paid to a person whom you or your Spouse are entitled to claim as a dependent for federal income tax purposes.

(D) Expenses incurred prior to becoming a Participant in the DCAP.

(E) Education expenses for a child in kindergarten or any higher grade.

(F) Overnight care at a convalescent nursing home for a dependent Spouse or relative.

(G) Overnight camp.

(H) Expenses for lessons, tutoring, or certain types of transportation expenses.

(I) Forfeited deposits, but may include application fees, agency fees, and deposits if you are required to pay the expenses to obtain dependent care.

(l) *Run-Out Period*. "Run-Out Period" means the period that begins at the close of the Plan Year and ends 90 days following the close of the Plan Year. Eligible expenses must be submitted for reimbursement before the end of the Run-Out Period.

(m) *Electronic Payment Card.* The Employer permits the use of an electronic payment card, such as a debit card, to pay for Qualified Dependent Care Expenses. The electronic payment card may only be used at service providers which are authorized by the Employer.

(n) *Claims Procedures.* In the event you have a claim for benefits under the DCAP, you should submit a claim using the claim form that will be provided to you by the Claims Administrator and follow the instructions on that form.

(i) *Claims Administrator.* The Employer has designated Paylocity to act as the Claims Administrator for the DCAP. As the Claims Administrator, Paylocity shall have the sole authority to grant or deny any claims for benefits under the DCAP. If the Claims Administrator denies a claim, it will state its denial in writing and will deliver or mail to the Participant a notice of denial of benefits, setting forth the specific reasons for the denial. In addition, the Claims Administrator will give any Participant whose claim for benefits has been denied a reasonable opportunity for a review of the decision denying the claim.

(ii) *Electronic Payment Card.* If the Employer permits the use of an electronic payment card, such as a debit card, you may be able to access your DCAP through the use of such card, provided that the claim is properly adjudicated. If your funds are accessible by an electronic payment card, you must comply with the substantiation procedures in accordance with Rev. Rul. 2003-43 and other IRS guidance. Under those procedures, some payments with your electronic payment card may be automatically substantiated by this DCAP; other payments may require further substantiation by you to the DCAP.

(iii) *When to Submit a Claim.*

(A) *Deadline for Incurring Claims Following Cessation of Participation*. If you cease to participate in this DCAP for any reason, your salary reductions and election to participate will terminate on that date. You will not be able to receive reimbursements for Qualified Dependent Care Expenses incurred after the end of the last day of the Plan Year.

(B) *Deadline for Seeking Reimbursement of Claims Following Cessation of Participation*. To the extent you seek reimbursement for expenses incurred, you must do so in the following timeframes:

(1) Except as provided otherwise by Subsection (2) below, if you terminate employment or otherwise ceases to be an Eligible Employee, you (or your estate) must apply for reimbursement of Qualified Dependent Care Expenses by submitting a claim no later than the last day of the Plan Year.

(2) If this DCAP is terminated, you (or your estate) must submit any claim for reimbursement of Qualified Dependent Care Expenses within the 90-day period following the date the DCAP terminates.

(iv) *Claims Decisions and the Right to Appeal*. Within a reasonable time, not exceeding 90 days (unless the Claims Administrator notifies you of an extension of up to 90 days), the Claims Administrator will inform you of its decision to approve or deny your claim. If the Claims Administrator denies your claim, in whole or in part, you may have a right to appeal the decision.

(v) *Payment of Claims.* Approved claims will be paid directly to you. No claims will be paid to the provider of any services.

(vi) *Information Regarding Claims.* Prior to making any payment of benefits under the DCAP, the Claims Administrator may require you to provide such information and complete appropriate documents or forms necessary for the proper administration of the Plan. The Claims Administrator may rely upon all such information furnished to it, including your current mailing address.

(o) *Not An ERISA Plan.* The DCAP is not considered an employer-sponsored employee benefits plan under ERISA.

(p) *Termination of Coverage.* Your participation in the DCAP ends on whichever of the following dates occurs first:

(i) The date that you terminate your employment with the Employer, except that you may remain a Participant for purposes of incurring additional "qualified dependent care expenses" prior to the end of the Plan Year for purposes of being reimbursed from any money left in your account on the date your participation would otherwise have ended.

(ii) The date in which your election to participate expires;

(iii) The end of a period in which you last paid a required contribution;

(iv) The date the Employer terminates the DCAP; or

(v) You will not be authorized to continue use of an electronic payment card, such as a debit card, to access funds the funds in your DCAP as of the date of your termination from employment. Any claim submitted following your termination must be submitted in paper form.

(8) AFLAC Plan

The Employer maintains the AFLAC Plan that permits Participants to elect to receive benefits under one or more insurance contracts issued by American Family Life Assurance of Columbus ("AFLAC"), 1932 Wynnton Road, Columbus, Georgia 31999.

(a) *Type of Plan.* The AFLAC Plan is administered by the Employer; however, benefit claims are processed and paid by the Claims Administrator.

(b) *Eligibility/Plan Entry Date.* The eligibility conditions and the AFLAC Plan entry date are the same as those for the Plan, as described in Section (2).

(c) *Enrollment in the Plan.* **To become a Participant in the AFLAC Plan, you must enroll using the form or forms provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before your AFLAC Plan entry date. **If you do not elect to participate in the AFLAC Plan, you will not receive any benefits under the AFLAC Plan.**

(d) *Plan Benefits.* If you elect to participate in the AFLAC Plan, you will be able to select from the following policies, whether they be individual policies of insurance or group contracts, which are issued by AFLAC:

(i) Cancer Plan;

(ii) Accident Plan;

(iii) Hospital Plan; and/or

(iv) Short Term Disability Plan.

You will be insured under either individual contracts or group contracts issued by AFLAC. The contracts provide you (and your dependents, if family coverage is selected) with various types of insurance. AFLAC has prepared materials which explain the benefits of each individual policy or group contract, as applicable, in detail. AFLAC will provide these materials to you. If you do not receive a copy of these materials, you should request a copy from the Plan Administrator. These materials are an additional part of this SPD.

(e) *Obligation to Pay Benefits.* AFLAC is solely obligated to pay for the benefits provided under the AFLAC Plan. The Employer makes no promise, and will have no obligation, to provide or pay for benefits under the AFLAC Plan.

(f) *Premiums.* The monthly premiums for insurance coverage under the various individual policies or group contracts, as applicable, listed in (d) above are determined by AFLAC and may change from time to time. You may obtain current premium rates by contacting the Plan Administrator. You are required to pay one hundred percent of the monthly premium cost. Premiums for the benefits listed in (i) through (iii) must be paid on a pre-tax basis through the Plan; premiums for the benefit listed in (iv) must be paid on an after-tax basis through the Plan.

(g) *Claims Procedures.* In the event you have a claim for benefits under the AFLAC Plan, you should follow the procedures outlined in the materials prepared by AFLAC as applicable. The Plan Administrator, upon your request, will assist you in making these claims.

AFLAC has been delegated full discretionary authority to make all determinations regarding the administration and payment of such benefit claims, in accordance with the terms of the individual policy of insurance or group contract, as applicable.

(h) *Termination of Coverage.* Your participation in the AFLAC Plan ends on whichever of the following dates occurs first:

(i) The last effective date of coverage as specified by the individual policies or group contract;

(ii) The date on which your election to participate expires;

(iii) The end of a period for which a required contribution by you was last paid, taking into account any grace periods required by law;

(iv) The last day of the month in which you cease to be an Eligible Employee; or

(v) The date the Employer terminates the AFLAC Plan.

Your coverage for benefits under the AFLAC Plan ends with the termination of your participation. However, if you are covered under an individual insurance policy, you may be able to remain covered under the individual insurance policy outside the Plan. Similarly, if you are covered under a group contract, you may be able to remain covered under an *individual* insurance policy outside the Plan. Please refer to the individual policies or the group contract, as applicable, for further details.

(9) Health Savings Account

The Employer permits you, to the extent that you are eligible, to contribute to an individual Health Savings Account on a pre-tax basis through the Plan.

(a) *Type of Benefit.* The HSA is not an employer-sponsored employee benefit plan or ERISA plan. It is an individual trust or custodial account that you, as an eligible individual, open with a qualified HSA trustee/custodian selected by the Employer to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Employer will forward the contributions to be deposited to the trustee/custodian. This funding feature constitutes the HSA benefits offered under the Plan.

(b) *Eligibility Conditions.* In addition to the eligibility conditions for the Plan, in order to contribute to an HSA, you must meet each of the following conditions:

(i) You have enrolled in employee-only, employee plus Spouse, employee plus children, or family coverage under the "high deductible health plan" ("HDHP") coverage option of the Four County Mental Health Center Medical Plan;

(ii) You cannot be claimed as another person's tax dependent;

(iii) You are not enrolled in Medicare; and

(iv) If you are enrolled in any other health coverage *other than* coverage under the Four County Mental Health Center Medical Plan, that coverage is either: (A) HDHP coverage; or (B) permitted non-HDHP insurance or coverage.

For example, if you are also covered under your Spouse's medical plan, that coverage must be HDHP medical coverage. However, limited scope dental and/or vision coverage is considered to be "permitted non-HDHP coverage" and will not, by itself, prevent you from being eligible to contribute to an HSA.

(c) *High Deductible Health Plan Coverage*. High Deductible Health Plan ("HDHP") Coverage means the high deductible health coverage option offered by the Employer that is intended to qualify as HDHP coverage under Code § 223(c)(2).

(d) *Contributions to the HSA.* **To contribute to an individual HSA after you have satisfied the eligibility conditions, you must complete and return a salary reduction form provided by the Plan Administrator.** These forms must be completed and returned to the Plan Administrator on or before you may begin making contributions to your account.

(e) *Effective Date of Election.* An election to participate in an HSA shall take effect as follows:

(i) If you elect to make contributions during the Annual Enrollment Period under the Plan, the election shall take effect as of the first day of the next Plan Year; and

(ii) If you elect to make contributions at any other time during the Plan Year, the election shall take effect as of the first day of the next month.

(f) *Carryover of Unused Amounts.* Your individual HSA is permitted to grow from year to year. Any amounts remaining in the account at the end of the Plan Year may be carried forward.

(g) *Funding of HSA*. You may receive an annual Employer contribution if you have elected coverage under the Medical Plan, provided you have an HSA account with Health Equity or Paylocity. If you are newly eligible to contribute to an HSA, the Employer contribution will be prorated based on the number of months remaining in the Plan Year in which you become eligible. Any additional contributions through the Plan can be funded only with your pre-tax salary reductions. The Employer contribution is conditioned on you properly establishing an HSA pursuant to policies established by the Employer.

(h) *Election Changes*. Assuming you continue to be eligible, your election to contribute to an HSA can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next month following the date that the Election change was filed.

(i) *HSA and Health FSA*. The HSA benefit cannot be elected in combination with a Health FSA benefit (including that of your Spouse).

(j) *Maximum Annual Contribution Limit*. The amount you contribute to an HSA (including any Employer contributions made on your behalf) may not exceed the statutory maximum amount for HSA contributions, as adjusted annually to reflect changes in the cost-of-living,

applicable to your HDHP coverage option (i.e., single or family) for the calendar year in which the contribution is made. This amount is referred to as the Maximum Annual Contribution Limit and is subject to the provisions below:

(i) *Current Limit for Calendar Year.* The HSA Maximum Annual Contribution Limit for the current calendar year is the annual maximum dollar limit set forth in Code Section 223(g), as adjusted annually to reflect changes in the cost-of-living. Please contact the Plan Administrator to find out what the IRS limit is for the current year.

(ii) *No Proration for Less Than Full Year Participation.* The Maximum Annual Contribution Limit applies regardless of when you first become eligible to contribute to the HSA during the Plan Year, provided that you satisfy the "testing period." The "testing period" begins the last month of your tax year (generally, December 1) and ends on the last day of the 12th month following that month (generally, December 31 of the following year). Failure to complete the "testing period" will result in a ten percent penalty on the amount of the contributions and the contributions must be included in your gross income. An exception only applies if you become disabled or die.

Example of Testing Period. You first become eligible for and enroll in HDHP coverage on December 1. If you begin contributing to an HSA on December 1, you may contribute the statutory maximum amount for the year, not a prorated amount equal to one-twelfth of the year. In other words, you are treated as if you had been HSA-eligible all year long. If you contribute more than the pro rata amount, you must remain HSA-eligible until December 31 of the following year in order not to undergo any penalties.

If you become ineligible for the HSA the following, say, June (for reasons other than death or disability), the amount equal to your contributions for January through November of the previous year will be included in your gross income for the year and a ten percent penalty will apply to such amount.

(iii) *Catch-up Contributions.* If you are, or will be, age 55 or older on December 31 of the Plan Year, you may make an additional catch-up contribution for that Plan Year. For Plan Years beginning on, or after, January 1, 2009, the amount of the additional catch-up contribution may not exceed $1,000. A catch-up contribution is not taken into account for purposes of applying the Maximum Annual Contribution Limit.

(k) *Recording Contributions for HSA.* The Plan Administrator will maintain records to keep track of your HSA contributions made through the pre-tax salary reduction agreement. The Plan Administrator will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

(l) *HSA Providers.* The qualified HSA trustee/custodian, not the Employer, will establish and maintain the HSA. In order to make pre-tax contributions to an HSA and receive the annual funding amount from the Employer, you must choose Health Equity or Paylocity as the qualified HSA trustee/custodian of your HSA.

(m) *Trust/Custodial Agreement*. The HSA benefit consists solely of the ability to make contributions to the HSA on a pre-tax basis pursuant to a salary reduction agreement. The terms and conditions of coverage and benefits (e.g. eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA documents provided by your qualified custodian/trustee. The terms and conditions of your individual HSA trust or custodial account are described in the HSA trust or custodial agreement provided by your trustee/custodian and are not a part of the Plan.

(n) *Tax Treatment of HSA Contributions and Distributions*. The tax treatment of the HSA (including contributions and distributions) is governed by Code § 223.

(o) *Not An ERISA Plan.* The HSA is not an employer-sponsored employee benefits plan under ERISA. It is a savings account that is established and maintained by a qualified HSA trustee/custodian outside the Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2).

(10) COBRA Coverage for Group Health Plans

Generally, your Employer is required to offer COBRA continuation coverage unless the "small employer" exception to COBRA applies. This exception is based on the number of employees that your Employer employed during the previous calendar year. Generally, if such number is *less than 20*, then your Employer is *not* subject to COBRA and you should disregard this Section. **In the event, however, that your Employer has 20 or more employees as determined under COBRA**, this Section will apply to an employee covered under a Group Health Plan sponsored by the Employer and to such employee's covered Spouse and/or covered dependents. **If COBRA applies, you should read this Section carefully.**

COBRA coverage is a temporary extension of coverage under Group Health Plans, under certain circumstances, when coverage would otherwise end. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Group Health Plans when group health coverage would otherwise be lost. **This Section generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The group health components of the Plan in which you may be enrolled are the Medical Plan, the Dental Plan, the Vision Plan, and the Health FSA. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the Group Health Plan benefits offered under the Plan and not to any other benefits offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires and nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

(a) *Qualified Beneficiary.* After a qualifying event (described below) occurs, and any required notice of that event is properly provided to the Plan Administrator, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your dependent children may become qualified beneficiaries

and may be entitled to elect COBRA if coverage under a Group Health Plan is lost because of the qualifying event. (Certain newborns, newly-adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

(b) *Continuation Coverage.* Continuation coverage is the same coverage that the Group Health Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Group Health Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

(c) *Qualifying Events.* COBRA continuation coverage is a continuation of group health coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events with respect to each type of qualified beneficiary are as follows:

(i) *Employee.* If you are an employee, you will become a qualified beneficiary if you lose (or will lose) your group health coverage under the Plan because either one of the following qualifying events happens:

(A) Your hours of employment are reduced; or

(B) Your employment ends for any reason other than for gross misconduct.

(ii) *Spouse*. If you are the covered Spouse of an employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because any of the following qualifying events happens:

(A) Your Spouse dies;

(B) Your Spouse's hours of employment are reduced;

(C) Your Spouse's employment ends for any reason other than for gross misconduct;

(D) Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(E) You become divorced or legally separated from your Spouse. If your Spouse (the employee) reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

(iii) *Dependents.* If you are the covered dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

(A) Your parent-employee dies;

(B) Your parent-employee's hours of employment are reduced;

(C) Your parent-employee's employment ends for any reason other than for gross misconduct;

(D) Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

(E) Your parents become divorced or legally separated; or

(F) You stop being eligible for coverage under the plan as a "dependent child."

In addition to the above qualifying events, filing a proceeding in bankruptcy under Title 11 of the United States Code can sometimes be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

(d) *FMLA Leave.* If you take FMLA leave and do not return to work at the end of the leave, you (and your Spouse and dependent children, if any) will be entitled to elect COBRA if you, your Spouse, and dependent children, if any, (i) were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave), and (ii) will lose Plan coverage within 18 months because of your failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Group Health Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

(e) *Special Rule for Health FSAs.* COBRA coverage under a Health FSA will be offered only to qualified beneficiaries who have underspent accounts. A qualified beneficiary has an underspent account if he/she has been reimbursed less money than he/she has contributed.

(i) *COBRA Coverage.* COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year, and COBRA coverage will terminate at the end of the Plan Year.

(ii) *Qualified Beneficiaries.* Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. Each beneficiary, however, has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, you should contact the Plan Administrator for more information.

(f) *COBRA Notice Procedures*. When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Employer of any of these three qualifying events. **For all other qualifying events, you must notify the Plan Administrator in writing within 60 days after the date on which the qualifying beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event and in accordance with these Notice Procedures. The Plan will not provide you with an Election form to begin or extend COBRA coverage if it does not receive proper notice from you regarding such qualifying events.**

Warning: If your notice is late or if you do not follow these Notice Procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable). If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

(i) *Notices Must Be In Writing And Submitted On Plan Forms.* Any notice that you provide must be in writing and must be submitted on the Plan's required form. (You may obtain copies of required forms from the Plan Administrator.) Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

(ii) *How, When, And Where To Send Notices.* You must mail or hand-deliver your notice to the Plan Administrator, whose address is provided at the beginning of this SPD.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the Plan Administrator individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described above in this Section of the SPD.)

(iii) *Information Required For All Notices.* Any notice you provide must include: (A) the name of the Plan; (B) the name and address of the employee who is (or was) covered under the Plan; (C) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (D) the qualifying event and the date it happened; and (E) the certification, signature, name, address, and telephone number of the person providing the notice.

(iv) *Additional Information Required For Notice of Divorce Or Legal Separation.* If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

(v) *Additional Information Required For Notice Of Disability.* Any notice of disability must include: (A) the name and address of the disabled qualified beneficiary; (B) the date that the qualified beneficiary became disabled; (C) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (D) the date that the Social Security Administration made its determination; (E) a copy of the Social Security Administration's determination; and (F) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

(vi) *Additional Information Required For Notice Of Second Qualifying Event.* Any notice of a second qualifying event must include: (A) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (B) the second qualifying event and the date that it happened; and (C) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

(vii) *Who May Provide Notices.* The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice of the qualifying event, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

(g) *Electing COBRA Coverage*. Once the Plan Administrator receives *timely* notice that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect continuation coverage. For example, the covered employee's Spouse may elect COBRA even if the employee does not. COBRA may be elected for one, several, or for all dependent children who are qualified beneficiaries. Covered employees and Spouses (if the Spouse of a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the date that Plan coverage would otherwise have been lost.

(h) *Sixty-Day Election Period.* A qualified beneficiary must elect coverage in writing within 60 days of losing coverage under the Plan (or, if later, within 60 days of being provided a COBRA election notice), using the Plan's Election form and following the procedures specified on the Election form. (A copy of the Plan's Election form may be obtained from

the Plan Administrator.) The Election form must be mailed or hand delivered to the address indicated at the beginning of this SPD and as indicated on the Plan's Election form. If you mail your Election, it must be postmarked no later than the last day of the 60-day Election period. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

(i) *Failure to Return Election Form.* **If you or your covered Spouse or covered dependent children do not elect continuation coverage within the 60-day election period, you will lose your right to elect continuation coverage.**

(ii) *Rejection of COBRA Rights.* If a qualified beneficiary rejects COBRA before the due date, he/she may change his/her mind as long as a completed Election form is furnished before the due date.

(iii) *Elections Under More Than One Group Health Plan.* Qualified beneficiaries may be enrolled in one or more group health benefits under the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he/she may elect COBRA under any or all of the group health benefits under the Plan, and in which he/she was covered on the day before the qualifying event.

(i) *Length of COBRA Coverage.* The COBRA coverage periods described below are *maximum* coverage periods for each type of qualified event. COBRA coverage can end before the end of the maximum coverage periods for several reasons outlined in Subsection (k) below.

(i) *Employee's Termination of Employment.* COBRA continuation coverage may last for up to 18 months for the former employee, the Spouse, and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in Subsection (j) below.

(ii) *Employee's Reduction of Hours.* COBRA continuation coverage may last for up to 18 months for the employee, Spouse, and any dependents who are qualified beneficiaries. The 18-month period for the Spouse and/or dependent child may be extended if a qualified beneficiary is disabled or if there is a "second qualifying event" as described in Subsection (j) below.

(iii) *Death of Employee*. COBRA continuation coverage may last for up to 36 months for the Spouse and any dependents who are qualified beneficiaries.

(iv) *Employee Entitlement to Medicare*. COBRA continuation coverage may last for up to 36 months for the Spouse and any dependents who are qualified beneficiaries.

(v) *Divorce or Legal Separation*. COBRA continuation coverage may last for up to 36 months for the Spouse and any dependents who are qualified beneficiaries.

(vi) *Loss of Dependent Status*. COBRA continuation coverage may last for up to 36 months for the dependent who is a qualified beneficiary.

(vii) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA may not be continued beyond the end of the Plan Year in which the qualifying event occurred.

(j) *Extension of Maximum Coverage Period (Not applicable to Health FSA)*. If the qualifying event that resulted in your COBRA election was the employee's termination of employment or reduction in hours, the 18-month maximum period may be extended if a qualified beneficiary who has elected COBRA coverage becomes disabled, if a "second qualifying event" occurs, or if the employee became entitled to Medicare in the 18-month period preceding his/her termination of employment or reduction of hours. (These extension opportunities do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce or legal separation, or a dependent child's loss of eligibility.)

(i) *Disability Extension.* If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

(ii) *Extension Due to a Second Qualifying Event.* An extension of coverage will be available to Spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce, or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan if the first qualifying event had not occurred.

(iii) *Medicare Extension for Spouse and Dependents.* If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the Spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

These extensions in subparagraphs (i) through (iii) above are available only if you timely notify the Employer in writing of the Social Security Administration's determination of disability and the second qualifying event within the 60-day notice period and the entitlement to Medicare within 30 days of entitlement in accordance with the Plan's Notice Procedures found in Section (f) above.

(iv) *Special Rule for Health FSAs.* Regardless of which of the above qualifying events occurs, COBRA coverage under the Health FSA will not be extended and will only continue until the end of the Plan Year in which the initial qualifying event occurred.

(k) *Termination of COBRA Coverage before End of Maximum Period.* Continuation coverage will be terminated before the end of the maximum period if:

(i) Any required premium is not paid before the end of the grace period;

(ii) After electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan;

(iii) After electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both);

(iv) The employer ceases to provide any Group Health Plan for its employees;

(v) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled; or

(vi) Coverage would have been terminated under the same circumstances for a Participant or beneficiary not receiving continuation coverage, for example, if a Participant or beneficiary engages in fraudulent activities against the Plan.

(l) *Cost of COBRA Coverage.* Each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed one hundred two percent (or, in the case of an extension of continuation coverage due to a disability, one hundred fifty percent) of the cost to the Group Health Plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

(m) *First Payment.* All COBRA premiums must be paid by check or money order, unless your COBRA administrator accepts a debit card. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election form. However, you must make your first payment for COBRA coverage within 45 days after the date of your Election. (This is the date the Election notice is post-marked, if mailed, or the date your Election form is received by the individual at the address specified for delivery of the Election form, if hand-delivered.) Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the address indicated on the Election notice (unless, as stated above, your COBRA administrator accepts payment via

debit card). You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise. **If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment.

EXAMPLE: You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on November 15. Your initial payment equals the premiums for October and November and is due on or before December 30, which is the 45th day after the date of your COBRA election. You are responsible for making sure that the amount of your first payment is correct. You may contact the Employer to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

(n) *Monthly Payments for COBRA Coverage.* After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month, for each qualified beneficiary, will be disclosed in the Election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage.

EXAMPLE: You terminate employment on September 30 and lose coverage on September 30. You elect COBRA on October 15. Your initial payment is due on or before November 29 and should equal the premium for October. You will be required to make monthly premiums, starting with the month of November, by the first of each month. This means that the premium for November is due by the first of November.

(o) *Grace Periods*. Although periodic payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a monthly payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that payment/month, you will lose all rights to COBRA coverage under the Plan.

(p) *Children Born to or Placed for Adoption.* A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself/herself. The child's COBRA

coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

(q) *Alternate Recipients Under QMCSOs.* A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

(r) *Address Changes.* In order to protect your family's rights, you should keep the Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer.

(s) *Questions.* Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, HIPAA and other laws affecting group health plans, contact the nearest regional or district office of the U.S. DOL's Employee Benefits Security Administration ("EBSA") or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through this website.)

(11) USERRA Continuation Rights

If you are absent from employment as a result of military service, you will have the right to elect continuation coverage for a period of up to 24 months if such coverage would otherwise be lost as a result of such military service. Your right to continue coverage is subject to the following:

(a) *Payment of Premium.* You must pay the applicable premium for any USERRA continuation coverage. For a leave of absence for less than 31 days, you may not be required to pay more than you would have paid had you not been on leave. For a leave of absence of more than 30 days, you must pay the entire cost of coverage plus an additional two percent.

(b) *Failure to Apply for Reemployment.* Following completion of your military service, your right to continue coverage under USERRA will end if you do not apply for reemployment within the applicable time period set forth in USERRA (43 U.S.C. § 4312(c)).

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your Employer's group health plan when you are reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

(12) Recovery of Benefits by the Self-Funded Group Health Plans (other than the Health FSA)

(a) *Subrogation*. The right of subrogation means the right of the self-funded Group Health Plans to "step into your shoes" and take over your right to receive payments from third parties or to pursue a cause of action against third parties, to the extent of payments made

by the Group Health Plans. By *accepting* benefits from the Group Health Plans, you are agreeing to the Group Health Plans' right of subrogation to any claim or right of action that you may have against a third party. You may be required to sign an agreement affirming these rights of the Group Health Plans before any benefits are paid in connection with a particular injury or condition.

> *Example of Subrogation:* You are injured in a car accident and the Medical Plan pays your medical expenses resulting from the accident. You have a claim against the other driver for your injuries. The Medical Plan may make a claim against the other driver because either (i) you do not assert a claim against the driver, or (ii) you assert a claim against the other driver, but it does not include damages for medical expenses that were paid by the Medical Plan.

(b) *Reimbursement.* The right of reimbursement is the right of the Group Health Plans to recover from you or your covered dependent any and all benefits previously paid by the Group Health Plans with respect to an injury or condition when you are compensated for such injury or condition from any source, whether by settlement, judgment, compromise, or otherwise. The right to reimbursement also includes future health expenses, if any. In addition, the Group Health Plans' right to reimbursement includes any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which you, your covered dependent, or assignee were not entitled.

By *accepting* benefits under the Group Health Plans, you are agreeing to reimburse the Group Health Plans out of any recovery you might receive from third parties. If you bring a liability claim against any third party, benefits payable under the Group Health Plans must be included in the claim.

You must not do anything which would prejudice the Group Health Plans' rights of reimbursement, and you may be required to sign and deliver documents reasonably necessary to secure the rights of the Group Health Plans to reimbursement.

> *Example of Reimbursement:* You are injured in a car accident and the Medical Plan pays your medical expenses resulting from the accident. You bring a claim against the other driver for your injuries, which you eventually settle against the other driver. The Medical Plan is entitled to immediate reimbursement from what you recovered in your settlement for *all benefits* paid by the Medical Plan in connection with your injuries. You may not reduce the amount owed the Medical Plan in order to account for attorney's fees and costs. Further, the Medical Plan must be paid *first* out of the *total* amount of the settlement.

(c) *Amount Due.* The amount owed to the Group Health Plans may not be reduced by the attorney's fees and costs incurred in asserting your claim against third parties. In addition, the Group Health Plans' rights of reimbursement and subrogation take precedent over your right to be made whole.

(d) *Condition of Payment.* At the Group Health Plans' request, you (or your covered dependent) must take any action, give information, and/or execute instruments required by the Plan, in its discretion, in order to aid the Group Health Plans in their enforcement

of its rights of recovery through reimbursement and subrogation. Among other things, if you (or your covered dependent, assignee, or someone legally qualified and authorized to act on your behalf) discover that a third party may be liable for an injury or illness for which the Plan has paid benefits, you must promptly notify the Plan Administrator. Such notice must occur before any legal action has been commenced against such third party. Further, if a settlement is reached with the third party without the formal filing of a legal action, you must notify the Plan Administrator before the settlement is finalized. If you (or your covered dependent/assignee/legal representative) fail to comply with these notice directives and/or you do not comply with any information request by the Plan Administrator, the Group Health Plans may withhold benefits, services, payments, or credits due under the Group Health Plans.

(e) *Coordination of Benefits*. If you (or your covered dependent) seek benefits under the Group Health Plans that are also payable under another plan or reimbursement arrangement (such as Medicare), the plans will coordinate how benefits are to be paid. The procedures governing this coordination of benefits are set forth in the summary of benefits prepared by the insurance company (if the plan is fully-insured) or the claims administrator (if the plan is self-insured).

(13) Group Health Plan Claims Procedures (Not applicable to the Health FSA)

Payment by the Claims Administrator is based on data furnished by you. In order to collect benefits under the Plan, you must first provide the Claims Administrator with information about your claim for benefits.

Claims made for benefits under the fully-insured Group Health Plans, and any appeals from the denial of such Claims, shall be processed in accordance with the claims procedures of the insurer. Unless otherwise stated in your applicable insurance policy, before filing any legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator, you must first exhaust the administrative remedies summarized in your policy. This means, for example, that, if a claim is denied, you must appeal the denial following the procedures provided in your policy of insurance. If you do not exhaust your administrative remedies, you will not be allowed to file a civil action concerning a claim for benefits under the Plan. Unless otherwise stated in your applicable insurance policy, following the Plan's issuance of a final adverse benefit determination, you will have 180 days to file a legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator. Failure to meet this deadline will result in the forfeiture of any Claim that you may have.

Claims made for benefits under the self-funded Group Health Plans (other than the Health FSA), and any appeals from the denial of such Claims, shall be processed in accordance with the claims procedures of the Claims Administrator. Before filing any legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator, you must first exhaust all administrative remedies. This means, for example, that, if a claim is denied, you must appeal the denial to the Claims Administrator. If you do not exhaust your administrative remedies, you will not be allowed to file a civil action concerning a claim for benefits under the Plan. Following the Plan's issuance of a final adverse benefit determination, you will have 180 days to file a legal action against the Plan, the Employer, the Plan Administrator, or the Claims Administrator. Failure to meet this deadline will result in the forfeiture of any Claim that you may have.

(14) Miscellaneous

(a) *Qualified Medical Child Support Orders.* Participants in a Group Health Plan and their beneficiaries may obtain from the Plan Administrator, without charge, a copy of the plan's procedures governing the determination of whether an order is a "qualified medical child support order" ("QMCSO").

(b) *Family and Medical Leave Act.* If you take an unpaid leave under the FMLA, the Employer will, to the extent required by the FMLA, continue to maintain your benefits under a Group Health Plan on the same terms and conditions as though you were still an active Employee.

If you choose to continue your coverage while you are on a FMLA leave, the Employer will continue to pay its share (if any) of the premiums. You will be required, if you choose to continue your coverage, to pay your share of the premiums in one or more of the following ways:

(i) You may pay your share of the premiums with after-tax dollars while you are on FMLA leave (or with pre-tax dollars to the extent you receive compensation from the Employer during your leave).

(ii) You may pay your share of the premium pursuant to such other arrangement as may be agreed upon between you and the Plan Administrator.

If your coverage ceases while you are on FMLA leave, you will be permitted to reenter the Plan immediately upon your return from FMLA leave on the same basis that you were participating in the Plan prior to your leave, or as otherwise required by the FMLA. If you fail to remit your premium payments within thirty (30) days after the premium payment is due, then the Employer – following any requisite notice mandated by FMLA regulations – may terminate your coverage retroactive to the date the unpaid premium payment was due.

(c) *Return of Premium.* If money is returned in any form by an insurance company that provided or is providing benefits under the Plan, including, but not limited to, a rebate of premiums previously paid, proceeds from demutualization, or rebates resulting from an insufficient "medical loss ratio" (MLR), the Plan Administrator shall have the discretion to apply such amounts to the payment of Plan expenses, the reduction of premiums, and/or benefit enhancements. The Plan Administrator shall further have the discretion to allocate such funds in any manner deemed appropriate.

(d) *Returns of Benefit Payments Made in Error*. The Plan shall have the right to reimbursement from you, your covered dependents, or assignees for any benefit overpayments attributable to mistake, clerical error, fraud, or any other reason contributing to benefit payments to which you, your covered dependents, or assignees were not entitled.

(15) Participant's Rights under ERISA

As a Participant in the Plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). You have ERISA rights with respect to all benefits provided through the Plan except for the DCAP and HSA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. DOL and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if applicable. If, and to the extent, the plan is required to file an annual financial report with the government, the Plan Administrator is required by law to furnish each participant with a copy of a summary annual report. If the plan is not required by law to file an annual financial report, no summary annual report is required.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, or dependents if there is a loss of coverage under a Group Health Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, but only after first exhausting the Plan's internal claims procedures (i.e., exhausting your administrative remedies) within the time frame set forth

in the Plan document. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. DOL, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

(16) Notice of Hospital Rights for Newborns and Mothers

HIPAA requires this SPD to include the following explanation of your rights under the Health Insurance Portability and Accountability Act of 1996. Please note that this statement is made to you by the federal government. Therefore, the Employer and the Plan Administrator are not responsible for the accuracy or completeness of the explanation, and some of the provisions may not apply to the Plan.

Group health plans and health insurance issuers 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 caesarean 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).

(17) Notice of Rights under the Women's Health and Cancer Rights Act of 1998

The Employer is required by federal law to provide the following notice:

If a group medical plan provides medical and surgical benefits for mastectomies, that plan must also provide coverage for the following, if they are agreed upon by a participant or beneficiary who is receiving benefits in connection with a mastectomy and that person's attending physician:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and physical complications of mastectomies, including lymph edemas.

This coverage must be the same as for any other benefit under the plan and is subject to the plan's annual deductibles and co-payment requirements.

(18) Right of Employer to Amend or Terminate

The Employer may at any time amend or terminate the Plan, including any of the plans that are summarized in this SPD, by a written instrument signed by the Executive Director of the Employer, as provided for in each of the respective plan documents. Any amendment to any plan will be added to the Plan in writing and communicated to Participants.

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APPENDIX A
SPECIAL ELIGIBILITY RULES UNDER LOOK-BACK MEASUREMENT METHOD

Although the Plan ordinarily requires that an Employee be *regularly scheduled to work at least 30 hours per week* in order to be eligible to participate in the Plan, certain part-time, variable hour, and seasonal workers may be eligible for coverage if they average at least 30 hours per week during the applicable Look-Back Measurement Period. These rules, which were established under regulations adopted pursuant to the Patient Protection and Affordable Care Act ("PPACA"), are extremely complicated and are set forth in detail in the Addendum 1 to the Plan. What follows is simply a general summary of how the Look-Back Measurement Method works. If you have additional questions, please contact the Plan Administrator.

Ongoing Employees

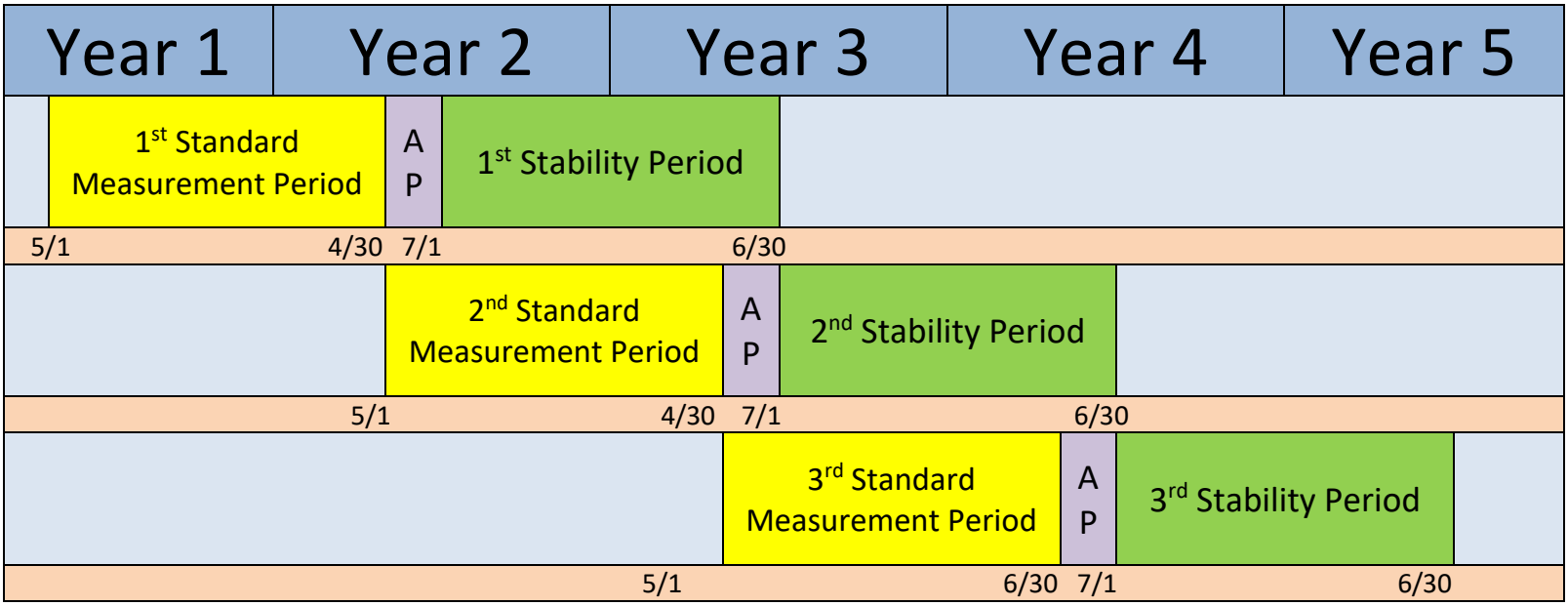
In general, for any Employee who is (i) not already regularly scheduled to work at least 30 hours per week and (ii) not categorically excluded from eligibility for the Plan regardless of hours worked, the Employer will add up the Employee's hours over a specified 12-month period of time (referred to as the "Standard Measurement Period") and determine if the Employee averaged at least 30 hours per week during that 12-month period. If the Employee *did* average at least 30 hours per week during the Standard Measurement Period, then he/she will be considered full-time (and thus will be offered coverage under the Plan) during the 12-month Stability Period that follows, and is associated with, that Standard Measurement Period. This is true regardless of how many hours the Employee actually works during that Stability Period.

If, on the other hand, the Employee *did not* average at least 30 hours per week during the Standard Measurement Period, then he/she will not be considered to be full-time (and thus will not be offered coverage in the Plan) during the 12-month Stability Period that follows the Standard Measurement Period. With some exceptions, this is true regardless of how many hours the Employee actually works during that Stability Period.

In addition, the Employer will be using an "Administrative Period" of approximately 30-60 days as a buffer between the Standard Measurement Period and Stability Period. This Administrative Period will be used by the Employer to count up the Employees' hours and to serve as an open enrollment period, if applicable.

The rules described above apply to all Employees who were employed by the Employer as of the first day of the Standard Measurement Period. These individuals are all referred to as "Ongoing Employees."

Although the Look-Back Measurement Method is complicated, the chart that appears at the top of the next page is designed to provide a visual illustration of what this Look-Back Measurement Method will look like for Ongoing Employees. As you can see from each of the three rows, the Standard Measurement Period and Stability Period will run for the same length of time and same time frame each year. So an individual may be deemed to be a "full-time" employee (and thus offered coverage) during one year's Stability Period (based on his/her hours in the preceding Standard Measurement Period), but then not be deemed a "full-time" employee (and thus not offered coverage) during some other year's Stability Period.



New Employees

A similar, but slightly different rule is used for *new employees*. A "New Employee" is any part-time, variable hour, or seasonal employee who was not employed by the Employer as of the first day of the Standard Measurement Period. A New Employee who, at the time of hire, is expected to average at least 30 hours per week will be treated as full-time immediately and offered coverage no later than the first day following the end of any applicable waiting period. But if the New Employee is a part-time, variable hour, or seasonal employee, the New Employee will *not* be eligible to enter the Plan unless he/she averages 30 hours per week during his/her Initial Measurement Period as described below. Instead, the New Employee's hours will be tracked using measurement and stability periods similar to those used for Ongoing Employees.

Basically, the Employer will start tracking the hours of the New Employee (who is either a part-time, variable hour, or seasonal employee) immediately – or almost immediately – after the New Employee begins employment. This tracking period is known as the "Initial Measurement Period." The Initial Measurement Period will be 12 months, and it will begin on approximately the first day of the first month after the New Employee's start date. If the New Employee *did* average at least 30 hours per week during this Initial Measurement Period, then he/she will be considered full-time (and thus will be offered coverage in the Plan) during the subsequent 12-month Initial Stability Period that follows, and is associated with, that Initial Measurement Period. This is true regardless of how many hours the Employee actually works during that Initial Stability Period.

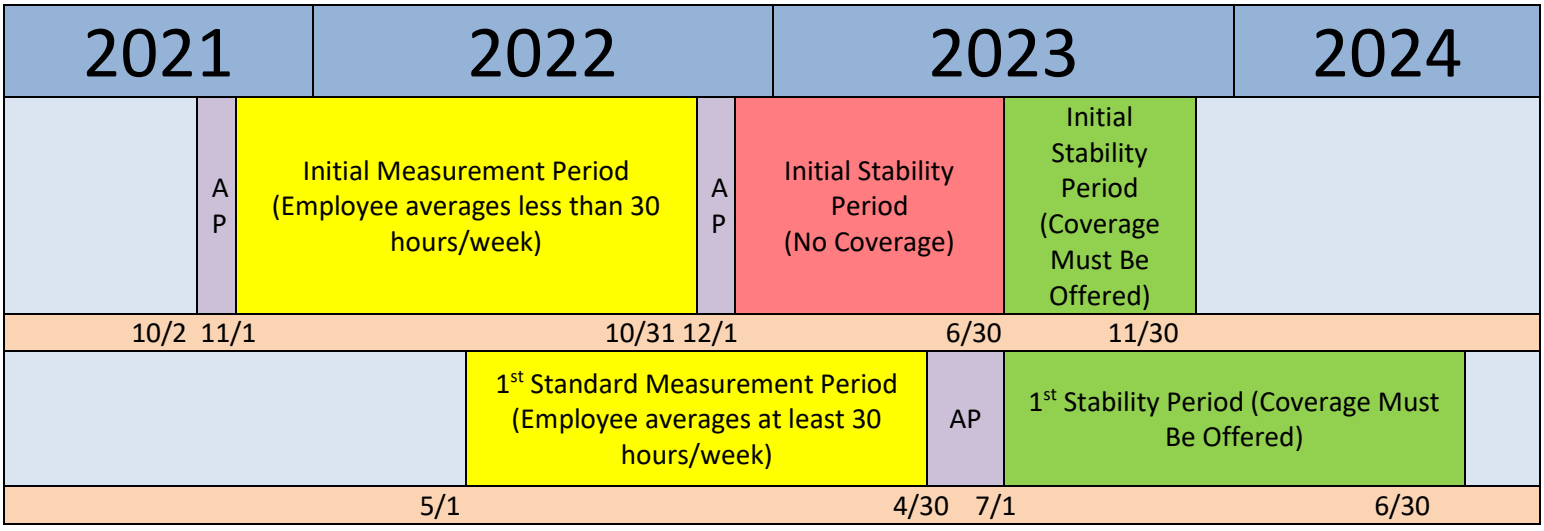
If, on the other hand, the New Employee *did not* average at least 30 hours per week during the Initial Measurement Period, then he/she will not be considered to be full-time (and thus will not be offered coverage in the Plan) during the subsequent 12-month Initial Stability Period that follows the Initial Measurement Period. With some exceptions, this is true regardless of how many hours the Employee actually works during that Initial Stability Period.

At the same time that a New Employee's hours are being tracked in the Initial Measurement Period, they are also being tracked in the Standard Measurement Period that is applicable to Ongoing Employees. In other words, once a New Employee has been employed for an entire

Standard Measurement Period, the (now formerly) New Employee must also be tested for full-time status using the Standard Measurement Period applicable to all other Ongoing Employees. In other words, there will be dual, overlapping measurement periods. Moreover, during this transition from New Employee to Ongoing Employee, the employee must be given the "best of either" treatment. That is, if one test causes the employee to be considered "full-time," while the other test does not, the "full-time" result must be followed.

To see what these rules look like in a visual format, consider the following example, which is detailed on the chart below. The plan is a July 1 year plan. A New Employee is hired on October 2, 2021. During this New Employee's Initial Measurement Period (which runs from November 1, 2021 through October 31, 2022), he/she averages less than 30 hours per week. Accordingly, the Employer normally would be able to exclude the New Employee from coverage during the entire Initial Stability Period (which runs from December 1, 2022 through November 30, 2023). But in our example, assume that this employee does average at least 30 hours per week during the Standard Measurement Period that runs from May 1, 2022 through April 30, 2023. As a result, the employee must be offered coverage during the Stability Period that is associated with that Standard Measurement Period. That Stability Period, which overlaps with the plan year, runs from July 1, 2023 through June 30, 2024. So, even though the Initial Stability Period runs through November 30, 2023, the employee must be offered coverage no later than July 1, 2023, which is the beginning of the Stability Period that is associated with the Standard Measurement Period in which the employee averaged at least 30 hours per week.

The following chart provides a visual of the preceding example:



There are special rules that apply to employees who have employment status changes (e.g., from variable hour to full-time) during their Initial Measurement Period. There are also special rules that apply to employees who are terminated and later rehired. A description of those special rules, however, is simply not possible in this very brief summary.

We recognize that these eligibility rules are incredibly complex. There is no easy way to summarize all the intricate rules and exceptions in a brief 2-3 page summary. If you have questions, we encourage you to contact the Plan Administrator.

MINUTES AND RESOLUTIONS

RESOLUTION – RESTATEMENT OF PLAN DOCUMENT

The undersigned hereby certifies that he is the Executive Director of Four County Mental Health Center, Inc. (the **"Corporation"**) and, as Executive Director, he has been delegated the authority to amend and restate the Four County Mental Health Center Welfare Benefit Plan (the **"Plan"**):

WITNESSETH:

WHEREAS, the undersigned hereby approves the amended and restated Plan, effective July 1, 2024; and

WHEREAS, the Executive Director be, and hereby is, authorized and directed to execute and deliver the Plan as amended and restated, which restated plan reflects the Plan as it existed on July 1, 2024.

NOW THEREFORE, BE IT RESOLVED, effective July 1, 2024, the amended and restated Plan is hereby adopted pursuant to the authority that has been delegated by the Corporation to the undersigned.

DocuSigned by:
Greg Hennen
C1B677564C83421...

Greg Hennen, Executive Director

CERTIFICATE OF RESOLUTION

I do hereby certify that I am the Executive Director of Four County Mental Health Center, Inc., (**"Health Center"**) duly organized and existing under and by virtue of the laws of the State of Kansas, and, as Executive Director, I do hereby certify that at a meeting of the Directors of the Health Center, duly called, held and convened according to the laws and bylaws of the Health Center, on the 12th day of May, 2022, a quorum being present and voting thereon the following resolutions were approved by the Directors, that the following is a full, true and correct copy of the resolutions as they appear on the records of the Health Center; that they have not been altered, amended or repealed and are now in full force and effect; that I am one of the duly authorized and proper officers of the Health Center to make certified copies of its records on its behalf.

WHEREAS, the Executive Director of the Health Center has recommended that the **Four County Mental Health Center Welfare Benefit Plan** (the **"Plan"**) be temporarily amended, effective March 1, 2020, to reflect that employees who exercise a HIPAA special enrollment right under the Medical Plan may make a corresponding election change as long as the election change is made no later than *the earlier of* (A) one year plus 30 or 60 days, as applicable, after the date of the Participant's HIPAA special enrollment event, or (B) 60 days after the end of the "Outbreak Period" (defined as the period from March 1, 2020 until 60 days after the end of the national state of emergency due to the COVID-19 pandemic);

WHEREAS, the Executive Director of the Health Center has recommended that the Plan be amended, effective July 1, 2022, to provide for a change the change in the claims administrator for the Health Flexible Spending Account and Dependent Care Assistance Plan from Discovery Benefits, Inc. to Paylocity, that Health Equity is the claims administrator for any prior Health Savings Accounts and that Paylocity is the claims administrator for any new Health Savings Accounts, and to reflect updates for recent judicial and regulatory legal developments;

WHEREAS, the Executive Director of the Health Center has advised that the amendments to the Plan may be made by replacement pages, with the amended Articles II, V, VII, XI, and Appendices A, C, D, and F dated 09/22 being substituted for the corresponding pages currently within the Plan, reflecting the Plan as it existed on July 1, 2022, and by adding the Special COVID-19 Plan Amendment No. 2; and

WHEREAS, having had the opportunity to review the same, the Directors deem it to be in the best interests of the Health Center to approve the amendment of the Plan as proposed and that the Health Center could make the necessary amendment by replacing certain pages of the plan documents.

NOW THEREFORE, BE IT RESOLVED, that, effective July 1, 2022, the amendments to the Plan shall be, and hereby are, adopted, and that the amended pages Articles II, V, VII, XI, and Appendices A, C, D, and F dated 09/22 of the Plan shall be substituted for pages Articles II, V, VII, XI, and Appendices A, C, D, and F of the current document, the Special COVID-19 Plan Amendment No. 2, a copy of the amended pages shall be attached to and made a part of this Resolution, and that a copy of the pages being replaced shall be retained as part of the permanent records of the Health Center.

IN WITNESS WHEREOF, effective as of the dates indicated above, the undersigned has executed this Resolution to be filed as part of the records of the Health Center.

DocuSigned by:
Greg Hennen
C1B677564C83421...

Greg Hennen, Executive Director

CERTIFICATE OF RESOLUTION

I do hereby certify that I am the Executive Director of Four County Mental Health Center, Inc., ("Health Center") duly organized and existing under and by virtue of the laws of the State of Kansas, and, as Executive Director, I do hereby certify that at a meeting of the Directors of the Health Center, duly called, held and convened according to the laws and bylaws of the Health Center, on the 13th day of May, 2021, a quorum being present and voting thereon the following resolutions were approved by the Directors, that the following is a full, true and correct copy of the resolutions as they appear on the records of the Health Center; that they have not been altered, amended or repealed and are now in full force and effect; that I am one of the duly authorized and proper officers of the Health Center to make certified copies of its records on its behalf.

WHEREAS, the Executive Director of the Health Center has recommended that the **Four County Mental Health Center Welfare Benefit Plan ("Plan")** be temporarily amended, effective March 1, 2020, to reflect that employees who exercise a HIPAA special enrollment right under the Medical Plan may make a corresponding election change as long as the election change is made no later than *the earlier of* (A) one year plus 30 or 60 days, as applicable, after the date of the Participant's HIPAA special enrollment event, or (B) 60 days after the end of the "Outbreak Period" (defined as the period from March 1, 2020 until 60 days after the end of the national state of emergency due to the COVID-19 pandemic);

WHEREAS, the Executive Director of the Health Center has recommended that the Plan be amended to reflect that the medical benefit is self-funded and administered by Meritain, the addition of the Hospital Plan, and to allow for reimbursement of certain over-the-counter drugs as well as permitted menstrual products under the Health FSA pursuant to the CARES Act;

WHEREAS, the Executive Director of the Health Center has recommended that the Plan be temporarily amended from March 23, 2020 through the date the applicable insurance company allows to reflect that employees who experience a reduction in hours may remain eligible for the applicable benefit due to the COVID-19 pandemic;

WHEREAS, the Executive Director of the Health Center has advised that the amendments to the Plan may be made by replacement pages, with the amended pages 2.2, 2.3, 2.4, 3.2, 4.1, 4.2, 5.1, 6.1, 7.1, 9.1, and Appendices A, B, C, D, E, F, G, and H dated 09/21 being substituted for the corresponding pages currently within the Plan, reflecting the Plan as it existed on July 1, 2021, and by adding the Special COVID-19 Plan Amendment; and

WHEREAS, having had the opportunity to review the same, the Directors deem it to be in the best interests of the Health Center to approve the amendment of the Plan as proposed and that the Health Center could make the necessary amendments.

NOW THEREFORE, BE IT RESOLVED, that, effective July 1, 2021, the amendments to the Plan shall be, and hereby are, adopted, and that the amended pages 2.2, 2.3, 2.4, 3.2, 4.1, 4.2, 5.1, 6.1, 7.1, 9.1, and Appendices A, B, C, D, E, F, G,

and H dated 09/21 of the Plan shall be substituted for pages 2.2, 2.3, 2.4, 3.2, 4.1, 4.2, 5.1, 6.1, 7.1, 9.1, and Appendices A, B, C, D, E, F, G, and H of the current document, the Special COVID-19 Plan Amendment, a copy of the amended pages shall be attached to and made a part of this Resolution, and that a copy of the pages being replaced shall be retained as part of the permanent records of the Health Center.

BE IT FURTHER RESOLVED, effective until the date the insurance company(s) for the underlying component benefit(s) no longer permits a special extension of eligibility for COVID-19 related reasons, the **"Special COVID-19 Plan Amendment No. 2"** to the Plan shall be, and hereby is, adopted, and a copy of the Amendment shall be attached to and made a part of these Resolution.

IN WITNESS WHEREOF, effective as of the dates indicated above, the undersigned has executed this Resolution to be filed as part of the records of the Health Center.

DocuSigned by:

Greg Hennen

C0B677...

Greg Hennen, Executive Director

LANGUAGE FOR THE MINUTES
FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN

WHEREAS, under the current terms of the **Four County Mental Health Center Welfare Benefit Plan ("Plan")**, covered employees who have their regularly scheduled hours reduced to below 30 hours per week will experience a loss of eligibility on the date his/her hours are reduced (although the Plan will allow coverage under the component benefit(s) to continue through the end of the month if so provided under the component benefit(s);

WHEREAS, under the current terms of the Plan, covered employees who are placed on an unpaid leave of absence will experience a loss of eligibility for any of the component benefit plans in which they are enrolled after six weeks;

WHEREAS, the Secretary of the County has recommended that the Plan be temporarily amended, effective March 23, 2020 through December 31, 2020, to allow employees who are currently participating in one or more of the component welfare benefits offered under the Plan and who, as a result of the coronavirus pandemic, would lose their eligibility for these benefits by virtue of a reduction in their hours or an extended unpaid leave of absence, remain eligible for the Plan and any underlying welfare benefit coverage for ninety days;

WHEREAS, the **"Special COVID-19 Plan Amendment"** (attached hereto) has been presented to the Board by the Secretary and recommended for adoption; and

WHEREAS, it is deemed in the best interests of the County to further approve the same.

NOW THEREFORE, BE IT RESOLVED, effective March 23, 2020 through December 31, 2020, the **"Special COVID-19 Plan Amendment"** to the Plan shall be, and hereby is, adopted, and a copy of the Amendment shall be attached to and made a part of these minutes.

LANGUAGE FOR THE
FOUR COUNTY METAL HEALTH CENTER WELFARE BENEFIT PLAN

WHEREAS, the Secretary of the County has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended, effective July 1, 2017, to provide for a change in the insurance company for the Vision Plan from Superior Vision to EyeMed Vision Care and for the removal of the Dependent Life benefit through the AFLAC After-Tax Plan;

WHEREAS, the Secretary of the County has advised that the amendments to the **Four County Mental Health Center Welfare Benefit Plan** may be made by replacement pages, with the amended pages 4.1, 4.2, and Appendices E and H dated 05/17 being substituted for the corresponding pages currently within the Four County Mental Health Center Welfare Benefit Plan and reflects the Plan as it existed on July 1, 2017; and

WHEREAS, it is in the best interests of the County to further approve the same.

NOW THEREFORE, BE IT RESOLVED, effective July 1, 2017, the amendments to the **Four County Mental Health Center Welfare Benefit Plan** shall be, and hereby are, adopted, and that the amended pages 4.1, 4.2, and Appendices E and H dated 05/17 of the **Four County Mental Health Center Welfare Benefit Plan** shall be substituted for pages 4.1, 4.2, and Appendices E and H of the current document, a copy of the amended pages shall be attached to and made a part of these minutes, and that a copy of the pages being replaced shall be retained as part of the permanent records of the County.

LANGUAGE FOR THE
FOUR COUNTY METAL HEALTH CENTER WELFARE BENEFIT PLAN

WHEREAS, the Secretary of the County has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended and restated to reflect numerous changes, such as a new definition of a "spouse," updated election change events, changes brought about by health care reform, and adjustments to the maximum reimbursement limit under the Health Flexible Spending Account Plan;

WHEREAS, the Secretary of the County has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended and restated to reflect the addition of the Vision Plan and the change in eligibility conditions; and

WHEREAS, it is in the best interests of the County to further approve the same.

NOW THEREFORE, BE IT RESOLVED, that the Secretary be, and hereby is, authorized and directed to execute and deliver the **Four County Mental Health Center Welfare Benefit Plan** as amended and restated, which restated plan is to be effective as of July 1, 2015.

LANGUAGE FOR THE
FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN

WHEREAS, the President of the Corporation has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended, effective July 1, 2013, to reflect that the claims administrator for the Four County Mental Health Center Health Flexible Spending Account Plan and the Four County Mental Health Center Dependent Care Assistance Plan is Discovery Benefits, Inc.;

WHEREAS, the President of the Corporation has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended, effective July 1, 2013, to reflect updated HIPAA Medical Privacy language for the Four County Mental Health Center Health Flexible Spending Account Plan;

WHEREAS, the President of the Corporation has advised that the amendments to the **Four County Mental Health Center Welfare Benefit Plan** may be made by replacement page, with the amended pages 2.2, 7.3, Articles V, VIII, IX, X, B-4, C-4, F-1, and F-2 dated 05/13 being substituted for the corresponding pages currently within the Four County Mental Health Center Welfare Benefit Plan; and

WHEREAS, having had the opportunity to review the same, the Directors deem it to be in the best interests of the Corporation to approve the amendment of the Plan as proposed and that the Corporation could make the necessary amendment by replacing certain pages of the plan documents.

NOW THEREFORE, BE IT RESOLVED, that, effective July 1, 2013, the amendments to the **Four County Mental Health Center Welfare Benefit Plan** shall be, and hereby are, adopted, and that the amended pages 2.2, 7.3, Articles V, VIII, IX, X, B-4, C-4, F-1, and F-2 dated 05/13 of the **Four County Mental Health Center Welfare Benefit Plan** shall be substituted for pages 2.2, 7.3, Articles V, VIII, IX, B-4, C-4, F-1, and F-2 of the current document, a copy of the amended pages shall be attached to and made a part of this Resolution, and that a copy of the pages being replaced shall be retained as part of the permanent records of the Corporation.

LANGUAGE FOR THE
FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN

WHEREAS, the President of the Corporation has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended, effective January 1, 2011, to reflect that there is a change in reimbursement for over-the-counter drugs and medicine (other than insulin) pursuant to the Patient Protection and Affordable Care Act of 2010;

WHEREAS, the President of the Corporation has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended, effective July 1, 2011, to reflect that adult children up to age 26 may be covered under the Health FSA pursuant to IRS Notice 2010-38;

WHEREAS, the President of the Corporation has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended, effective July 1, 2011, to provide for a change in the insurance company for the Four County Mental Health Center Medical Plan from Preferred Health Systems to Blue Cross Blue Shield of Kansas;

WHEREAS, the President of the Corporation has advised that the amendments to the **Four County Mental Health Center Welfare Benefit Plan** may be made by replacement pages, with the amended pages 2.1-2.3 and Appendices A and B dated 05/11 being substituted for the corresponding pages currently within the Four County Mental Health Center Welfare Benefit Plan; and

WHEREAS, having had the opportunity to review the same, the Directors deem it to be in the best interests of the Corporation to approve the amendment of the Plan as proposed and that the Corporation could make the necessary amendment by replacing certain pages of the plan documents;

NOW THEREFORE, BE IT RESOLVED, that, effective July 1, 2011, the amendments to the **Four County Mental Health Center Welfare Benefit Plan** shall be, and hereby are, adopted, and that the amended pages 2.1-2.3 and Appendices A and B dated 05/11 of the **Four County Mental Health Center Welfare Benefit Plan** shall be substituted for pages 2.1-2.3 and Appendices A and B of the current document, a copy of the amended pages shall be attached to and made a part of this Resolution, and that a copy of the pages being replaced shall be retained as part of the permanent records of the Corporation.

LANGUAGE FOR THE
FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN

WHEREAS, the President of the Corporation has recommended that the amendments to the **Four County Mental Health Center Welfare Benefit Plan** be amended, effective April 1, 2009, to reflect two new HIPAA special enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009;

WHEREAS, the President of the Corporation has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended, effective May 1, 2010, to provide that election changes can be made when there is a significant change in the cost of coverage and/or when there is a change in coverage of a spouse or dependent under the plan of some other employer.

WHEREAS, the President of the Corporation has advised that the amendments to the **Four County Mental Health Center Welfare Benefit Plan** may be made by replacement pages, with the amended pages 5.3-5.9 and Appendices B, C and F dated 05/10 being substituted for pages 5.3-5.7 and Appendices B, C and F currently within the Four County Mental Health Center Welfare Benefit Plan; and

WHEREAS, having had the opportunity to review the same, the Directors deem it to be in the best interests of the Corporation to approve the amendment of the Plan as proposed and that the Corporation could make the necessary amendment by replacing certain pages of the plan documents;

NOW THEREFORE, BE IT RESOLVED, that, effective May 1, 2010, the amendments to the **Four County Mental Health Center Welfare Benefit Plan** shall be, and hereby are, adopted, and that the amended pages 5.3-5.9 and Appendices B, C and F dated 05/10 of the **Four County Mental Health Center Welfare Benefit Plan** shall be substituted for pages 5.3-5.7 and Appendices B, C and F of the current document, a copy of the amended pages shall be attached to and made a part of this Resolution, and that a copy of the pages being replaced shall be retained as part of the permanent records of the Corporation.

LANGUAGE FOR THE
FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN

WHEREAS, the President of the Corporation has recommended that the **Four County Mental Health Center Welfare Benefit Plan** ("Plan") be amended, effective March 1, 2009, to reflect the changes made to COBRA coverage, including the premium assistance for such coverage, as provided for under the American Recovery and Reinvestment Act of 2009 (commonly referred to as the Economic Stimulus Bill);

WHEREAS, the Directors deem it to be in the best interests of the Corporation to further approve the amendment of the Plan as proposed.

NOW THEREFORE, BE IT RESOLVED, that the President of the Corporation be, and hereby is, authorized and directed to execute and deliver the amendment to the Plan, and a copy of the amendment shall be attached to and made a part of this Resolution.

LANGUAGE FOR THE
FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN

WHEREAS, the President of the Corporation has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be amended, effective July 1, 2008, to provide for the addition of the Four County Mental Health Center Health Savings Account Plan, the addition of the Four County Mental Health Center Dental Plan, which was previously included in the Four County Mental Health Center Medical Plan, an additional benefit offered by the Four County Mental Health Center AFLAC After-Tax Plan, the addition of the High Deductible Health Plan option to the Four County Mental Health Center Medical Plan and an increase in the maximum amount of reimbursement for the Four County Mental Health Center Health Flexible Spending Account Plan.

WHEREAS, the President of the Corporation has advised that the amendments to the **Four County Mental Health Center Welfare Benefit Plan** may be made by replacement pages, with the amended pages 2.2, 2.3, 4.1, 4.2, 5.1, 5.7, B-3, Appendices A, E, F and G dated 06/08 being substituted for the corresponding pages currently within the Four County Mental Health Center Welfare Benefit Plan; and

WHEREAS, having had the opportunity to review the same, the Directors deem it to be in the best interests of the Corporation to approve the amendment of the Plan as proposed and that the Corporation could make the necessary amendment by replacing certain pages of the plan documents;

NOW THEREFORE, BE IT RESOLVED, that, effective July 1, 2008, the amendments to the **Four County Mental Health Center Welfare Benefit Plan** shall be, and hereby are, adopted, and that the amended pages 2.2, 2.3, 4.1, 4.2, 5.1, 5.7, B-3, Appendices A, E, F and G dated 06/08 of the **Four County Mental Health Center Welfare Benefit Plan** shall be substituted for pages 2.2, 2.3, 4.1, 4.2, 5.1, 5.7, B-3, Appendices A, E, F and G of the current document, a copy of the amended pages shall be attached to and made a part of this Resolution, and that a copy of the pages being replaced shall be retained as part of the permanent records of the Corporation.

LANGUAGE FOR THE
FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN

WHEREAS, the President of the Corporation has recommended that the **Four County Mental Health Center Welfare Benefit Plan** be approved;

WHEREAS, the Directors deem it to be in the best interests of the Corporation to further approve the same;

NOW THEREFORE, BE IT RESOLVED, that the President of the Corporation be, and hereby is, authorized and directed to execute and deliver the **Four County Mental Health Center Welfare Benefit Plan**, which plan is to be effective as of January 1, 2005.

BENEFIT ELECTION FORMS

FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN
PRE-TAX EMPLOYEE BENEFIT ELECTION AND SALARY REDUCTION AGREEMENT

Employee Name:_____ Social Security Number:_____

Benefit Election – Select One of the Options Below

_____ I want to receive the pre-tax benefits available through the Four County Mental Health Center Welfare Benefit Plan ("Plan"). By signing below, I authorize Four County Mental Health Center, Inc. to reduce my salary by the amount necessary to pay my share of the cost for the following benefits in which I have enrolled myself and/or my beneficiaries:

☐ Medical Coverage ☐ Dental Coverage

☐ Accident Coverage ☐ Cancer Coverage

☐ Vision Coverage ☐ Hospital Coverage

☐ Health FSA - $_____ / year*

(*The reduction in your salary for any calendar year may not exceed the legal "Health FSA limit" for that year as set by the IRS or, if lesser, the limit set by the Company. The IRS may increase the legal limit annually for inflation. Please contact the Plan Administrator to find out what the Health FSA limit is for the current year.)

☐ Dependent Care Account - $_____ / year

($5,000 maximum; $2,500 if married but filing a separate return)

☐ Health Savings Account ("HSA"): $_____ per payroll period

(*Note:* Total contributions for HSA cannot exceed certain IRS limits. Please contact the Plan Administrator to find out what the IRS limit is for the current year.)

(Check the coverage(s) in which you have enrolled yourself and/or your beneficiaries)

_____ I decline to participate in the above benefits offered under the Plan. I understand that, as a result of this decision, I will not receive any of the above benefits available through the Plan.

Important Information

(1) By signing below, you are making a binding election concerning your benefits. With the exception of the HSA contribution amount, you may not change your election until the next enrollment period unless you experience a qualifying "election change event" as defined in the provisions of the Plan.

(2) A special rule applies to the dollar amounts elected for the Health FSA. If you experience a qualifying "election change event" after the beginning of a plan year, you may begin, increase, decrease or cease your participation in the Health FSA. You may not, however, *decrease* the dollar amount of your election below the total of the amount you have already been reimbursed through the date of the election change event.

(3) Your election will remain in effect for subsequent plan years (except for the dollar amounts you elect for the Health FSA and Dependent Care Account) unless it is revoked or changed according to the provisions of the Plan. The dollar amounts elected for the Health FSA and Dependent Care Account will automatically be reset to zero for subsequent plan years unless you make a new election for a subsequent plan year.

(4) The dollar amounts, if any, remaining in your Health FSA and/or Dependent Care Account at the end of the Plan Year will be forfeited, as required by IRS regulations, if your eligible expenses are not properly submitted for reimbursement before the end of the Run-Out Period. This is commonly referred to as a "use it or lose it" rule. The Run-Out Period is 90 days, measured from the last day of the Plan Year.

(5) If you have elected above to pay for a benefit, this may cause insurance benefit payments received from the insurance company to be subject to federal and state taxes. This may happen if the medical and health benefits you receive from the insurance company exceed the amount of your unreimbursed medical expenses. In other words, to the extent the indemnification amount you receive from the insurance company exceeds the amount you must pay for out-of-pocket medical expenses, you may have "excess indemnification," and the "excess indemnification" would be taxable. Accident benefits will generally be tax-free.

(6) By choosing to receive the benefits available through the Plan, you are authorizing Four County Mental Health Center to reduce your salary by the amount necessary to pay your share of the cost for those benefits. By doing this you will reduce your taxable compensation. As a result, depending on your compensation level, you may pay less Social Security tax and this may have some effect on the amount of your Social Security retirement benefits.

The above information is a summary of the provisions of the Plan. In the event of a conflict between this summary and the provisions of the Plan, the provisions of the Plan will control.

By signing below, you agree that the Company can deduct from your wages, to the extent permitted by applicable state law, the amount of any reimbursement paid to you under the Company's Health FSA or Dependent Care Account that is later determined to have been made without proper substantiation or otherwise improperly reimbursed.

I have read and understand the above information and I also acknowledge that I have received the Summary Plan Description for the Plan. I have chosen the Benefit Election(s) marked on this form.

_____ _____

Signature Date

FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN
AFTER -TAX EMPLOYEE BENEFIT ELECTION AND SALARY REDUCTION AGREEMENT

Employee Name:_____ Social Security Number:_____

Benefit Election – Select One of the Options Below

By signing below, I authorize Four County Mental Health Center, Inc., to deduct from my compensation, on an **after-tax** basis, the amount necessary to pay my share of the cost for the following benefit(s) in which I have enrolled myself and/or my beneficiaries:

☐ Short Term Disability Coverage

(Check the coverage(s) in which you have enrolled yourself and/or your beneficiaries)

_____ I decline to participate in the above benefits offered under the Plan. I understand that, as a result of this decision, I will not receive any of the above benefits available through the Plan.

Important Information

This election will remain in effect until it is revoked or changed in accordance with the terms of the Plan in question. Information about the Plan is found in the Summary Plan Description for the Plan. Copies of the Plan documents are available upon request from the Plan Administrator.

I have read and understand the above information and I acknowledge that I have received the Summary Plan Description for the Plan. I have chosen the Benefit Election(s) marked on this form.

_____ _____
Signature Date

FOUR COUNTY MENTAL HEALTH CENTER WELFARE BENEFIT PLAN
REQUEST TO CHANGE PRE-TAX ELECTIONS

Employee Name: _____ **Social Security Number:** _____

INSTRUCTIONS. *Please read the following instructions carefully.*

In order to change your election(s) under the Four County Mental Health Center Welfare Benefit Plan, you must do the following:

(1) Fill out and return a new Benefit Election and Salary Reduction Agreement
(2) Tell us why you would like to make a new election or change your current election(s) (using this form)
(3) Tell us when the event that may allow you to change your election took place (or will take place) (using this form)

After you have provided us with the above information, we will review your request. In determining whether we should accept or deny your request, we must follow IRS rules and the rules set forth in the Four County Mental Health Center Welfare Benefit Plan. This means, among other requirements, that your request to change your election(s) must be consistent with and on account of the "event(s)" that you have marked below. ***In addition, you must submit your request within 30 days from the date of the event(s) (or 60 days if the election change event is a HIPAA special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP).***

If your request to change your election(s) is approved, it will become effective as follows:

(1) HIPAA Special Enrollment for New Dependent. If your request relates to enrolling a dependent that you have acquired by birth or adoption in the Four County Mental Health Center Medical Plan, your request will take effect on the date of birth or adoption, even if you submit your request *after* the event (provided you do so within 30 days from the date of the event).

Example. You give birth to a child on March 24th. You submit the appropriate paperwork on April 15th to add your newborn to coverage under the Four County Mental Health Center Medical Plan. Your new election will be effective retroactively as of March 24th.

(2) All Other Changes. If your request relates to any other type of event, your request will not take effect until the first day of the month coincident with or next following the event, assuming you have completed this form and the Benefit Election and Salary Reduction Agreement. If you timely turn in your forms after the event and after the first business day of the month, your election will not take effect until the first day of the next month.

Example. You are married on January 15th. You submit the appropriate paperwork on January 20th to add your spouse to coverage. The change will take effect February 1. If, on the other hand, you do not submit the completed paperwork until February 5th, your new election will not take effect until March 1st.

REASON YOU WOULD LIKE TO MAKE A CHANGE

HIPAA SPECIAL ENROLLMENT EVENT: ***(Applies only to medical benefits)***

If any of the following events occur, you may change your election under the medical benefits in order to add coverage for yourself, your spouse, and/or your dependents. These are known as "HIPAA special enrollment rights." Please check the appropriate box below if you have experienced a HIPAA special enrollment event and you would like to change your coverage (including changing a coverage option) under the medical benefits:

☐ Loss of coverage under another group health plan

☐ New spouse through marriage

☐ New dependent through birth or adoption

☐ Loss of eligibility for Medicaid or a State's children's health insurance program (SCHIP)

☐ Become eligible for a State premium assistance subsidy from either Medicaid or SCHIP

ALL OTHER EVENTS:

(1) CHANGE IN NUMBER & ELIGIBILITY OF YOUR DEPENDENT CHILD(REN)

- □ Marriage
- □ Divorce, legal separation, or annulment *(must provide documentation)*
- □ Death of spouse

(2) CHANGE IN NUMBER & ELIGIBILITY OF YOUR DEPENDENT CHILD(REN)

- □ Birth or adoption of a child *(must provide documentation of adoption)*
- □ Change in "dependent" status (e.g., age, marriage, obtain full-time employment, no longer lives with you)
- □ Death of dependent

(3) CHANGE IN EMPLOYMENT STATUS *(if it affects benefits eligibility)*

	You	**Spouse/Dependent**
□ Change from part-time without benefits to part-time with benefits or full-time	____	____
□ Change from full-time or part-time with benefits to part-time without benefits	____	____
□ Beginning of Family and Medical Leave ("FMLA")	____	N/A
□ Return from Family and Medical Leave ("FMLA")	____	N/A
□ Beginning of an unpaid leave of absence	____	____
□ Returning from unpaid leave of absence	____	____
□ Change in worksite	____	____
□ Salaried to hourly pay	____	____
□ Hourly to salaried pay	____	____
□ Termination of employment	____	____
□ Beginning of employment	____	____

Name of dependent: _____

(4) CHANGE FROM 30 OR MORE HOURS PER WEEK TO LESS THAN 30 HOURS PER WEEK *(only applies to group health plans other than a health FSA and eligibility for the group health plan is not affected by the reduction in hours worked)*

- □ Revoke coverage in the following plan(s)*:_____

*In order to make an election change under this option, you (and, if applicable, your Spouse and/or dependents) must enroll in other minimum essential coverage that takes effect no later than the first day of the second month following the month in which you revoke your election under this plan.

(5) CHANGE IN COVERAGE (DOES NOT APPLY TO HEALTH FSA)

- □ Addition or significant improvement of a benefit package option

- □ Change in coverage under "another employer plan" (Employer, here, means my spouse's or dependent's employer, *or*, another of my employer's plans, if applicable) *and* that other plan permits a change for a reason that can be found on this form

- □ Open enrollment under "another employer plan" (Employer, here, means my spouse's or dependent's employer, *or*, another of my employer's plans) *and* my plan allows me to make an election for a period of coverage that is different from the period of coverage under the other plan

- □ Significant reduction in coverage, but *coverage is not lost*

  - □ Significant increase in the deductible
  - □ Significant increase in the co-pay
  - □ Significant increase in the out-of-pocket cost sharing limit
  - □ Other reduction, constituting an *overall* reduction in coverage (specify):_____
    _____

□ Significant reduction in coverage *resulting in a complete loss of coverage*

- □ Elimination of a benefit option
- □ HMO ceasing to be available in the area where I reside
- □ Overall lifetime or annual limitation
- □ Substantial decrease in the medical care providers available under the option
- □ Reduction in the benefits for a specific type of medical condition or treatment with respect to which: ___ I am, ___ my spouse is, ___ a dependent is (Name: _____) currently in a course of treatment.
- □ Other reason that has resulted in a fundamental loss of coverage (specify): _____

□ Loss of coverage under any group health coverage sponsored by a governmental or educational institution, such as one of the following (*please check*): **(DOES NOT APPLY TO DCAP)**

- □ State Children's Health Insurance Program ("SCHIP")
- □ A medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization
- □ A State health benefits risk pool
- □ A Foreign government group health plan
- □ Other: _____

(6) CHANGE IN COST OF COVERAGE (DOES NOT APPLY TO HEALTH FSA)

- □ Significant *increase* in the cost of my benefit package option
- □ Significant *decrease* in the cost of my benefit package option

(7) DEPENDENT CARE ASSISTANCE PLAN ("DCAP")

- □ Adding a daycare provider or changing daycare providers
- □ Change in hours of dependent care
- □ Coverage under spouse's or dependent's DCAP decreases or ceases
- □ Dependent's enrollment in school has decreased the necessary hours for daycare for *(name)*: _____
- □ Significant *increase* in the cost of the dependent care provider (except no change can be made where the cost change is imposed by a dependent care provider who is a relative)
- □ Significant *decrease* in the cost of the dependent care provider (such that you want to make an election)

(8) OTHER (DOES NOT APPLY TO DCAP ELECTION)

- □ Change in residence *(if it affects benefits eligibility)*
- □ Issuance of Judgment, Decree, or Order (relating to medical coverage)
- □ Entitlement to Medicare or Medicaid is ___ lost ___ gained *(does not apply to non-group health plan benefits)*
- □ Enrollment in a "qualified health plan" through the Marketplace due to a special enrollment event or the Marketplace's annual open enrollment period *(does not apply to a health FSA)*

DATE OF EVENT

Please provide the date for each event that you marked above:

Event: _____ Date of Event: _____

Event: _____ Date of Event: _____

By signing below, I understand and agree to the following:

- An election change may be made only if it is permitted under the terms of the Plan and under the terms of Section 125 of the Internal Revenue Code.

- The Plan Administrator may require me to provide appropriate documentation for any event(s) I have marked.

- The Plan Administrator must review and approve any change before it is given effect. The Plan Administrator, in his or her sole discretion, will make election change determinations.

- ***I have 30 days from the date of the event to turn in my forms; provided, however, that I have 60 days to turn in my forms if the election change event is a HIPAA special enrollment right related to eligibility for a State premium assistance subsidy or related to a loss of eligibility for Medicaid or SCHIP (see box on page 1).*** If the Plan Administrator determines that I have a valid election change event and the requested change is on account of and consistent with the event, my new election will take effect the first day of the month coincident with or next following the later of the date of the event or the date of the submission of my completed Request to Change Pre-Tax Elections form and Benefit Election and Salary Reduction Agreement. If, however, the event is the birth or adoption of my child, retroactive enrollment in the medical benefit is permitted.

  Note: In certain instances, such as the loss of dependent eligibility status, enrollment in certain benefits ends immediately, thereby requiring retroactive termination of coverage. Your dollar election, however, may only be changed prospectively. Thus, if you can anticipate the occurrence of a valid election change event (e.g., the birthday of a dependent, the upcoming hire date of a dependent for a full-time job), then you should submit your completed form and the Benefit Election and Salary Reduction Agreement prior to the date your salary will be reduced to pay for such coverage.

- The statements I have made on this form, including the boxes I have checked, are true and accurate.

_____ _____

(*Participant's Signature*) *(Date Submitted)*

RETURN COMPLETED FORM TO:

Four County Mental Health Center, Inc.
Employee Benefits Department
3751 W. Main
P.O. Box 688
Independence, Kansas 67301
(620) 332-1940

For internal use only:

Decision: □ Denied □ Accepted with respect to _____ benefit for _____.
(Benefit) *(Name of Individual)*

□ Denied □ Accepted with respect to _____ benefit for _____.
(Benefit) *(Name of Individual)*

Reason for Denial *(if applicable)*: _____.

Accepted and Agreed to: _____ _____
(Plan Administrator's Signature) *(Date)*

Effective: ____ / ____ / 20___

INITIAL NOTICE OF COBRA RIGHTS

INTRODUCTION

You are receiving this Initial Notice of COBRA Rights (the "Notice") because you have recently become covered under the **Four County Mental Health Center Medical Plan, Four County Mental Health Center Dental Plan, Four County Mental Health Center Vision Plan, and/or Four County Mental Health Center Health Flexible Spending Account** (collectively known hereinafter as the "Plan"). This Notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end.

This Notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This Notice gives only a summary of your COBRA continuation coverage rights. The Plan provides no greater COBRA rights than what COBRA requires – and nothing in this Notice is intended to expand your rights beyond COBRA's requirements. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description *or* contact the Plan Administrator.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

The name, address, and telephone number of the Plan Administrator are as follows:

Four County Mental Health Center, Inc.
3751 W. Main
P.O. Box 688
Independence, Kansas 67301
(620) 332-1940

The Plan Administrator has the responsibility for administering COBRA continuation coverage, but may have contracted with a third-party administrator to carry out the day-to-day COBRA administrative functions on behalf of the Employer. The party responsible for administering day-to-day COBRA administrative functions, or that party's address and telephone number, may change from time to time. You should consult the Plan Administrator or Summary Plan Description for the most current address if the COBRA administrator changes.

COBRA CONTINUATION COVERAGE

COBRA coverage is a continuation of coverage under the Plan when the coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events are listed later in this Notice. After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You, your covered spouse, and your covered dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.[1] Under the Plan, qualified beneficiaries who elect COBRA coverage must pay the cost of COBRA coverage.

Employee. If you are an employee, you will become a qualified beneficiary *if* you lose your coverage under the Plan because either one of the following qualifying events takes place:

(1) Your hours of employment are reduced so that you are no longer eligible for coverage; or

(2) Your employment ends for any reason other than your gross misconduct.

Spouse. If you are the spouse of an employee, you will become a qualified beneficiary *if* you lose your coverage under the Plan because any one of the following qualifying events takes place:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced so that you are no longer eligible for coverage;

(3) Your spouse's employment ends for any reason other than for gross misconduct;

(4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.[2]

Dependent Child. Your dependent children will become qualified beneficiaries *if* they will lose coverage under the Plan because any one of the following qualifying events takes place:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced so that you are no longer eligible for coverage;

(3) The parent-employee's employment ends for any reason other than for gross misconduct;

---

[1] Certain newborns, newly-adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.

[2] If your spouse cancels coverage for you in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you lost coverage earlier. You must notify the administrator within 60 days after the divorce or legal separation and establish that your ex-spouse, the employee, canceled the coverage earlier in anticipation of the divorce or legal separation in order for COBRA coverage to be made available for the period after the divorce or legal separation.

(4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child no longer satisfies the definition of a "dependent child" under the Plan.

Filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Each qualified beneficiary will have an independent right to elect COBRA. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all the qualified beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. A qualified beneficiary's COBRA coverage will terminate automatically, however, if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health coverage.

– IMPORTANT –

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. For each qualified beneficiary who timely elects COBRA coverage, COBRA coverage will begin on the first of the month following the date of the qualifying event.

When the qualifying event is the end of employment, a reduction in hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

For all other qualifying events – that is, divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child – *you must notify the Plan Administrator* in writing within 60 days after *the later of* the qualifying event *or* the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

You must follow the Plan's reasonable procedures for providing notice which are found on the last two pages of this Notice and in your Summary Plan Description. If these procedures are not followed or if notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

MAXIMUM PERIOD OF COVERAGE UNDER THE PLAN

The duration of the maximum period of COBRA coverage will vary depending on (1) the qualifying event and (2) whether or not there is a second qualifying event or a disability extension. The following are COBRA qualifying events if they are coupled with a loss of coverage under the Plan. The maximum period of coverage permitted under COBRA is listed along with each event:

(1) **Death of the employee –** COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.

(2) **Employee becomes entitled to Medicare (under Part A, Part B, or both) –**

(A) COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.

(B) See the examples under qualifying events (5) and (6) below for how an employee's entitlement to Medicare may affect the spouse's or dependent child's maximum coverage period when coverage has been lost due to the employee's termination of employment or reduction in hours.

(3) **Divorce or legal separation –**

(A) COBRA continuation coverage may last for up to 36 months for the spouse and any dependents who are qualified beneficiaries.

(B) *Example.* A covered employee and his spouse divorce. If the Plan Administer is timely and appropriately notified of the divorce, the spouse, who would otherwise lose coverage, may elect COBRA coverage if it is elected within 60 days after the later of the divorce or the loss of coverage in accordance with the Plan's reasonable procedures for providing notice. Any dependent child, who was also covered at the time of the divorce and who will otherwise lose coverage due to the divorce, may also elect COBRA coverage.

(4) **Dependent child losing eligibility as a dependent child –**

(A) COBRA continuation coverage may last for up to 36 months for the dependent who is a qualified beneficiary.

(B) *Example.* A dependent child is covered under the Plan. The dependent child turns age 26. As a result, the dependent child will "age-out" of the Plan and lose coverage at the end of the month. Following the Plan's reasonable procedures for providing notice as found in the Summary Plan Description, however, COBRA coverage is timely elected and the individual is given 36 months of continuation coverage.

(5) **Termination of employment –**

(A) COBRA continuation coverage may last for up to 18 months for the former employee, the spouse and any dependents who are qualified beneficiaries.

(B) The 18-month period for the spouse and/or dependent child may be extended if there is a "second qualifying event." See (7) below.

(C) If the employee became entitled to Medicare benefits less than 18 months before his or her termination of employment, COBRA coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement.

(i) *Example*. A covered employee became entitled to Medicare eight (8) months before the date on which his employment terminated. COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which, in this case, is equal to 28 months after the date of his termination (36 months minus 8 months).

(6) **A reduction in the employee's hours of employment, causing the employee to lose eligibility for coverage –**

(A) COBRA coverage may last for up to 18 months for the employee, spouse and any dependents who are qualified beneficiaries.

(B) The 18-month period may be extended if there is a "second qualifying event." See (7) below.

(C) If the employee became entitled to Medicare benefits less than 18 months before coverage is lost due to a reduction in hours of employment, COBRA coverage for qualified beneficiaries other than the employee may last until 36 months after the date of Medicare entitlement.

(i) *Example*. A covered employee became entitled to Medicare eight (8) months before the date on which he stopped being eligible for coverage due to a drop in the number of hours employed. COBRA coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which, in this case, is equal to 28 months after the date of the reduction in hours (36 months minus 8 months).

(7) **Second Qualifying Event –**

(A) If the employee's family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction of hours (including COBRA

coverage during a disability extension period as described below), the spouse and dependent children (along with certain newborns and newly adopted children) can get up to 18 additional months of COBRA coverage, for a maximum of 36 months. In order for this to occur, the following requirements must be met:

(i) The spouse and dependent children must be qualified beneficiaries who have elected and paid for COBRA coverage.

(ii) COBRA coverage is still in effect for the qualified beneficiaries at the time of the second qualifying event.

(iii) The event is one that would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

(iv) The Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. The Plan requires you to follow its reasonable procedures for providing notice as found in the Summary Plan Description.

(B) **If the notice procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, then there will be no extension of COBRA continuation coverage due to a second qualifying event.**

(8) **Disability Extension –**

(A) COBRA coverage may be extended from 18 months to 29 months.

(B) If the covered employee or anyone in his/her family covered under the Plan is determined by the Social Security Administration to be disabled and the Plan Administrator is notified in a timely fashion, the covered employee and his/her entire family (along with certain newborns and newly adopted children) may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months.

(C) In order to receive the disability extension, each individual must be a qualified beneficiary who has elected and is paying for COBRA coverage and whose COBRA coverage is still in effect at the time of the disability determination.

(D) The disability must have started some time before the 61st day of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage.

(E) The Plan Administrator must be notified in writing of the Social Security Administration's determination within 60 days after the latest of (a) the date of the determination, (b) the date of the covered employee's termination or reduction of hours, and (c) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours. In addition, notice must be given before the end of the 18-month period of COBRA coverage.

(F) You must follow the Plan's procedures providing notice. **If these procedures are not followed or if notice is not provided in writing to the Plan Administrator within the required period, then there will be no disability extension of COBRA continuation coverage.**

SPECIAL RULES FOR HEALTH FSA

COBRA coverage under a health flexible spending account ("Health FSA") maintained by the Employer will only be offered to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if he or she has been reimbursed for an amount that is less than his or her contributions through the time of the qualifying event. In addition, the use-it-or-lose-it rule will continue to apply, so any unused amount will be forfeited at the end of the plan year. Finally, COBRA coverage will end on the *last day of the plan year* in which the qualifying event occurred, regardless of the qualifying event.

Each beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate annual limit and a separate premium. If you are interested in this alternative, contact the Plan Administrator for more information.

Other Coverage Options In Addition To COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, a qualified beneficiary may have other coverage options during a "special enrollment period" through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan). Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.

Children Born To Or Placed For Adoption With The Covered Employee During COBRA Period

A child born to, adopted by, or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (e.g., regarding age).

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Choosing To Enroll in Medicare Instead Of COBRA Continuation Coverage after Group Health Plan Coverage Ends

In general, if the covered employee does not enroll in Medicare Part A or B when first eligible because the covered employee is still employed, then after the Medicare initial enrollment period, the covered employee has an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on *the earlier of*:

- The month after the covered employee's employment ends; or
- The month after group health plan coverage based on current employment ends.

If the covered employee doesn't enroll in Medicare and elects COBRA continuation coverage instead, he/she may have to pay a Part B late enrollment penalty and may have a gap in coverage if he/she decides that he/she wants Part B later. If the covered employee elects COBRA continuation coverage and later enrolls in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate the COBRA continuation coverage. However, if Medicare Part A or B is effective *on or before* the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the covered employee enrolls in the other part of Medicare after the date of the election of COBRA coverage.

If the former covered employee is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if the covered employee is not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator's address as indicated on the first page of this Notice.

Keep Your Plan Informed Of Address Changes

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

COBRA NOTICE PROCEDURES

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable). If COBRA coverage should have been terminated but was not, due to a lack of notice from a qualified beneficiary, the Employer will immediately terminate coverage and require payment to the Plan of all benefits paid after what should have been the termination date.

Notices Must Be In Writing And Submitted On Plan Forms: Any notice that you provide must be in writing and must be submitted on the Plan's required form. (You may obtain copies of required forms from the Plan Administrator.) Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When, And Where To Send Notices: You must mail or hand-deliver your notice to the Plan Administrator, whose address is provided on the first page of this Notice.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the Plan Administrator individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described above in this Notice and in your Summary Plan Description.)

Information Required For All Notices: Any notice you provide must include: (1) the name of the Plan; (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required For Notice of Divorce Or Legal Separation: If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required For Notice Of Disability: Any notice of disability must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required For Notice Of Second Qualifying Event: Any notice of a second qualifying event must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices: The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice of the qualifying event, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PACKAGE

FOUR COUNTY MENTAL HEALTH CENTER, INC.
QMCSO PROCEDURES FOR THE
FOUR COUNTY MENTAL HEALTH CENTER MEDICAL PLAN
FOUR COUNTY MENTAL HEALTH CENTER DENTAL PLAN
FOUR COUNTY MENTAL HEALTH CENTER VISION PLAN
FOUR COUNTY MENTAL HEALTH CENTER HEALTH FLEXIBLE SPENDING ACCOUNT

ARTICLE I. - INTRODUCTION

This document sets forth the procedures to be followed by Four County Mental Health Center, Inc.'s "group health plans" upon receipt of "qualified medical child support orders" ("QMCSOs"), including National Medical Support Notices. These QMCSO procedures have been developed in accordance with Section 609(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), which requires "group health plans" to establish administrative procedures for determining whether orders are QMCSOs and administering the provision of benefits under QMCSOs. These procedures are designed to assist the plan administrator in determining whether a particular order is a QMCSO and in carrying out its responsibilities relating to QMCSOs.

In connection with these procedures, the following documents are included to assist the plan administrator in determining whether a particular order is a QMCSO and in carrying out its responsibilities:

- **General Medical Support Notices – Checklist for Assessing Whether an Order is a QMCSO.** The attached Checklist should be used to determine whether a judgment, decree or order, other than a National Medical Support Notice, meets certain legal requirements necessary to be considered "qualified." The Checklist is a step-by-step approach to determining qualification and refers the plan administrator to model letters that may be used to convey certain information to employees and alternate recipients. If a National Medical Support Notice ("NMSN") is received, the NMSN comes with instructions that should be followed to determine its qualification.

- **Model Letter One.** This letter may be used by the plan administrator to inform the participant/employee and alternate recipient(s) that an order or NMSN has been received by the plan. It also informs the individuals that the plan will begin its review of the order or NMSN to determine whether or not it is "qualified."

- **Model Letter Two.** This letter may be used by the plan administrator after having reviewed the order. It informs the participant/employee and alternate recipient(s) that the order is a QMCSO and that, using one of two alternatives, either (1) coverage will begin on the date specified or (2) the alternate recipient already has coverage under the plan. The letter also informs the individuals when coverage will end.

- **Model Letter Three.** This letter may be used by the plan administrator to inform the participant/employee and alternate recipient(s) that the order is *not* a QMCSO. If the child or children are not already enrolled in the plan, then the language labeled "alternative 1" should be used. If the child or children, however, are already enrolled in the plan, then the language labeled "alternative 2" should be used.

- **Model Letter Four.** This letter may be used by the plan administrator to inform the parties that the individual identified on the judgment, decree, or order is no longer a current employee and/or is not (and will not be) eligible for benefits under the plan.

- **Record of Completed QMCSO Procedures.** Also included in the QMCSO materials is the "Record of Completed QMCSO Procedures." This document should be used throughout the process of determining whether or not an order is qualified in order to document the various stages of the review process.

The model letters included with these procedures are examples that must be modified by the plan administrator to fit the particular order that has been submitted.

All actions related to QMCSOs must be made in accordance with these procedures and must be performed on a timely basis.

A. What is a QMCSO?

A QMCSO is a judgment, decree, or order, issued by a court or through a state administrative process, that requires health plan coverage for the child of a participant (called an "alternate recipient") and meets certain legal requirements. Such orders typically are issued as part of a divorce or as part of a state child support proceeding. Federal law requires a group health plan to pay benefits in accordance with such an order, if it is "qualified." A QMCSO may apply to an employer's major medical plan, as well as to other types of group health plans such as dental plans, vision plans, and health FSAs. In general, a child who is an "alternate recipient" under a QMCSO should be treated like any other beneficiary under the Plan.

State child support enforcement agencies are required to use the National Medical Support Notice ("NMSN") when enforcing the provision of health care coverage to children under an employment-related group health plan. This is a standard form that was jointly developed by the Department of Labor ("DOL") and the Department of Health and Human Services ("HHS"). When properly completed by the issuing agency, the NMSN will constitute a QMCSO. Other orders are not required to follow a standard format. Typically, such orders are drafted by divorce lawyers and may vary widely in terminology, format, and sophistication.

In some cases, the order will refer to or require a plan to comply with state laws enacted in response to Section 1908 of the Social Security Act, which requires states to enact certain medical child support laws in order to receive federal Medicaid funds. These state laws are designed to help state governments and non-employee parents obtain private-sector health coverage for children, including coverage under employee-sponsored group health plans.

B. What are the Plan's Rights and Responsibilities Relating to QMCSOs?

Plans are not required to provide coverage in accordance with child support or other court orders that are not "qualified" in accordance with ERISA § 609(a). The plan administrator has the ultimate authority to determine whether an order meets the requirements of ERISA § 609(a). If the order does not meet these requirements, the Plan need not (and should not) provide any benefits to the "alternate recipient," unless the child is otherwise eligible or the order's deficiencies are corrected by the parties.

ARTICLE II. - PROCEDURES FOR DETERMINING WHETHER ORDERS ARE QMCSOS

A. Upon Receipt of an Order

The procedures to be followed upon receipt of an order depend on whether the order is a NMSN or another type of order.

1. Upon Receipt of a National Medical Support Notice

Upon receipt of a NMSN, the plan administrator must:

- Promptly provide the participant and the "alternate recipient" named in the order (and their legal representatives, if any) with written notice of:

  (a) the receipt of the order; and
  (b) the Plan's QMCSO procedures.

  Use Model Letter One to accomplish this.

- Review the NMSN to determine if it has been properly completed and meets the legal requirements of a QMCSO, using the instructions to the employer and the plan administrator on the NMSN itself. Within twenty (20) business days or sooner (if reasonably possible), the Employer must either return Part A to the issuing agency or forward Part B of the NMSN to the plan administrator as instructed on the NMSN itself.

- Within forty (40) business days after the date of the NMSN, or sooner if reasonable, the plan administrator must notify the participant, "alternate recipient," state agency, and any legal representative or other parties indicated in the NMSN using the spaces indicated on the NMSN, that either:

  (a) the NMSN is a QMCSO; or
  (b) the NMSN is *not* a QMCSO (the plan administrator's reasons for rejecting the NMSN should be indicated in the space provided on the NMSN).

  Use the forms provided with the NMSN to accomplish this.

  This notification can generally be provided by sending copies of the completed "Plan Administrator Response" to the NMSN to the parties. In addition, if the NMSN is determined to be a QMCSO, the parties must be provided with certain information (see instructions to the NMSN), such as the following:

  (a) the effective date of the child's coverage (or the steps necessary to effectuate coverage);
  (b) a description of the coverage; and
  (c) any forms or documents necessary to enroll in the Plan.

2. Upon Receipt of Any Other Order

Upon receipt of any order *other than a NMSN*, the plan administrator must:

- Promptly provide the participant and the "alternate recipient" named in the order (and their legal representatives, if any) with written notice of:

  (a) the receipt of the order; and
  (b) the Plan's QMCSO procedures.

  Use Model Letter One to accomplish this.

- Review the order to determine if it meets the legal requirements of a QMCSO using the Checklist attached to these procedures.

- Within a reasonable time after receipt of the order (the time limits for reviewing the NMSN in Section A.1 above will be used as a guideline), the plan administrator must notify the participant and the "alternate recipient" that either:

  (a) the order is a QMCSO; or
  (b) the order is *not* a QMCSO (an explanation of the defective or missing provisions should be included).

  Use Model Letter Two for (a) above.
  Use Model Letter Three for (b) above.

- Copies of the notification should also be provided to the parties' legal representatives, if any.

B. Designation of Representative

An "alternative recipient" may designate a representative to receive copies of notices that are sent to him or her with respect to an order.

C. Disputes

- Within 30 days after the date of the plan administrator's notice as to whether an order is a QMCSO, the parties (or their legal counsel) will have the right to submit written comments regarding the determination.

- After considering any comments received, the plan administrator will make a final determination as to the qualified status of the order.

- If no comments are received during the 30-day period, the decision will become final.

D. Re-Submitted Orders

If an order, including a NMSN, is determined *not* to be a QMCSO, the parties or agency may submit a revised order to cure the deficiencies. If a revised order is submitted, the evaluation process in Subsection A above is repeated.

ARTICLE III - ADDITIONAL CONSIDERATIONS

A. Instructions for Assessing Whether an Order is a QMCSO

The Checklist, which is attached to these Procedures includes lists of the provisions that are required for a medical child support order (other than a NMSN) to be considered a QMCSO. If a NMSN is being reviewed, there are instructions accompanying the NMSN that should be followed.

B. Forms and Information

Additional forms and information may be necessary to effectively administer benefits under an order that has been determined to be a QMCSO and to enroll the "alternate recipient" in the applicable plans. These forms and information include the following:

- The name and address of the "alternate recipient's" custodial parent, legal guardian, or other person(s) to whom the summary plan descriptions ("SPDs") and other plan-related information and correspondence should be furnished following the "alternate recipient's" enrollment.

- Where an agency is involved (as in the case of a NMSN), it may be necessary or appropriate to provide certain plan information and/or correspondence to the agency as well.

- A completed enrollment form, if required under the plan.

- A change in the participant's cafeteria plan election, if applicable.

  If benefits required to be provided under a QMCSO are paid for on a pre-tax basis, the QMCSO may qualify as a permitted election change event under the cafeteria plan. If applicable, and if the cafeteria plan document permits an election change on account of the QMCSO, the participant may submit a change in his or her cafeteria plan election in accordance with the cafeteria plan's rules.

- The name and address of an individual to whom it is expected that benefit reimbursements may be made for the claimed expenses of the child of the "alternate recipient."

- The QMCSO rules provide that if medical expenses are paid by either the "alternate recipient" or the custodial parent or legal guardian of the "alternate recipient," a plan must reimburse that person (not the employee) for those expenses. If expenses are submitted for reimbursement, information identifying the individual to receive payment should be provided to the plan.

Note: A QMCSO may provide that a person or entity other than the participant is responsible to pay for coverage of the "alternate recipient." In such cases, the plan administrator should indicate how and when payment is to be made. For example, payments might be required concurrent with each payroll period or on a monthly basis as required of qualified beneficiaries receiving COBRA continuation coverage. The plan administrator should also make sure that it has contact information for the person or entity who will be making the payments.

C. "Alternate Recipient" as "Beneficiary"

In general, the "alternate recipient" must be treated like any other beneficiary under each plan in which he or she is enrolled, including the following:

- Unless a QMCSO is more restrictive, the "alternate recipient" should be given the same coverage as would be provided to any other dependent child under the plan.

- The "alternate recipient" should be treated as a qualified beneficiary and offered COBRA continuation coverage upon the occurrence of a COBRA qualifying event (such as the participant's termination of employment or the "alternate recipient's" ceasing to qualify as a dependent child under the plan due to age or student status).

D. "Alternate Recipient" as "Participant"

- With respect to ERISA reporting and disclosure rules, the "alternate recipient" generally is to be treated like a participant under each plan in which he or she is enrolled.

- Therefore, the "alternate recipient" should be sent copies of all applicable ERISA-required disclosures, including the summary plan descriptions, summary material modifications, summary annual report, Women's Health and Cancer Rights Act ("WHCRA") notices, etc.

- These items generally should be furnished to the "alternate recipient's" custodial parent or guardian. (If the "alternate recipient" is an adult, the plan administrator may provide copies to both the "alternate recipient" and the custodial parent or guardian.)

- Where an agency is involved (as in the case of a NMSN), it may be necessary or appropriate to provide copies of these items to the agency as well.

- Note that the "alternate recipient" need not be counted as a participant for purposes of the annual report (Form 5500).

E. Effective Date of Enrollment

- An "alternate recipient" generally will be enrolled in the plan as of the next regular enrollment date under the plan (i.e., the date on which the plan regularly adds new participants and beneficiaries) following:

(a) the plan administrator's approval of an order as a QMCSO (or the date provided in the order, if later); and
(b) receipt of any necessary enrollment forms.

- If an employee is eligible for the plan but is not enrolled, he or she will also be enrolled if his or her enrollment is necessary for the "alternate recipient" to have the coverage required under the QMCSO. However, if the employee has not yet satisfied the plan's waiting period, enrollment of the "alternate recipient" and employee will be delayed until the employee has completed the waiting period. Coverage is effective as of the date of enrollment.

F. Special Consideration - Child Already Enrolled

The parties may submit an order (including a NMSN) that purports to require that a child be covered under a plan in which he or she is already enrolled. In this circumstance, the plan administrator should process the order under these Procedures but should also inform the parties of the child's status as a current beneficiary under the plan. Model Letters Two and Three have alternative language that may be used in these circumstances.

G. Plans With Multiple Options

An otherwise-qualified order may identify a plan or type of coverage with multiple options without designating the option in which the "alternate recipient" is to be enrolled or the manner in which an option is to be chosen:

- In the case of a NMSN, the administrator should follow the instructions in the NMSN regarding plans with multiple options.

- For other orders, the plan administrator should enroll the "alternate recipient" in the same option as the employee if the employee is enrolled in the plan.

- Otherwise, the plan administrator may follow procedures similar to those in the NMSN. That is, the plan administrator may, instead of rejecting the order, provide the parties with information about the available options and direct them to make a selection.

- If the plan has a default option, the plan administrator may also notify the parties that the "alternate recipient" and employee will be enrolled in this option if a response is not received within a specified time period (e.g., 20 business days).

_____ **PLAN**

(Insert Name of Plan)

– GENERAL MEDICAL SUPPORT ORDERS –

CHECKLIST FOR ASSESSING WHETHER AN ORDER IS A QMCSO

Section 609 of the Employee Retirement Income Security Act of 1974 ("ERISA") requires group health plans to honor the terms of a "qualified medical child support order" ("QMCSO"). The determination as to whether an order is "qualified" is made by the Plan Administrator. The Plan Administrator must complete this checklist to implement the Plan's QMCSO Procedures. If the order applies to more than one plan then this checklist should be completed for each plan to which the order applies.

DO NOT USE THIS FORM FOR NATIONAL MEDICAL SUPPORT NOTICES.

The Plan Administrator should complete this checklist as soon as possible after receiving an order. If all items are present, the parties should be notified that the order is a QMCSO. If one or more items is not present, the parties should be notified that the order is not a QMCSO.

1. Identifying Information. The order concerns:

Employee*: _____ SSN:_____

Participant's address: _____

_____

Alternate Recipient(s):

Name	Date of Birth	Address	Social Security Number
_____	____/____/___	_____	_____
_____	____/____/___	_____	_____
_____	____/____/___	_____	_____
_____	____/____/___	_____	_____

*If the person identified in the order is not a current employee and has never been an employee of the company, then it may be that the order was sent by mistake. You should contact whomever sent the order and inform them of the mistake.

2. Order Received.

The order was received: _____.

(Month / Day / Year)

3. Employee's Status. If the "employee" identified on the order is (1) no longer an employee or (2) is not and will not be eligible for benefits under the Plan, it may not be necessary to complete this checklist. Please answer the following questions:

❑ Yes / ❑ No **a. Employment.** Does the judgment, order or decree specify the name of a current employee of the company?

❑ Yes / ❑ No **b. Employee Eligibility.** Does the judgment, order or decree relate to an employee who is eligible or will be eligible to participate in the Plan? (If the employee is not currently eligible to participate but will be eligible when, for example, he or she completes a waiting period, then you should answer "yes" to this question.)

You must answer "Yes" to (a) and (b) above in order to continue to paragraph 4. If you answer "No" to either question, then the alternate recipient(s) cannot be covered under the Plan. You should inform the appropriate parties of this using Model Letter Four.

4. Notification. The Plan Administrator should mail notification of receipt of the order and the Plan's QMCSO procedures, by first class mail, to the Employee and Alternate Recipient(s). The letter acknowledging receipt of the order should also be sent to the Employee's and/or the Alternate Recipient's attorney, if applicable.

Date acknowledgment letter and QMCSO procedures sent _____.
(Month / Day / Year)

Letter sent to the following individuals:

- ❑ Employee
- ❑ Alternate Recipient(s)
- ❑ Attorney(s) (for the ❑ Employee and/or ❑ Alternate Recipient)

5. Type of Order. An order may be issued by a court of competent jurisdiction or through an administrative process that has the force and effect of law under applicable state law. Agreements made by the parties but not formally approved by a court are *not* acceptable. If the order you have received was initially rejected as not qualified and the deficiencies are later corrected by the parties, a revised order may be submitted to the Plan. The revised order, however, must have been formally approved by the court or administrative agency to be qualified.

❑ Yes / ❑ No **Judgment, Decree or Order.** Is the document a judgment, order or decree? (including approval of a settlement agreement)

If you answered "Yes" to the above question, continue to paragraph 7. If you answered "No," complete paragraph 6 below and then skip to paragraph 13 in the Certification section and complete the Certification of Nonqualified Status. There is no need to complete the other paragraphs in this checklist if you answered "No."

6. Disqualification – Type of Document.

❑ The "order" is not a QMCSO because the document is not a judgment, order or decree.

7. Technical Requirements. The Plan Administrator must complete review of the order within a reasonable time. For a National Medical Support Notice, which is a federal form used by child support agencies, a reasonable amount of time to complete the review is forty (40) days or less. This same time frame was considered by the Plan Administrator in reviewing the order. Please answer the questions below.

❑ Yes / ❑ No **a. Child of Participant.** Does the judgment, order or decree provide for medical coverage for a child of a participant under a group health plan?

❑ Yes / ❑ No **b. State Domestic Relations Law.** Was the judgment, order or decree made pursuant to state domestic relations law, such as a state law relating to divorce or child support?

❑ Yes / ❑ No **c. Benefits under the Plan.** Does the judgment, order or decree relate to benefits under the Plan?

---------- **OR** ----------

❑ Yes / ❑ No **d. State Law Relating to Medical Child Support.** Does the judgment, order or decree enforce a state law relating to medical child support described in Section 1908 of the Social Security Act (which requires states to enact certain medical child support laws in order to receive federal Medicaid funds)?

The order may be a QMCSO only if the Plan Administrator answered "Yes" to (a), (b) and (c) above *or* if the Plan Administrator answered "Yes" to (d) above. If this requirement is met, then check (b) immediately below in paragraph 7a. If this requirement is *not* met, then check (a) immediately below in paragraph 7a.

7a. Consequence of Responses in Paragraph 7 Above.

❑ **a. Not a QMCSO.** The order is not a QMCSO because of the "No" answers above. *Please skip to paragraph 10.*

❑ **b. May Be a QMCSO.** The order *may be* a QMCSO, *depending on how other questi*ons are answered on this checklist. *Proceed to paragraph 8 below.*

8. Substance of the Order. Please answer the questions below:

❑ Yes / ❑ No	**a.**	**Reasonable Description.** Does the order provide a reasonable description of the type of coverage to be provided by the plan to each *alternate recipient* or indicate the manner in which the type of coverage is to be determined?
❑ Yes / ❑ No	**b.**	**Period of Coverage.** Does the order identify when coverage begins and how long it should continue?
❑ Yes / ❑ No	**c.**	**Eligibility of Child.** Is the child eligible for coverage under the plan? (assuming that the employee enrolls and selects family coverage)
❑ Yes / ❑ No	d.	**Type of Benefit.** Does the order require the plan to provide benefits that are available under the plan?

In order to be a QMCSO, the Plan Administrator must answer "Yes" to all of the above questions. If this requirement has been met, then check (b) immediately below in paragraph 8a. If the Plan Administrator answers "No" to *any* of the above questions, then check (a) immediately below in paragraph 8a.

8a. Consequence of Responses in Paragraph 8 Above.

❑	**a.**	**Not a QMCSO.** The order is *not* a QMCSO because of the "No" answers above.
❑	**b.**	**May Be a QMCSO.** The order *may be* a QMCSO, depending on how other questions are answered on this checklist.

(Whether you answered (a) or (b) above, proceed to paragraph 9.)

9. State and Federal Withholding. A determination must be made as to whether the required employee contribution (if any) for coverage will exceed applicable State and Federal limits. A plan must ensure that it does not withhold amounts for coverage that exceed the maximum amount permitted under the Consumer Credit Protection Act (CCPA). Under the CCPA, an employer cannot withhold more than (a) 50% of the employee's disposable weekly earnings where the employee is supporting a spouse or dependent child (other than the potential alternate recipient); or (b) 60% of the employee's disposable weekly earnings where the employee is not supporting a spouse or other child. Applicable state law wage withholding limitations, which may be even more restrictive than the CCPA, must also be reviewed.

❑ Yes / ❑ No	**State and Federal Withholding.** Does the order require the employee contributions to exceed applicable State and Federal withholding limits?

In order to be a QMCSO, the Plan Administrator must answer "No" to the question above. If the Plan Administrator has answered "No," then check (b) below in paragraph 9a. If the Plan Administrator has answered "Yes," check (a) immediately below in paragraph 9a.

9a. Consequence of Response in Paragraph 9 Above.

❑ **a. Not a QMCSO.** The order is not a QMCSO because the order requires the employee contributions to exceed applicable State and Federal withholding limits.

❑ **b. May Be a QMCSO.** The order *may be* a QMCSO, depending on how other questions are answered on this checklist.

(Whether you answered (a) or (b) above, proceed to the next section, Determination of Status.)

DETERMINATION OF QUALIFIED STATUS

10. Summary of Above Responses.

The order qualifies as a QMCSO if the Plan Administrator has:

- ❑ Checked (b) in paragraph 7a; *and*
- ❑ Checked (b) in paragraph 8a; *and*
- ❑ Checked (b) in paragraph 9a.

If you have checked *all three of the above* boxes, continue to paragraph 11 and check the box. If you have *not* checked *all* of the above boxes, continue to paragraph 12 and check the box.

11. QMCSO.

❑ The order qualifies as a QMCSO. The Plan Administrator should sign the Plan Administrator's Certification of the QMCSO in paragraph 13. This determination needs to be communicated to the employee and *alternate recipient(s).* The Plan Administrator should notify the employee and *alternate recipient(s)* of the determination by mailing a copy of this QMCSO checklist to each party. *Model Letter Two may be used to communicate that the order is qualified*.

12. Not a QMCSO.

❑ The order does **NOT** qualify as a QMCSO. The Plan Administrator should sign the Plan Administrator's Certification of Nonqualified Status in paragraph 13. This determination needs to be communicated to the employee and *alternate recipient(s).* By looking at the "(a) answers" in paragraphs 7a, 8a, and/or 9a, you should be able to tell why the order is not qualified and then communicate this information to the appropriate parties. *Model Letter Three may be used to inform the appropriate parties of any defects or missing information in the order.*

CERTIFICATION

13. Plan Administrator's Certification. Sign the certification paragraph which states the Plan Administrator's determination with respect to the qualified status of the order. ***COMPLETE ONLY ONE CERTIFICATION.***

PLAN ADMINISTRATOR'S CERTIFICATION OF QMCSO

I, the undersigned Plan Administrator, certify the order identified in paragraph 1 is a qualified medical child support order. The Plan will provide medical coverage in accordance with its terms and in accordance with the QMCSO.

_____ Plan

Date: _____ By: _____
Plan Administrator

---------- OR ----------

PLAN ADMINISTRATOR'S CERTIFICATION OF NONQUALIFIED STATUS

I, the undersigned Plan Administrator, certify the order identified in paragraph 1 is **not** a qualified medical child support order.

_____ Plan

Date: _____ By: _____
Plan Administrator

RECORD OF COMPLETED QMCSO PROCEDURES

Initial Response to Receipt of Order

Employee's Name _____ Social Security Number _____-_____-_____

Alternate Recipient(s):

Name	Date of Birth	Address	Social Security Number
_____	____/____/___	_____	_____
_____	____/____/___	_____	_____
_____	____/____/___	_____	_____
_____	____/____/___	_____	_____

Date order received ___/___/____ Date acknowledgment letter/procedures sent ___/___/____

Assessment of Order (attach completed checklist)

Is Order a National Medical Support Notice? _____

Date checklist completed ____/____/____ Completed by _____

Plan(s) to which order applies _____

Representative(s) designated to receive copies of notices sent to alternate recipient(s):

_____

_____

Is legal counsel's review necessary? ❑ Yes / ❑ No

Date of legal counsel review____/_____/_____ Reviewed by _____

Determination: ❑ QMCSO ❑ Not a QMCSO (reasons to be noted on checklist)

Steps Taken Pursuant to QMCSO

Is an additional contribution required for coverage of alternate recipient(s)? ❑ Yes / ❑ No

Has determination been made that withholding the additional contribution does not exceed applicable state and federal wage withholding limitations? ❑ Yes / ❑ No

If withholding limitations would prevent the withholding of the additional contribution, have parties been notified? Date of notification ____/____/____ ❑ Yes / ❑ No

Any response received? Date received ___/____/____ ❑ Yes / ❑ No

Is employee currently enrolled in the Plan(s)? ❑ Yes / ❑ No
Date employee enrolled in Plan(s) ___/____/____

Is/are alternate recipient(s) currently enrolled as dependent(s) in the Plan(s)? ❑ Yes / ❑ No
Date alternate recipients enrolled in Plan(s) ___/____/____

Person(s) to whom it is expected that benefit reimbursements may be made:

Name _____

Address _____

Relationship to alternate recipient(s):

❑ Employee Parent
❑ Other Parent
❑ State Agency
❑ Legal Guardian
❑ Other: _____

Date alternate recipient(s) added to mailing list for plan information (SPDs, SARs, etc): ___/____/____

Person(s) to whom plan information should be furnished following enrollment of alternate recipient(s):

Name _____

Address _____

Response to Parties

Date parties notified of administrator's determination ____/____/____

Any response from parties? Date received ____/____/____ ❑ Yes / ❑ No

Date referred to legal counsel ____/____/____

Notes on further action: _____

_____

_____

– MODEL LETTER ONE –

(Use to inform Participant and Alternate Recipients that the order/NMSN has been received and is being reviewed.)

[Date]

[Employee]
[Address]
[City, State Zip Code]

["Alternate recipient" (Child) or designate named in QMCSO]
[Address]
[City, State Zip Code]

Dear _____ and _____:
[Employee] *[Alternate Recipient or Designate]*

This is to advise you that on [*INSERT Date*], we received [an order][a National Medical Support Notice ("NMSN")] relating to the coverage of [*INSERT name of Alternate Recipient(s)*] under the *[INSERT name of group health plan(s)]* as [*a child*] [*children*] of [*INSERT name of Employee*].

We are in the process of reviewing this [order][NMSN] to determine if it is a "qualified medical child support order" ("QMCSO"), as defined in Section 609(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"). Our review process will include an inquiry as to [*INSERT name of Employee*]'s eligibility for medical benefits under the [*INSERT names of group health plan(s)*], as well as a review of the terms of the [order][NMSN] to determine if it complies with the provisions of the plan[s] and applicable federal law. We have enclosed a copy of the procedures used by the plan[s] to determine whether [orders][NMSNs] are QMCSOs and to administer the provision of benefits under QMCSOs.

We will notify you in writing of our preliminary determination, and if we find that this [order] [NMSN] is not a QMCSO, we will advise you as to what corrective steps are necessary. Within 30 days after the date of that notification, you (or your attorney) will have the right to submit written comments regarding our determination. After considering any comments received, we will make a final determination as to the qualified status of the [order][NMSN]. If no comments are received during that 30-day period, the determination will become final.

Please keep us advised as to your current mailing address while our review is underway. In addition, please advise us if [*INSERT name of Alternate Recipient(s)*] wish[es] to designate a representative to receive copies of notices that are sent to [him][her][them] relating to this [order][NMSN]. Your cooperation is appreciated.

Sincerely,

[INSERT name of Plan Administrator]
On behalf of [INSERT name of Plan(s)]

Enclosure [Enclose a copy of QMCSO procedures]

cc: *[Employee's Attorney, if any]*
[Alternate Recipient's Attorney, if any]
[State Agency, if any]

– MODEL LETTER TWO –

(Use to inform Employee and Alternate Recipient(s) that the order has been reviewed and the order is qualified.)

[Date]

[Employee]
[Address]
[City, State Zip Code]

["Alternate recipient" (Child) or designate named in QMCSO]
[Address]
[City, State Zip Code]

Dear _____ and _____:
[Employee] *[Alternate Recipient or Designate]*

This is to advise you that we have reviewed the court order received on *[INSERT Date]*, relating to the coverage of *[INSERT name of Alternate Recipient(s)]* under the *[INSERT name of group health plan]* (the "Plan) as [a] *[child(ren)*] of *[INSERT name of Employee]*. We have determined that this order is a qualified medical child support order ("QMCSO") as defined in Section 609(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

In reviewing the order, we found that the following provisions, which are required for the order to be qualified, were present:

- The order provides a reasonable description of the type of coverage to be provided by the plan to each *alternate recipient* or indicates the manner in which the type of coverage is to be determined.

- The order identifies the period to which it applies.

- The [child][children][is][are] eligible for coverage under the Plan.

- The order requires the Plan to provide benefits that are available under the Plan.

- The required employee contribution does not exceed applicable state and federal withholding limits.

[Include one of the two alternative paragraphs below. The first paragraph is included if the child is not already enrolled as a dependent under the Plan. The second paragraph is included if the child is already enrolled as a dependent].

[Alternative 1:]

Coverage for *[INSERT name of Alternative Recipient(s)]* will begin as of the [*describe enrollment dates–e.g. first day of the month*] and the following additional conditions have been met: *[Describe any other conditions for enrollment, such as a waiting period to be completed by the employee.] [If applicable, address selection of coverage options and any default options under the Plan; enclose information about the coverage options.]* Your monthly premiums will increase by $[enter dollar amount] due to the coverage of this individual.

[Alternative 2:]

Our records indicate that *[INSERT name of Alternative Recipient(s)]* [is/are] already enrolled as [a] dependent(s) of *[INSERT name of Employee]* under the terms of the *[INSERT name of group health plan]*, and there will be no interruption in coverage as a result of the court order.

Coverage for *[INSERT name of Alternate Recipient(s)]* will end at the time stated in the order or, if sooner, when otherwise provided under the terms of the *[INSERT name of group health plan]*. For example, coverage will end when *[INSERT name of Employee]* or *[INSERT name of Alternate Recipient(s)]* ceases to be eligible (subject to any right the Alternate Recipient may have to elect continuation coverage under COBRA or other applicable law).

You have the right to submit written comments regarding this preliminary determination for a period of 30 days after the date of this letter. You should direct your comments to *[INSERT name of the Plan Administrator]* at the following address, *[INSERT address*]. If you do not intend to comment, please notify us of your intentions in writing. If comments are received during such period, the plan administrator will consider them and notify you of its final determination. If no comments are received within such period, this determination shall become final.

Please keep us informed of your current address. In addition, please advise us if there is anyone else who should be receiving copies of correspondence relating to any benefits that may be available to *[INSERT name of Alternative Recipient(s)]*. Your cooperation is appreciated.

Sincerely,

[INSERT name of Plan Administrator]
On behalf of [INSERT name of Plan]

Enclosure [Enclose SPDs and enrollment materials, unless alternative recipient is already enrolled]

cc: *[Employee's Attorney, if any]*
[Alternate Recipient's Attorney, if any]
[State Agency, if any]

– MODEL LETTER THREE –

(Use to inform Employee and Alternate Recipient(s) that the order has been reviewed and the order is NOT qualified.)

[Date]

[Employee]
[Address]
[City, State Zip Code]

["Alternate recipient" (Child) or designate named in QMCSO]
[Address]
[City, State Zip Code]

Dear _____ and _____:
[Employee] *[Alternate Recipient or Designate]*

This is to advise you that we have reviewed the court order received on *[INSERT Date]*, relating to the coverage of *[INSERT name of Alternate Recipient(s)]* under the *[INSERT name of group health plan(s)]* as [*a child*][*children*] of *[INSERT name of Employee]*. We have determined this order is *not* a "qualified medical child support order" ("QMCSO") as defined in Section 609(a) of the Employee Retirement Income Security Act ("ERISA").

In reviewing the order, we found the following provision(s) to be defective or missing:

[Using paragraphs 7a, 8a, and/or 9a of the checklist, check the boxes below to inform the parties about which information is missing or is defective in the order.]

- ❑ The order does not provide for child support or health benefit coverage for a child of an employee under a group health plan.
- ❑ The order is not made pursuant to state domestic relations laws, such as laws relating to divorce or child support.
- ❑ The order does not relate to benefits under the Plan.
- ❑ The order does not enforce a state law relating to medical child support as described in Section 1908 of the Social Security Act.
- ❑ The order does not provide a reasonable description of the type of coverage to be provided by the Plan to each *alternate recipient* or indicate the manner in which the type of coverage is to be determined.

- ❑ The order does not identify the period to which it applies.
- ❑ The child is not eligible for coverage under the Plan.
- ❑ The order requires the Plan to provide for benefits that are not available under the Plan.
- ❑ The order requires the employee contributions to exceed applicable state and federal withholding limits.

[In addition, include one of the two alternative paragraphs below. The first paragraph is included if the child is not already enrolled as a dependent under the Plan. The second paragraph is included if the child is already enrolled as a dependent.]

[Alternative 1:]

Because the order does not meet the requirements of a QMCSO, *[INSERT name of Alternative Recipient(s)]* will not be provided coverage under the *[INSERT name of group health plan(s)]* at this time.

[Alternative 2:]

Despite these defects, our records indicate that *[INSERT name of Alternative Recipient(s)]* [*is/are*] already enrolled as [*a dependent*][*dependents*] of *[INSERT name of Employee]* under the terms of the *[INSERT name of group health plan(s)]* and there will be no interruption in coverage as a result of the order. Coverage for *[INSERT name of Alternate Recipient(s)]* will continue only as long as otherwise provided under the terms of the *[INSERT name of group health plan(s)]*.

You have the right to submit written comments regarding this preliminary determination for a period of 30 days after the date of this letter. You should direct your comments to *[INSERT name of Plan Administrator]* at the following address, [*INSERT address*]. If you do not intend to comment, please notify us of your intentions in writing. If comments are received during such period, the plan administrator will consider them and notify you of its final determination. If no comments are received within such period, this determination shall become final.

Please keep us informed of your current address during this period.

Sincerely,

[INSERT name of Plan Administrator]
On behalf of [INSERT name of Plan(s)]

cc: *[Employee's Attorney, if any]*
[Alternate Recipient's Attorney, if any]
[State Agency, if any]

– MODEL LETTER FOUR –

(Use to inform Parties that the Individual is not an employee or is not eligible for coverage.)

[Date]

[Individual]
[Address]
[City, State Zip Code]

["Alternate recipient" (Child) or designate named in QMCSO]
[Address]
[City, State Zip Code]

Dear _____ and _____:
[Individual] *[Alternate Recipient or Designate]*

This is to advise you that we have received a judgment, order or decree on *[INSERT Date]*, relating to the coverage of *[INSERT name of Alternate Recipient(s)]* under the *[INSERT name of group health plan(s)]* as [*a child*][*children*] of *[INSERT name of Individual]*. We will not review the document for the following reason(s):

- ❑ The judgment, order or decree relates to an individual who is no longer a current employee of the company.

- ❑ The judgment, order or decree relates to an employee who is not currently eligible to participate in the Plan and will not be eligible to participate.

You have the right to submit written comments regarding this preliminary determination for a period of 30 days after the date of this letter. You should direct your comments to *[INSERT name of Plan Administrator]* at the following address, [*INSERT address*]. If you do not intend to comment, please notify us of your intentions in writing. If comments are received during such period, the plan administrator will consider them and notify you of its final determination. If no comments are received within such period, this determination shall become final.

Please keep us informed of your current address during this period.

Sincerely,

[INSERT name of Plan Administrator]
On behalf of [INSERT name of Plan(s)]

cc: *[Individual's Attorney, if any]*
[Alternate Recipient's Attorney, if any]
[State Agency, if any]

CHECKLIST OF DOCUMENTS TO BE DISTRIBUTED TO PARTICIPANTS UPON BECOMING ELIGIBLE TO PARTICIPATE IN THE PLAN

The following documents should be given to participants at the time they become eligible to participate in the Plan:

1) Summary Plan Description

This is a summary of the main provisions of the Plan. It is recommended that the SPD be distributed to new participants immediately, although, technically, under ERISA, you have 90 days from the participant's date of entry to distribute the SPD.

2) Pre-Tax Benefit Election and Salary Reduction Agreement

This form is used by the participant to elect in which benefits under the Plan the participant would like to participate and have his or her compensation reduced in order to pay for his or her share of the cost of such benefits on a pre-tax basis. In addition, the form allows the participant to specify how much of his or her salary he or she would like to contribute to the health flexible spending account and/or the dependent care assistance plan. The form also authorizes the company to reduce the participant's compensation and it explains how often the participant can revoke or change the election.

The participant should complete and return this form to the Plan Administrator.

3) After-Tax Benefit Election and Salary Reduction Agreement

This form is used by the participant to elect in which benefits under the Plan the participant would like to participate and have money deducted from his or her compensation in order to pay for such benefits on an after-tax basis. It also authorizes the company to make such deductions and explains how often the participant can revoke or change the election.

The participant should complete and return this form to the Plan Administrator.

4) Initial COBRA Notice

Federal law requires that a notice explaining COBRA rights be given to all covered employees and their spouses participating in group health plans. It is recommended that you send the Initial COBRA Notice via first class mail addressed to the covered employee and the covered employee's spouse (if the spouse is also covered under the Plan). For example, if Jane Smith is your employee, both she and her

husband John Smith are covered under your plan, and they are both living at the same address, an Initial COBRA Notice should be mailed to either "Mr. and Mrs. John Smith" or to "John and Jane Smith." This should be done as soon as possible so that they are aware of their notice obligations to notify the plan administrator if certain events take place, such as a divorce or legal separation. Separate mailings should be made if the employee and spouse live at different addresses. If you give the Notice to an employee at the workplace, you should mail a separate copy to the employee's spouse.

5) HIPAA Privacy Notice

A HIPAA Privacy Notice must be given to the participant if he/she is enrolled the self-funded medical plan and/or the health flexible spending account. This notice informs the participant how his/her "protected health information" may be used or disclosed and it explains his/her individual rights with regard to "protected health information."

6) Other

Any other forms required by the insurance company for an insured plan.

FOUR COUNTY MENTAL HEALTH CENTER, INC.
AFFIDAVIT OF COMMON LAW MARRIAGE

PERSONALLY APPEARED before me the undersigned, who first being duly sworn, deposes and states:

1. We understand that in the State of Kansas, a common-law marriage exists if the parties agree to be married, are not married to anyone else, and hold themselves out to other people as being married to each other.

2. We declare that neither of us is legally married to another party, that we are each of lawful age to enter into a marriage contract, and there are no other impediments to our common law marriage.

3. We hereby affirm our intent to be married to each other and declare that we have considered ourselves common-law married since: _____ (Month/Date/Year).

4. We understand that the Internal Revenue Code of 1986, as amended, imposes certain obligations on married individuals when filing their personal income tax returns and we hereby affirm that we have filed and/or will file appropriate income tax returns indicating that we are married.

5. We understand that, upon this affirmation of marriage, we may be considered spouses by: (i) Four County Mental Health Center, Inc.; (ii) the various welfare benefit plans and qualified retirement plans that are sponsored and maintained by Four County Mental Health Center, Inc. (referred to collectively hereinafter as the "Plans"); (iii) any external insurance company that is providing coverage in connection with any of the Plans; and (iv) and any other parties that may be involved in providing or administering benefits under any of the Plans.

6. We further understand that Four County Mental Health Center, Inc., and any other parties that may be involved with the Plans, will continue to treat us as spouses for purposes of determining and/or administering benefits under the respective Plans, if any, until such time as we produce a divorce decree from an appropriate court or other court order declaring that we are no longer spouses.

7. We understand that this affidavit may be used in any legal proceeding as evidence that we have entered into a marriage contract. In addition, we understand that a common law marriage is legally recognized as a marriage and must be terminated through formal divorce proceedings.

Signature of Employee: _____

Printed Name: _____

Signature of Spouse: _____

Printed Name: _____

SWORN to and SUBSCRIBED before me this _____ day of _____, 20___.

Notary Public Name:_____

Notary Public Signature:_____

County of:_____ [NOTARY SEAL]

State of:_____

Notary Commission Expiration:_____