MISSOURI EDUCATORS UNIFIED HEALTH PLAN

Plan Document
and
Summary Plan Description

Effective as of July 1, 2017

This document, together with the attached documents, constitutes a combined plan document and summary plan description.

TABLE OF CONTENTS

1. Introduction 1

1.1. Background and Purpose 1
1.2. Plan and Component Benefit Programs 1
1.3. Reservation of Rights 2

2. General Information About the Plan 3

3. Definitions 4

4. Eligibility and Participation Requirements 7

4.1. Employee Eligibility 7
4.2. Dependent Eligibility 7
4.3. Retirees, Families of Retirees, and Survivors Eligibility 7
4.4. Other Requirements Related to Eligibility 8
4.5. Enrollment and Election Procedures 10
4.6. Coverage 12
4.7. Termination of Participation 12

5. Summary of Plan Benefits 14

5.1. Description of Plan Benefits 14
5.2. Contributions 14
5.3. Sources of Benefits 14
5.4. Special Provisions and Disclosures for Component Benefit Programs That Are Group Health Plans 15
5.5. FMLA and Non-FMLA Leaves of Absence 25

6. Circumstances Which May Affect Benefits 27

6.1. Denial or Loss of Benefits 27
6.2. Amendment or Termination of Plan 27
6.3. Subrogation and Reimbursement 27
6.4. Coordination of Benefits 27
6.5. Right to Information 28

7. How the Plan is Administered 29

7.1. Plan Administration 29
7.2. Duties of the Third-Party Plan Administrator 29
7.3. Claims Administrator 30

8. Claims Procedures 31

8.1. Submitting Claims for Benefits 31
8.2. Denial of Claims 33
8.3. Filing an Appeal 34
8.4. Appeals Process 35
8.5. Final Decision 36
8.6. External Review 37

8.7. Culturally and Linguistically Appropriate Notices 43
8.8. Construction 43
8.7. Statute of Limitations for Plan Claims 43

9. General Plan Provisions 44

9.1. No Guarantee of Employment 44
9.2. Assignment of Benefits 44
9.3. Medical Care Decisions and Treatment 44
9.4. No Waiver of Terms 44
9.5. Limitation of Rights 45
9.6. Severability 45
9.7. Use of Captions 45
9.8. Plurals and Gender 45
9.9. No Oral Modifications 45
9.10. Tax Consequences 45
9.11. Incapacity 45
9.12. Beneficiary Designations 46
9.13. Applicable Law 46

1. INTRODUCTION

1.1. Background and Purpose.

The Missouri Educators Unified Health Plan, Inc. (the "MEUHP") is a mutual benefit corporation organized under the Missouri Nonprofit Corporation Act. Pursuant to the Articles of Incorporation and the Bylaws of the MEUHP, the Board of Directors of the MEUHP (the "Board") has the authority to establish and maintain a health plan (the "Plan") that provides to MEUHP members accident, health, dental and vision insurance either directly or indirectly through the purchase of insurance policies or excess or reinsurance contracts, or on a self-funded basis. The Plan was originally established to provide medical and prescription drug benefits to MEUHP members, effective as of July 1, 2009. All benefits provided under the Plan were fully-insured. Effective January 1, 2014, the Board elected to self-fund the medical and prescription drug benefits provided under the Plan.

The members of the MEUHP consist of Missouri school districts that are political subdivisions of the State of Missouri. As such, pursuant to Section 537.620 of the Missouri Revised Statutes, the MEUHP and the Plan are not deemed insurance companies or insurers, and therefore, the Plan is not considered a multiple employer self-insured health plan subject to Sections 376.1000 to 376.1045 of the Missouri Revised Statutes. In addition, the MEUHP and the Plan are not subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). Any references to ERISA in any documents relating to the Plan, including but not limited to the Component Benefit Programs listed in Schedule A of this Plan or participant disclosures required under Federal law, are not applicable and should not be construed as subjecting the MEUHP and the Plan to ERISA's requirements.

The Plan is subject to the Patient Protection and Affordable Care Act of 2010 (as amended by the Health Care and Education Reconciliation Act of 2010) ("PPACA"). The Plan is not "grandfathered" for purposes of PPACA.

1.2. Plan and Component Benefit Programs.

A. Single Plan. The Plan and the Component Benefit Programs are a single plan.

B. Wrap Plan. The Plan itself is sometimes referred to as a "wrap plan," because it takes different health benefit programs offered by the MEUHP and wraps them up into one unified and bundled plan.

C. Component Benefit Programs. All of the specific programs that are part of the Plan are listed on Schedule A (attached to the Plan). They are called "Component Benefit Programs" throughout this Plan document, and they are specifically incorporated into this Plan by reference. All of the Benefits under the Plan are offered under a particular Component Benefit Program and are determined by the terms of the Component Benefit Program. Schedule A, and each of the Component Benefit Programs, may be revised or replaced from time to time without formal amendment to this Plan.

D. Official Plan Documents. Taken together, the Plan document and the documents related to each Component Benefit Program described in Schedule A, as each document may be amended or replaced from time to time, are the official documents of the Plan and summary plan description.

E. Prior Documents Superseded. This Plan document supersedes any other plan documents and summary plan descriptions for the Plan. This Plan document will generally control and prevail in the event of any discrepancies or differences in interpretation between the terms, conditions or language in this Plan document, and in the terms, conditions or language contained in any other documents that comprise part of a Component Benefit Program or in any information provided by the MEUHP, the Third-Party Plan Administrator, the Claims Administrator or a Participating Member, in connection with the administration of the Plan or any of the Component Benefit Programs.

1.3. Reservation of Rights. The MEUHP reserves the right, at any time and at its sole and absolute discretion, to unilaterally amend or terminate the Plan, any Component Benefit Program, or any Benefit offered under a Component Benefit Program.

2. GENERAL INFORMATION ABOUT THE PLAN

Plan Name: Missouri Educators Unified Health Plan

Plan Sponsor: The Missouri Educators Unified Health Plan, Inc. ("MEUHP")
3130 Broadway
Kansas City, MO 64111
1-800-821-7303

Type of Plan: The Plan is a welfare plan, providing medical and prescription drug benefits.

Type of Administration: The Plan is administered by Forrest T. Jones & Company, Inc. (the "Third-Party Plan Administrator") and Cigna will serve as the Plan's Claims Administrator. The MEUHP may also contract with one or more service providers, including additional third party administrators, to assist in the administration of part or all of the Plan or any Component Benefit Program.

Agent for Service of Legal Process: Service for legal process may be made upon the Third-Party Plan Administrator.

Source of Contributions: All Benefits are self-insured. Premiums for Benefits provided under the Plan are paid (a) in part by the Participating Members out of general assets and in part by Employees' contributions, (b) solely through the contributions of Employees, or (c) solely through the contributions of Participating Members.

The MEUHP provides Participating Members with a schedule of applicable premiums for Benefits under each Component Benefit Program during the initial and later open enrollment periods and on request. Each Participating Member provides its employees with a schedule of Employee Contributions required for Benefits under each Component Benefit Program.

Funding Medium: The MEUHP established a depository account with the Central Bank, Jefferson City, Missouri (the "Bank Account") for purposes of collecting premiums and paying claims for Benefits provided under the Component Benefit Programs and to satisfy any reserve requirements, if applicable.

Plan Year: The Plan Year is July 1 to June 30.

3. DEFINITIONS

The following terms, when capitalized, shall have the following meanings, unless a different meaning is clearly required by the context. Words and phrases that are not defined in this Section will have the meaning set forth in an applicable Component Benefit Program.

Adverse Benefit Determination means, with respect to a Medical Plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including (a) any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or Dependent's eligibility to participate, (b) 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, (c) a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate, and (d) any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at the time).

Benefit means an option available to Employees and their Dependents, on an elective or non-elective basis, as further described herein and in the Component Benefit Programs.

Board means the Board of Directors of the Missouri Educators Unified Health Plan.

Cafeteria Plan means a cafeteria plan under Section 125 of the Code, if any, maintained by a Participating Member for its Employees.

Child means a child who (1) is under the age of twenty-six (26) and is the child of the Employee or the Employee's Spouse; and (2) who meets the additional requirements for eligibility that are set out in the specific Component Benefit Program and the Participation Agreement under which the Employee is covered.

Claims Administrator means Cigna; an administrative services organization that regularly engages in the business of managing health care services and/or providing claims administration or adjudication services to employee welfare plans; or any other entity appointed by the MEUHP to receive and review claims for Benefits under the Plan, to determine what amount, if any, is due and payable, to make appropriate disbursements to persons entitled to Benefits thereunder, and to review and determine denied claims.

COBRA means the Public Health Service Act, as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, as applicable to public school districts and as it applies to continuation coverage for health care Benefits, and any regulations or interpretations issued thereunder.

Code means the Internal Revenue Code of 1986, as amended, and any regulations or interpretations issued thereunder.

Component Benefit Program means an employee welfare benefit plan described in Schedule A. The Component Benefit Programs are specifically incorporated into the Plan by reference, and the documents associated with the Component Benefit Programs are also specifically incorporated into the Plan by reference. Schedule A may be revised from time to time as necessary without formal amendment to this Plan.

Covered Person(s) means an individual who participates in, and may be entitled to receive Benefits from, the Plan or any of the Component Benefit Programs. Covered Persons include any covered Employees and their covered Dependents, or any individual who meet the requirements as outlined in Section 4.

Dependent means, to the extent provided in the Plan and the Participation Agreement adopted by a Participating Member, a Spouse, or Child of an Employee.

Employee means a person classified by a Participating Member as a common law employee of the Participating Member, who meets the eligibility criteria set forth in the Participation Agreement adopted by the Participating Member, or any former employee who meets the requirements as outlined in Section 4. The word "employee" when not capitalized will not be limited to the meaning given in this Section 3.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld on appeal pursuant to Section 8.4 or for which the internal claims and appeals process has been deemed exhausted pursuant to Section 8.6.A.(2).

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations and interpretations issued thereunder.

Medical Plan means any Component Benefit Program that is a group health plan as defined under Section 2791(a)(1) of the Public Health Services Act.

PPACA means the Patient Protection and Affordable Care Act of 2010 (as amended by the Health Care and Education Reconciliation Act of 2010 as amended), and the regulations and interpretations issued thereunder.

Participating Member means a Missouri school district that has executed a membership agreement with the Board to become a member of the MEUHP and to participate in the Plan. Participating Members are listed on Schedule B of the Plan, which schedule may be revised or replaced from time to time without formal amendment to this Plan.

Participation Agreement means the agreement signed by the Participating Member and the MEUHP to evidence the Participating Member's participation in the Plan, and the terms and conditions upon which Employees of the Participating Members will become eligible to participate in the Plan.

Plan means the Missouri Educators Unified Health Plan, as set forth herein, together with the Component Benefit Programs, as such Plan and the Component Benefit Programs may be amended from time to time.

Plan Year means the twelve (12)-month period beginning each July 1 and ending June 30.

Qualified Beneficiary means an Employee, Spouse, or Child who is a Dependent of an Employee who loses coverage under this Plan because of a qualifying event described in Section 5.4(B)(1). A child born to, adopted by, or placed for adoption with an Employee during a period of COBRA coverage is also a Qualified Beneficiary, provided that (a) the child is otherwise eligible under the terms of the Component Benefit Program and the Participation Agreement and (b) if the Employee is a Qualified Beneficiary, the Employee has elected COBRA coverage for himself.

Rescission means a cancellation or discontinuance of coverage under a Component Benefit Plan that is a group health plan subject to PPACA and that has a retroactive effect; provided, however that a cancellation is not a Rescission if (a) the cancellation or discontinuance of coverage has only a prospective effect; or (b) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to failure to timely pay required premiums or contributions towards the cost of coverage.

Spouse means in the case of a Participating Member electing to make available spousal coverage, an individual meeting the criteria set forth in the Participation Agreement adopted by a Participating Member.

Third-Party Plan Administrator means Forrest T. Jones & Company, Inc.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and the regulations and interpretations issued thereunder.

4. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

4.1. Employee Eligibility.

A. In order to participate in any particular Component Benefit Program under the Plan, an Employee must (1) have been designated by a Participating Member as an eligible Employee, (2) satisfy the eligibility requirements set forth in the Component Benefit Program and the Participation Agreement under which the Employee is covered, (3) have met any applicable waiting periods set forth in the Component Benefit Program and the Participation Agreement under which the Employee is covered, and (4) have satisfied the applicable enrollment requirements for the Component Benefit Program within the required time period.

B. Each Component Benefit Program may have its own additional requirements for eligibility for some or all of the benefits it provides. The documents related to the specific Component Benefit Programs contain additional information.

C. The eligibility requirements in this Plan supersede any less restrictive eligibility requirements for employees in the Component Benefit Programs.

4.2. Dependent Eligibility.

A. In order for a Dependent to be eligible for coverage under any particular Component Benefit Program under this Plan, the Dependent must (1) have been determined by the Participating Member to be an eligible Dependent; (2) satisfy the eligibility requirements set forth in the Component Benefit Program and the Participation Agreement under which the Employee is covered; (3) have met any applicable waiting periods set forth in the Component Benefit Program and the Participation Agreement under which the Employee is covered; and (4) have satisfied the applicable enrollment requirements for the Component Benefit Program within the required time period.

B. Notwithstanding clauses (1) and (2) of Section 4.2(A)(1), in the case of a Participating Member that is an "applicable large employer" (within the meaning of Code Section 4980H(c)(2)), any individual who is under age 26 and is a child of an eligible Employee (determined under Section 4.1 above) of such Participating Member shall be eligible for coverage under each Component Benefit Program that provides "minimum essential coverage" (within the meaning of Section 5000A(f)(1)(B)).

4.3. Retirees, Families of Retirees, and Survivors Eligibility.

A. In accordance with Section 169.590.1 of the Missouri Revised Statute, this Plan shall provide Benefits under any particular Component Benefit Program made available to Employees of Participating Members to (1) any Employee who retires, or who has retired, (2) the spouse or children of any Employee who retires, or who has retired, and (3) the spouse or children, or the surviving spouse or surviving children, of any Employee, provided the person described under this Section 4.3.A is receiving or is eligible to receive retirement benefits under the Missouri Teacher and School Employee Retirement System (described in Sections 169.010 to 169.750 of the Missouri Revised Statutes). Persons described in this Section 4.3.A shall be responsible for paying the premiums for coverage under this Plan, including the premiums for any covered Dependents.

B. The MEUHP may develop specific Component Benefit Programs for retirees who are age 65 and older and eligible for Medicare that provide a different level of coverage than the Component Benefit Programs made available to Employees of Participating Members.

C. The enrollment period for coverage under this Plan for persons described in Section 4.3.A shall be specified in the Component Benefit Program. Such enrollment period cannot be less than thirty days.

D. A person described in Section 4.3.A shall have one year from the last date of employment with a Participating Member to enroll in coverage under this Plan as specified in 4.3.C.

4.4 <u>Other Requirements Related to Eligibility</u>.

A. <u>Documentation and Verification</u>. The MEUHP or Third-Party Plan Administrator may require such documentation as it deems necessary from the Employee in order to determine that an individual qualifies as a Retiree, as a Spouse or Child, and the Third-Party Plan Administrator also may take whatever steps it deems necessary to verify whether an individual continues to qualify as a Dependent. In addition, each Participating Member may require such documentation and verification from its Employees and their Dependents as it deems necessary or appropriate.

B. <u>Multiple Employees in a Family</u>. An Employee cannot be covered under the Plan as both an Employee and a Dependent. If a Child is a Dependent of two eligible Employees, only one Employee may elect coverage for that Child.

C. Benefits Conditioned Upon Accurate Information. All payments under the Plan from any Component Benefit Program to the Employee or to a provider are conditioned upon the accuracy of the personal and/or Dependent information provided in regard to the Plan and the Component Benefit Program. If false or misleading information is provided about the Employee or any Dependent, or about expenses or about entitlement to benefits or other coverage, the MEUHP will take appropriate action, up to and including the forfeiture of Benefits, the loss of coverage, and termination of the Participating Member's participation in the Plan. In no event, however, will an Employee's or Dependent's coverage under a Component Benefit Program that is a group health plan that is subject to PPACA be Rescinded unless (1) the Employee or a Dependent (or a person seeking coverage on his behalf) performs an act, practice, or omission that constitutes fraud; or (2) the Employee or a Dependent (or a person seeking coverage on his behalf) makes an intentional misrepresentation of material fact. In no case will coverage be Rescinded without providing at least thirty (30) days prior written notice.

D. MEUHP's Status Determinations Control. In determining any individual's eligibility for coverage, the policies, procedures and classifications of the MEUHP and the Participating Member regarding an individual's status will govern, regardless of how the individual's status might be determined for Federal tax purposes.

4.5. Enrollment and Election Procedures.

A. Initial Enrollment.

(1) An Employee becomes eligible to participate in the Plan on the date specified in the Participation Agreement under which the Employee is covered (the "Eligibility Date").

(2) To participate, the Employee must make an election to participate within 30 days of his Eligibility Date. This election is made by providing to the Participating Member all required information and documentation.

B. Annual Open Enrollment. Before the beginning of each Plan Year, the MEUHP will offer an open enrollment period during which each Participating Member may allow its Employees to enroll, make new elections, or change existing elections for the next Plan Year. The MEUHP will specify the deadline for Employees of existing Participating Members to enroll and/or make annual elections, which will be no later than June 30 of the year before the year to which the enrollment and elections apply. Each Participating Member shall transmit to the Third-Party Plan Administrator such enrollment information required by the MEUHP before the deadline specified by the MEUHP.

C. Election Changes. An election of Benefits under the Plan, and any salary reduction agreements to pay the Employee's share of required contributions for such Benefits, are irrevocable during the entire Plan Year to which they apply, unless changed or revoked as provided below:

(1) If the Employee terminates employment with a Participating Member during a Plan Year, the Employee's elections will be deemed revoked for the remainder of the Plan Year.

(2) For any Component Benefit Program that is a group health plan, each Employee (and his eligible Dependents) will be entitled to certain special enrollment rights, to the extent required under HIPAA. Special enrollment rights are available:

(a) If an Employee declines enrollment in this Plan for himself and his Dependents because of health coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (including divorce, death, termination of employment, reduction in hours, or exhaustion of the

COBRA period), he may be able to elect coverage under a Component Benefit Program that is a group health plan for himself and his Dependents who lost such coverage, provided that the Employee requests enrollment within 30 days after the applicable event.

Notwithstanding the foregoing, if an Employee declines enrollment in this Plan for himself or his Dependents because of health coverage under a Medicaid plan under Title XIX of the Social Security Act (a "Medicaid Plan") or under a State child health plan under Title XXI of the Social Security Act (a "State Child Health Plan"), and eligibility for such coverage is subsequently lost, he may be able to elect coverage under a Component Benefit Program that is a group health plan for himself and his Dependents who lost such coverage, provided that the Employee requests enrollment within 60 days after the date of termination of coverage under such Medicaid Plan or State Child Health Plan.

(b) If an Employee (or an Employee who retires and enrolled in coverage in accordance with Section 4.3) has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he may also be able to elect coverage for himself, his Spouse, and his newly-acquired Dependent, provided that the Employee (or the retired Employee) requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(c) If an Employee, his Spouse, or his Dependent becomes eligible for assistance, under either a Medicaid Plan or a State Child Health Plan, with respect to coverage under a Component Benefit Program for himself and his Dependents, he may be able to elect coverage under a Component Benefit Program that is a group health plan for himself and his Dependents who lost coverage, provided that the Employee requests enrollment within 60 days of the date the Employee or his Dependent is determined to be eligible for such assistance.

(3) For benefits paid for on a pre-tax basis under a Cafeteria Plan, the Employee may make any election change during the Plan Year that is permitted under the Cafeteria Plan.

(4) An employee cannot add or remove Dependents during the Plan Year, unless he has experienced a "change in status" that would permit an election change under the Cafeteria Plan (without regard to whether such a Dependent meets the definition of a Dependent under the Cafeteria plan).

(5) All election changes shall be effective on a prospective basis only, except those election changes made on account of HIPAA special enrollment rights in the event of birth, adoption, and placement for adoption.

4.6. Coverage. The types of coverage, the conditions to and limitations on coverage, the minimum and maximum amounts of coverage that may be elected for any Benefit for any Plan Year, and the circumstances under which coverage begins and terminates shall be as set forth from time to time in the applicable Component Benefit Programs.

4.7. Termination of Participation.

A. Except as otherwise specifically provided by a Component Benefit Program, an Employee's participation in a Component Benefit Program, and the participation of the Employee's Dependents, will terminate on the earliest of the following dates:

(1) The last day of the month during which the Employee no longer qualifies as an Employee.

(2) With respect to an Employee's covered Dependents, the last day of the month during which the Dependent no longer qualifies as a Dependent.

(3) With respect to any coverage requiring Employee contributions, the day on which contributions by the Employee are discontinued.

(4) The day on which the Employee reports for active duty as a member of the armed forces of any country.

(5) The day on which the MEUHP determines the Employee has submitted false claims.

(6) The day on which the applicable Benefit(s), or all Benefits, are terminated by amendment of the Plan, by whole or partial termination of the Component Benefit Program or the Plan.

(7) Any other date identified with respect to a reason specified in a Component Benefit Program. The individual Component Benefit Programs should be consulted for additional information on specific termination events.

(8) The date on which the Participating Member which employs the Employee ceases participation in the Plan.

B. Termination of an Employee's participation in a particular Component Benefit Program automatically cancels the Employee's required contributions with respect to that Benefit, effective as of the date the Employee's participation terminates. Further, Benefits stop under a Component Benefit Program when participation under that Component Benefit Program terminates.

5. SUMMARY OF PLAN BENEFITS

5.1. <u>Description of Plan Benefits</u>. The Plan provides Employees and their Dependents with the opportunity to choose Benefits provided under one of the Component Benefit Programs. Each Employee may elect to receive coverage under one Component Benefit Program for himself and his Dependents, to the extent provided in the Component Benefit Programs. Benefits provided under the Plan are set forth in the Component Benefit Programs, and are subject to such terms, conditions, and limitations of such Component Benefit Programs, as the same may be amended and replaced from time to time.

5.2. <u>Contributions</u>.

A. <u>Contributions</u>. The premiums for any self-insured Benefits are paid (1) in part by the Participating Members out of general assets and in part by Employees' contributions, (2) solely through the contributions of Employees, or (3) solely through the contributions of Participating Members. Contributions made by an Employee may be made on a pre-tax basis through the Cafeteria Plan, if the Participating Member has adopted a Cafeteria Plan. Each Participating Member shall determine and communicate the Employee's share of the cost of the Benefits provided through each Component Benefit Program before the start of the Plan Year, and at such other times as the Participating Member may determine.

B. <u>Determination of Amount</u>. The amount of Participating Member contributions, if any, and Employee contributions shall be determined by each Participating Member, in its sole and absolute discretion.

5.3. <u>Sources of Benefits</u>.

A. <u>Payment of Benefits</u>. Benefits provided under the Component Benefit Programs shall be paid out of the Bank Account. The liability of this Plan to provide Benefits under a Component Benefit Program will be limited by the terms of the Component Benefit Program.

B. <u>Self-Insured Benefits</u>. With respect to the self-insured Benefits provided under a Component Benefit Program, any person or entity who claims the right to any payment with respect to such Benefits will be entitled to receive only the Benefit for which payment must actually be made under the Component Benefit Program. Each person or entity will be entitled to look only to this Plan for payment of any such Benefit and will not have any rights, claim or demand with regard to the Benefit against the MEUHP, the Third-Party Plan

Administrator, the Claims Administrator, any Participating Member, or any employee, officer or director of any of the foregoing. The MEUHP does not assume any liability or responsibility whatsoever for any self-insured Benefit that is provided under the Plan or under any Component Benefit Program.

5.4. Special Provisions and Disclosures for Component Benefit Programs That Are Group Health Plans.

A. General Statement of Compliance. With respect to each Component Benefit Program that is a group health plan, the Plan will provide Benefits in accordance with, and subject to, the requirements of all applicable laws, including, but not limited to, the Public Health Service Act, COBRA, HIPAA, USERRA, the Family and Medical Leave Act of 1993, the Newborns' and Mothers' Health Protection Act of 1996, the Women's Health and Cancer Rights Act of 1998, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the Genetic Information Nondiscrimination Act of 2008, and PPACA, all of which requirements are incorporated herein by reference.

B. COBRA Continuation Rights. If coverage under a Component Benefit Program that is a group health plan ceases because of certain "qualifying events" specified in COBRA and described in this Section 5.4(B)(1), then a Covered Person is entitled to elect temporary health continuation coverage.

(1) Qualifying Events. Only Qualified Beneficiaries are entitled to elect COBRA. The definition of a qualifying event differs for Employees, their Spouses and their Dependents.

(a) Qualifying Events for Employees. An Employee covered under this Plan may be entitled to elect continuation coverage if he loses coverage under this Plan (or, in some cases, if his required premium payments or contributions for coverage increase) for either of the following reasons:

- A termination of employment (for reasons other than gross misconduct); or
- A reduction in hours of employment.

(b) Qualifying Events for Spouses. If a Spouse is covered under this Plan, he or she may be entitled to elect continuation coverage if he or she loses such coverage (or, in some cases, if required premium payments or

contributions for coverage increase) for any of the following reasons:

- A termination of employment (for reasons other than gross misconduct);
- A reduction in hours of employment;
- The Employee's death;
- Divorce from the Employee; or
- The Employee becomes entitled to Medicare (Part A or B).

(c) Qualifying Events for Dependent Children. If an Employee's dependent children are covered under this Plan, they may be entitled to elect continuation coverage if they lose such coverage (or, in some cases, if required premium payments or contributions for coverage increase) for any of the following reasons:

- A termination of employment (for reasons other than gross misconduct);
- A reduction in hours of employment;
- The Employee's death;
- The Employee's divorce from their spouse;
- The Employee becomes entitled to Medicare (Part A or B); or
- They cease to be a Dependent under the Plan.

(2) Notification Requirements. Under the law, an Employee, his Spouse, or his Dependent(s) has the responsibility to inform the Third-Party Plan Administrator of a divorce, legal separation, or a Dependent losing "dependent status." This notification must be made in writing within 60 days from the later of (a) the date of the qualifying event (*i.e.*, the divorce or child losing dependent status) or (b) the date that coverage would otherwise cease because of the qualifying event. It must be sent to:

Forrest T. Jones & Company, Inc.
ATTN: Mark Iglehart
3130 Broadway
Kansas City, MO 64111

If this written notification is not made in a timely manner, then the right to continuation coverage will be forfeited.

A Participating Member will notify the Third-Party Plan Administrator, which in turn will notify Qualified Beneficiaries of their right to elect continuation coverage as the result of a termination, reduction in hours of employment, death or Medicare entitlement. The Participating Member must notify the Third-Party Plan Administrator within 30 days after the Qualifying Event.

(3) Election Period. Each Qualified Beneficiary has a separate and independent election right and may elect continuation coverage within 60 days from the later of (a) the date of their COBRA election notice or (b) the date coverage would otherwise cease because of the qualifying event. This is the maximum election period. If a Qualified Beneficiary does not elect continuation coverage within this period, all rights to elect continuation coverage will end.

If a Qualified Beneficiary elects to continue coverage and pays the applicable premium, then the Participating Member is required to provide the Qualified Beneficiary with coverage that is identical to the coverage provided under this Plan to similarly situated active employees, including the opportunity to choose among the Component Benefit Programs during an open enrollment period. If coverage is changed or modified for similarly situated active employees, then continuation coverage may be similarly changed and/or modified.

(4) Length of Coverage. The length of continuation coverage will depend on the qualifying event that causes a Qualified Beneficiary to lose coverage under a group health plan.

(a) 18-month period. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in employment hours, then each Qualified Beneficiary will have the opportunity to continue coverage for up to 18 months.

(i) Disability extension. The 18-month period may be extended to 29 months if the Social Security Administration determines that, according to Title II or XVI of the Social Security Act, a Qualified Beneficiary was disabled *during the first 60 days of continuation coverage*, or in the case of a

child born to or placed for adoption with a covered employee during a COBRA coverage period, *during the first 60 days after a child's birth or placement for adoption.*

All Qualified Beneficiaries with respect to the same qualifying event as the disabled Qualified Beneficiary are entitled to the extension. It is the disabled Qualified Beneficiary's responsibility to obtain this disability determination from the Social Security Administration, and the responsibility of any of the related Qualified Beneficiaries to *provide a copy of the determination letter* to the Third-Party Plan Administrator within 60 days of the date of determination and before the original 18 months of continuation coverage ceases. It must be sent to:

Forrest T. Jones & Company, Inc.
ATTN: Mark Iglehart
3130 Broadway
Kansas City, MO 64111

If there is a final determination that the Qualified Beneficiary is no longer disabled, the Third-Party Plan Administrator must be notified in writing by the Qualified Beneficiary or a related Qualified Beneficiary within 30 days of the determination. It must be sent to:

Forrest T. Jones & Company, Inc.
ATTN: Mark Iglehart
3130 Broadway
Kansas City, MO 64111

Any coverage extended beyond the maximum that would otherwise apply will be terminated for all Qualified Beneficiaries.

(ii) Secondary events. Another extension of the 18-month period can occur, if *during the 18 months* of continuation coverage, a second qualifying event occurs (*e.g.*, divorce, legal

separation, death, entitlement to Medicare, or loss of status as a dependent child, and the event would have caused a loss of coverage had the first qualifying event not occurred). If these two requirements are met, then the 18 months of continuation coverage may be extended to 36 months. If a second event occurs, it is the Qualified Beneficiary's obligation to notify the Third-Party Plan Administrator in writing of the event within 60 days of the event and within the original 18-month period. It must be sent to:

Forrest T. Jones & Company, Inc.
ATTN: Mark Iglehart
3130 Broadway
Kansas City, MO 64111

In no event, however, will continuation coverage last beyond three years.

(b) 36-month period. If the original qualifying event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or loss of status as a dependent child, then each Qualified Beneficiary will have the opportunity to elect up to 36 months of continuation coverage.

(5) Eligibility. A Covered Person does not have to show that he is insurable to elect continuation coverage. However, he must be covered under this Plan at the time of a qualifying event in order to be eligible to elect continuation coverage (except for children born or placed for adoption with a covered employee during the continuation coverage period). The MEUHP reserves the right to verify eligibility and terminate continuation coverage retroactively if the Covered Person is determined to be ineligible or if there has been a material misrepresentation of the facts.

(6) Premiums. A Qualified Beneficiary will be required to pay up to 102% of the applicable premium for coverage under any particular Component Benefit Program. The premium may be adjusted in the future if the applicable premium amount changes. In addition, if the continuation period is extended beyond 18 months due to a disability determination

by the Social Security Administration, the MEUHP may charge up to 150% of the applicable premium during the extended period for the disabled Qualified Beneficiary and any nondisabled qualified beneficiaries in the disabled beneficiary's coverage group.

Initial premium payments must be made within 45 days of the date continuation coverage is elected. Subsequent premium payments must be made monthly and are due on the first of each month. There is a grace period of 31 days for the regularly scheduled monthly premiums. This is the maximum grace period under the Plan. Failure to submit all premium payments by the end of the grace period will result in loss of the right to further continuation coverage.

(7) Termination of Continuation Coverage. The law allows continuation coverage to be terminated prior to the maximum continuation period for any of the following reasons:

- The MEUHP ceases to provide group health coverage;
- Any required premium is not paid in a timely fashion;
- A Qualified Beneficiary becomes covered, after the date on which COBRA was elected, under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary (other than an exclusion or limitation that may be disregarded under law);
- A Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election;
- A Qualified Beneficiary who has extended coverage due to a disability is determined by the Social Security Administration to be no longer disabled;
- A Qualified Beneficiary notifies the Third-Party Plan Administrator that he wishes to cancel continuation coverage; or
- For cause, such as fraudulent claim submission, on the same basis that coverage could terminate for similarly situated active employees.

C. USERRA Continuation Rights. Continuation and reinstatement rights may also be available if an Employee is absent from

employment due to uniformed services pursuant to USERRA. More information about coverage under USERRA is available from the Third-Party Plan Administrator.

D. Benefits for Adopted Children. With respect to Component Benefit Programs that are group health plans, the Plan will extend benefits to Dependent children placed with an Employee for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children.

E. Special Rights on Childbirth. With respect to Component Benefit Programs that are group health plans, federal law prohibits any restriction on benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The physician or provider may need to obtain advance approval from the specific Component Benefit Program or from the Plan for any stay beyond 48 or 96 hours in order to avoid any reduction in benefits.

F. Women's Health and Cancer Rights Act of 1998. With respect to Component Benefit Programs that are group health plans, the federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If an individual is eligible for mastectomy benefits under such a Component Benefit Program and elects breast reconstruction in connection with such mastectomy, the individual is also covered for the following:

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

(2) Surgery and reconstruction on the other breast to produce a symmetrical appearance;

(3) Prostheses;

(4) Treatment of physical complications of all states of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it

otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the applicable Component Benefit Program. Coverage is subject to applicable deductibles, copayments and coinsurance payments as provided under the applicable Component Benefit Program.

G. HIPAA Privacy and Security Rules. Each Component Benefit Program that is a group health plan is subject to HIPAA's medical privacy and security rules, which are codified at 45 Code of Federal Regulations Parts 160 and 164, Subparts A and E (the "Privacy and Security Rules"). The Privacy and Security Rules require group health plans to preserve the confidentiality of protected health information, or "PHI." PHI is health information that can be linked to a specific individual. It includes, for example, information about the health care received by an individual and the amount paid for such care. All capitalized terms that are used in this Section 5.4.G. that are not otherwise defined by the provisions of this Plan or this paragraph shall have the same meaning as given under HIPAA and the Privacy and Security Rules.

As described in the Notice of Privacy Practices for each Component Benefit Program that is a group health plan subject to HIPAA, the MEUHP will not use or disclose PHI, except as necessary to administer the Component Benefit Program (including performing treatment, payment and health care operations) and any organized health care arrangement that may be established by the MEUHP, or as otherwise permitted or required by law. With regard to any Component Benefit Program that is a self-insured group health plan that is subject to HIPAA, the MEUHP agrees it will:

(1) Not use or further disclose PHI other than as permitted or required by such Component Benefit Program and the Privacy and Security Rules.

(2) Ensure that any agent, subcontractor, or other party with whom it shares PHI will agree to the same, or substantially similar, restrictions and conditions that apply to the MEUHP with respect to PHI. To be considered substantially similar, those restrictions and conditions must meet the requirements of the Privacy and Security Rules.

(3) Not use or disclose the PHI of any Employee for employment-related actions and decisions or in connection with any other benefit or benefit plan of the MEUHP.

(4) Report to such Component Benefit Program any use or disclosure of PHI that it becomes aware of that is inconsistent with the Privacy and Security Rules or such Component Benefit Program's Notice of Privacy Practices.

(5) Make available to each individual covered under such Component Benefit Program his PHI so that he may exercise his rights under HIPAA, including seeing and copying his PHI, receiving an accounting of certain of its disclosures and, under certain circumstances, amending the information. These rights are more fully explained in the Notice of Privacy Practices for such Component Benefit Program.

(6) Make the MEUHP's internal practices, books, and records relating to the use and disclosure of PHI received from such Component Benefit Program available to the Secretary of the U.S. Department of Health and Human Services, charged with the enforcement of the Privacy and Security Rules, for purposes of determining compliance with the Privacy and Security Rules. Providing this information to the Secretary will not waive any attorney-client, accountant-client, or other legal privilege or the work product rule.

(7) If feasible, return or destroy all PHI received from such Component Benefit Program when the PHI is no longer needed. If this is not possible, the MEUHP will limit further uses and disclosures of it to those purposes that meet the requirements of the Privacy and Security Rules and that make the return or destruction of the information infeasible.

(8) Ensure that there is adequate separation between the functions employees perform on behalf of the MEUHP in administering such Component Benefit Program and this Plan, and the employer functions of the Participating Members.

While the Third-Party Plan Administrator administers the Plan and each Component Benefit Program, employees are only given access to, and may only use and disclose, PHI for plan administration purposes. Any employee who uses or discloses PHI for a purpose other than plan administration or as permitted or required by law will be subject to disciplinary action and sanctions, up to and including termination, in accordance with the MEUHP's policies.

As a condition for obtaining Electronic Protected Health Information ("Electronic PHI") from the Plan and its Business Associates, the MEUHP agrees it will:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that they create, receive, maintain or transmit on behalf of each Component Benefit Program that is subject to the Privacy and Security Rules.

(2) Ensure the adequate separation between each such Component Benefit Program and the MEUHP, as required by 45 CFR Section 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

(3) Ensure that any agent, subcontractor and other party to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.

(4) Report to such Component Benefit Program any Security Incident of which it becomes aware.

Notwithstanding anything to the contrary in this Paragraph G, this Paragraph G and the Privacy and Security Rules do not apply to the following:

(1) Information about whether an individual is participating in the Plan or any Component Benefit Program; and

(2) Summary Health Information, provided that the Participating Member requests Summary Health Information for the purpose of obtaining premium bids providing insurance coverage under the Plan or any Component Benefit Program; or modifying, amending or terminating the Plan or any Component Benefit Program, all as permitted by the Privacy and Security Rules.

Questions about the Privacy and Security Rules or about the Notice of Privacy Practices issued by each Component Benefit Program that is a group health plan subject to HIPAA can be directed to the Third-Party Plan Administrator.

5.5. <u>FMLA and Non-FMLA Leaves of Absence</u>.

A. <u>FMLA Leaves of Absence</u>.

(1) If an Employee goes on a qualifying leave under the Family and Medical Leave Act of 1993 ("FMLA"), to the extent required by the FMLA, the Participating Member will continue to maintain the Employee's coverage under any Component Benefit Program that is a group health plan, on the same terms and conditions as if the Employee were still active (that is, the Participating Member will continue to pay its share of the premium, if any, to the extent that the Employee opts to continue coverage). A Participating Member may elect to continue all group health plan coverage for its Employees while they are on paid leave (so long as Employees on non-FMLA paid leave are required to continue coverage). If so, the Employee who is on FMLA leave will pay his share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis if that is what was used before the FMLA leave began).

(2) If an Employee is going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and the Employee opts to continue his group health plan coverage, then the Employee may pay his share of the premium in one of three ways: (a) with after-tax dollars while on leave; (b) with pre-tax dollars to the extent that the Employee receives compensation during the leave, or by pre-paying all or a portion of the Employee's share of the premium for the expected duration of the leave, or by pre-paying all or a portion of the Employee's share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of his pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, the Employee must make a special election before such compensation would normally be available to him (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year)); or (c) by other arrangements agreed upon between the Employee and the Participating Member (for example, the Participating Member may pay for coverage during the leave and withhold amounts from the Employee's compensation upon his return from leave).

(3) If a Participating Member requires all of its Employees to continue coverage under this Plan during the unpaid FMLA leave, the Employee may discontinue paying his share of the required premium until he returns from leave. Upon returning from leave, he must pay his share of any required premiums that he did not pay during the leave. Payment for the Employee's share will be withheld from his compensation either on a pre-tax or after-tax basis, as the Employee and the Participating Member may agree.

(4) If the Employee's coverage under this Plan ceases while on FMLA leave (*e.g.*, for non-payment of required contributions), the Employee will be entitled to re-enter the Plan upon return from such leave on the same basis as the Employee was participating in the Plan before the leave, or as otherwise required by the FMLA. The Employee is entitled to have coverage under this Plan automatically reinstated so long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

B. Non-FMLA Leaves of Absence. If an Employee goes on an unpaid leave of absence that does not affect eligibility, then the Employee will continue to participate and the premium due for the Employee will be paid by pre-payment before going on leave, after-tax contributions while on leave, or with catch-up contributions after the leave ends.

6. CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

6.1. **Denial or Loss of Benefits.** Benefits under the Plan or any of its Component Benefit Programs will cease when an Employee's or his Dependent's (or Dependents') participation in the Plan or any of such Component Benefit Programs terminates. Benefits will also cease on termination of the Plan. Other circumstances can result in the termination, reduction or denial of benefits. The particular Component Benefit Program should be consulted for additional information on other specific events that could cause the reduction or termination of Benefits.

6.2. **Amendment or Termination of Plan.**

A. The Plan has been established with the intention of it being maintained for an indefinite period of time; however, the MEUHP, in its sole and absolute discretion, may amend or terminate this Plan or any provision of the Plan, including any Component Benefit Program, at any time, or any policies, contracts or arrangements with any administrative service organizations, or other persons or entities. The Plan may be amended or terminated by a written instrument duly adopted by the MEUHP or any of its duly-authorized delegates, and such amendment shall be binding on all Participating Members.

B. No termination or amendment shall operate to reduce the amount of any benefit payment under the Plan or any Component Benefit Program for charges incurred prior to the effective date of such termination or amendment; however, nothing in this Plan shall be construed to require the continuation of the Plan or any Component Benefit Program with respect to existing or future participants or their beneficiaries.

C. Notwithstanding Section 6.2B, the Plan may be amended at any time, retroactively if necessary, to comply with the provisions of state and federal law, including but not limited to PPACA and any regulations or guidance promulgated thereunder.

6.3. **Subrogation and Reimbursement.** The Subrogation and reimbursement provisions in any Component Benefit Program shall be binding on all Covered Persons.

6.4. **Coordination of Benefits.** The coordination of benefits provisions in any Component Benefit Program shall be binding on all Covered Persons.

6.5. **Right to Information.** For purposes of determining the applicability and implementation of any subrogation, reimbursement or coordination of benefits provisions of any Component Benefit Program, or coverage obtained from a source other than the Plan, the Claims Administrator, without consent of or notice to any person, may release or obtain information that the Claims Administrator reasonably deems necessary. An individual claiming benefits under the Plan shall furnish, upon request by the Claims Administrator, any written information requested to implement this provision.

7. HOW THE PLAN IS ADMINISTERED

7.1. <u>Plan Administration</u> The MEUHP has delegated certain duties or powers to a third party plan administrator (hereinafter "Third-Party Plan Administrator"). The Third-Party Plan Administrator may delegate any of its duties or powers at any time, including, but not limited to, a delegation of its discretionary authority as described below, to a person or persons who are employees of the Third-Party Plan Administrator. The Third-Party Plan Administrator shall have the right to change its delegates from time to time, or to take over functions previously delegated, all without cause. The Third-Party Plan Administrator may allow the entities to which it delegates its duties or powers to further delegate such duties or powers.

The MEUHP shall have the absolute discretion and authority to construe and interpret the provisions of the Plan to make factual determinations, and to determine all questions concerning benefit entitlements, including the power to construe and determine disputed or doubtful terms. To the maximum extent permissible under law, the MEUHP's determinations on all such matters shall be final and binding upon all persons involved. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on review unless it is shown that the interpretation or determination was an abuse of discretion, i.e, arbitrary and capricious.

7.2. <u>Duties of the Third-Party Plan Administrator</u>.

A. The Third-Party Plan Administrator will administer the Plan, will determine all questions arising under or in connection therewith (other than those delegated to other administrators), and may from time to time prescribe and amend procedures for such administration with all such changes approved by MEUHP. MEUHP has delegated to the Third-Party Plan Administrator or its delegate the following duties and powers as may be necessary to discharge its responsibilities:

(1) The Third-Party Plan Administrator from time to time shall, in a uniform and nondiscriminatory manner, establish rules for the transaction of its business;

(2) To adopt such rules for the administration of the Plan for the orderly administration of the duties delegated;

(3) To prescribe enrollment procedures and forms;

(4) To prepare and distribute to Participating Members, Employees, and/or Covered Person information explaining the Plan and the Benefits available hereunder in such a

manner as the Third-Party Plan Administrator deems appropriate;

(5) To receive information from Participating Members, Employees, and/or Covered Persons necessary for the proper administration of the Plan; and

(6) To employ such agents and assistants, such counsel and such clerical and other services as the Third-Party Plan Administrator may require in carrying out the provisions of the Plan.

7.3. Claims Administrator.

A. The MEUHP has delegated the authority for claim determination under the Component Benefit Programs to the Claims Administrator. In exercising its responsibility, the Claims Administrator has discretionary authority to construe Plan terms and to make factual determination whether, and to what extent, individuals are entitled to benefits. The Claims Administrator shall have the duty to receive and review claims for benefits under the Plan, to review and determine denied claims, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of Benefits payments to persons entitled thereto.

B. The MEUHP has the authority to appoint, remove, and replace one or more Claims Administrators.

8. CLAIMS PROCEDURES

For a detailed description of the required procedures for filing claims and of the appeals procedures for any denied claims, please refer to the applicable Component Benefit Program. Following is a general overview of the basic requirements for filing appeal claims, but this summary does not cover incomplete claim filings, procedures for extension with notice, and certain other procedures. These provisions do not apply to the extent that claims procedures are set forth differently in an applicable Component Benefit Program; however, in the event that the claim procedure language in an applicable Component Benefit Program fails to comply with the requirements of applicable law, these provisions shall govern.

8.1. Submitting Claims for Benefits.

A. Generally a claim must be submitted in order to receive Benefits from a Component Benefit Program. For some Benefits, such as certain medical and prescription drug services, claims may be submitted by the provider. There are some time limits for submitting claims, and certain services must be pre-authorized as defined by the general plan specifications and outlined in the Component Benefit Programs. A delay in submitting a claim could result in the loss of benefits. Claim forms are available from the Claims Administrator.

B. No claim for Benefits is payable unless a properly completed claim form, including all necessary documentation for services or supplies received, is received by the Claims Administrator within the period prescribed in the applicable Component Benefit Program or as otherwise provided herein. As a condition of receiving a Plan Benefit, a Covered Person must submit such evidence to the Claims Administrator as it may require in order to determine that a claim is reimbursable under the terms of the Plan. Unless otherwise stated in a Component Benefit Program, claims must be received by the Claims Administrator within one year of the expenses being incurred.

C. If correct and complete claim forms are submitted, the claim will be processed within the time frames provided below. The time frames differ based on the category of benefits (and in the case of medical and dental claims, the type of claim). The determination of whether a claim falls under the procedures for health claims or under the procedures for disability and other non-health claims is based on the nature of the specific claim or benefit, not the characterization of the plan under which the claim is made or the benefit is offered.

D. Health Claims (Medical and Prescription Drug Benefits).

(1) Urgent Care Claim. This type of pre-service claim includes those situations commonly treated as emergencies. If a treating physician believes that the Covered Person has an urgent care claim, the Covered Person or his representative must provide pre-service notice to the Plan. If the claim is an urgent care claim, the Covered Person or his authorized representative will be notified of the Plan's decision about the claim not more than 72 hours after receipt of a complete claim. If the claim does not include sufficient information for the Claims Administrator to make a decision, the Covered Person or his representative will be notified of the need to provide additional information within 24 hours after receipt of the incomplete claim. The Covered Person will have at least 48 hours to respond to this request. The Claims Administrator will inform the Covered Person of its decision within 48 hours of receipt of the additional information.

(2) Pre-Service Claim. A pre-service claim is a claim for which a Covered Person must get approval before obtaining medical care or treatment. This process is often referred to as pre-certification or pre-authorization. If the claim is a pre-service claim, the Claims Administrator will notify the Covered Person of its initial determination not more than 15 days from the date it receives a complete claim. If more time is needed, the Covered Person will be notified that an additional processing period is required. If an extension is due to a failure to submit all the necessary information to decide the claim, the Covered Person will have at least 45 days to provide the additional information requested.

(3) Post-Service Claim. A post-service claim is a claim for which payment is requested after medical care or treatment has already been provided. If the claim is a post-service claim, the Covered Person will be notified if the complete claim is denied in whole or in part within 30 days after it is received. If more time is needed for review, the Covered Person will be notified that an additional processing period is required. If an extension is due to a failure to submit all the necessary information to decide the claim, the Covered Person will have at least 45 days to provide the additional information requested.

(4) Concurrent Care Claim. A concurrent care decision occurs where the plan approves an ongoing course of treatment to

be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (b) where an extension is requested beyond the initially-approved period of time or number of treatments.

(a) Concurrent Care Early Termination. A decision by the plan to reduce or terminate an initially-approved course of treatment is an Adverse Benefit Decision that may be appealed. Notification of a decision by the plan to reduce or terminate an initially-approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow an appeal of the adverse decision and receive a decision on review prior to the reduction or termination. All requests shall be decided in the otherwise applicable time frames for pre-service, post-service, or urgent care claims.

(b) Concurrent Care Extension Request. If the claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the initially-approved period of time or number of treatments, the claim shall be decided within no more than 24 hours after receipt of the claim. Any other request to extend a concurrent care decision shall be decided in the otherwise applicable time frames for pre-service, post-service, or urgent care claims.

8.2. Denial of Claims. If all or part of a claim is denied, the Claims Administrator will notify the Covered Person of the denial. All denials will be in writing, unless the claim involves urgent care, in which case notice of the denial may initially be made orally. A denial notice will:

A. State specific reason(s) for the denial, with specific references to the Plan provision(s) on which the denial was based;

B. List any additional material or information that may be needed in order to perfect the claim and explain why such material or information is necessary;

C. Describe in detail how to have the decision reviewed, the review procedures, how to file an appeal, and the applicable time frame for requesting review (including, the case of a health claim involving urgent care, a description of the expedited review process applicable to such claim);

D. If a claim under a group health plan is denied, include:

(1) Any internal rule, guideline, protocol, or other similar criterion relied upon or a statement that a copy of such will be provided upon request and free of charge; and

(2) An explanation of the scientific or clinical judgment for a determination based on a medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the medical circumstances of the Covered Person, or a statement that such explanation will be provided upon request and free of charge.

E. If a claim under a Medical Plan is denied, include:

(1) Information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the denial codes and their meanings, if applicable;

(2) A statement that diagnosis and treatment codes and their meanings, if applicable, will be provided upon request and free of charge;

(3) A description of the standard, if any, used in denying the benefit claim;

(4) A description of the process for having a decision reviewed, the review procedures, and the applicable time frame for requesting review; and

(5) The contact information for a state office of health insurance consumer assistance or ombudsman, if applicable.

8.3. Filing an Appeal. If a claim has been denied, the denial can be appealed and reviewed. The Covered Person must file the appeal, and the Claims Administrator must review the appeal, within the time frames provided below. Someone other than an individual involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the appeal. Please note that the time frames differ based on the

category of benefit (and in the case of medical and dental claims, the type of claim).

A. Health Claims. A Covered Person has 180 days after the receipt of the denial notice to request a review of the denial. The request for a review must be in writing unless the claim involves urgent care, in which case the request may be made orally and documentation may be provided by facsimile or other expeditious method. The Claims Administrator must respond within the time frames provided below.

(1) Urgent Care Claims. Not later than 72 hours after receiving a request for review.

(2) Pre-Service Claims. Not later than 30 days after receiving a request for a review.

(3) Post-Service Claims. Not later than 60 days after receiving a request for a review.

(4) Concurrent Care Claims.

(a) Concurrent Care Early Termination Claims. Before the proposed reduction or termination takes place.

(b) Concurrent Care Extension Request Claims. The appeal time frame for urgent care, pre-service, or post-service claims (as described above), as appropriate to the request.

8.4. Appeals Process.

A. Under any Component Benefit Program, in connection with the right of a Covered Person to appeal the denial, in whole or in part, of a claim for benefits, the Covered Person may request, free of charge, reasonable access to and copies of all relevant documents, records, and other information related to the claim, unless such relevant documents, records or other information are privileged. The Covered Person can also submit comments, documents, records, and other relevant information regarding why the claim should not be denied. These submissions must be in writing.

B. If the claim was denied based on a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience. The health care professional consulted for the appeal will not be the professional (if any)

consulted during the prior determination, nor a subordinate of such professional.

C. For any Component Benefit Program that is a Medical Plan, the Claims Administrator will provide the Covered Person with any new or additional evidence considered, relied upon, or generated by the Claims Administrator in connection with the claim, and any new or additional rationale relied upon in making a determination regarding an appeal. Such information will be provided to the Covered Person as soon as possible, and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is made to give the Covered Person a reasonable opportunity to respond prior to that date.

8.5. Final Decision. The final decision will be sent to the Covered Person in writing.

A denial will:

A. State the specific reasons(s) for the denial, with specific references to the Plan provision(s) on which the denial was based;

B. State that the Covered Person 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 for benefits;

C. Describe any voluntary appeal procedures offered by the Component Benefit Program;

D. If a claim under a group health plan is denied, include:

(1) Any internal rule, guideline, protocol, or other similar criterion relied upon or a statement that a copy of such will be provided upon request and free of charge; and

(2) An explanation of the scientific or clinical judgment for a determination based on a medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Component Benefit Program to the Covered Person's medical circumstances, or a statement that such explanation will be provided upon request and free of charge.

E. If a claim under a Medical Plan is denied, include:

(1) Information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, and the denial codes and their meanings, if applicable;

(2) A statement that diagnosis and treatment codes and their meanings, if applicable, will be provided upon request and free of charge;

(3) A description of the standard, if any, used in denying the benefit claim;

(4) A discussion of the Final Internal Adverse Benefit Determination;

(5) A description of any external review procedures and how to request external review (including any expedited time frame that may apply to an urgent care claim); and

(6) The contact information for a state office of health insurance consumer assistance or ombudsman, if applicable.

8.6. External Review.

A. Any Adverse Benefit Determination (including a Final Internal Adverse Benefits Determination) that is made under a Component Benefit Program that is a Medical Plan shall be eligible for external review under this Section 8.6 if such determination:

(1) Either: (a) involves medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational); or (b) relates to a Rescission; and

(2) Either: (a) the Claims Administrator does not adhere to all claim determination and appeal requirements under federal law; or (b) the standard levels of appeal have been exhausted.

An Adverse Benefit Determination based upon a determination as to eligibility is not eligible for external review.

B. The following rules shall apply with respect to an external review hereunder:

(1) Request for External Review. A Covered Person must formally request an external review in accordance with the procedures established by the Claims Administrator within four (4) months of the date the Covered Person received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

(2) Preliminary Review. Within five (5) business days of receipt of an external review request, the Claims Administrator shall complete a preliminary review request to determine whether:

(a) The claimant is or was covered by the Medical Plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under such plan at the time the health care item or service was provided;

(b) The Adverse Benefit Determination or Final Internal Adverse Benefit Determination relates to the Covered Person's failure to meet the eligibility requirements under the Medical Plan;

(c) The Covered Person has exhausted or is deemed to have exhausted the Medical Plan's internal claims and appeals process; and

(d) The Covered Person has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Claims Administrator shall issue a notification in writing to the Covered Person. If the request is complete but not eligible for external review, such notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and allow the claimant to perfect the request for external review within the original four (4) month filing period or 48 hours of the receipt of the notification, whichever is later.

(3) Referral to Independent Review Organization. If a claim is eligible for external review, the Claims Administrator shall assign an accredited independent review organization (IRO) to conduct the external review.

(4) Notice of Receipt from IRO. The assigned IRO shall timely notify the Covered Person in writing that his request for external review has been accepted. This notice shall provide that the claimant may submit additional information regarding his claim in writing to the assigned IRO within ten (10) days following the date of receipt of the notice. Any information received by the IRO within this time frame shall be considered by the IRO as part of the external review.

(5) Delivery of Claims History to IRO. Within five (5) business days after the IRO is assigned, the Claims Administrator shall provide the IRO with the documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review by making a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The IRO must notify the Covered Person and the Claims Administrator within one (1) business day of making such a decision.

(6) Claims Administrator's Right to Reconsideration. Upon receipt of any information submitted by the Covered Person, the assigned IRO must, within one (1) business day, forward that information to the Claims Administrator. Upon receipt of any such information, the Claims Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claims Administrator will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claims Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one (1) business day after making such a decision, the Claims Administrator will provide written notice of its decision to the Covered Person and the assigned IRO. The

assigned IRO will terminate the external review upon receipt of any such notice from the Claims Administrator.

(7) Review By the IRO. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* and not be bound by the decisions or conclusions of the Claims Administrator. In addition to the documents and information provided, the IRO may, to the extent it deems appropriate, consider the following in reaching a decision:

(a) The Covered Person's medical records;

(b) The attending health care professional's recommendation;

(c) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(d) The terms of the Plan to ensure that the IRO's decision is not contrary to its terms, unless the terms are inconsistent with applicable law;

(e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(f) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Section 8.6.B.(7) to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(8) Notice of Final External Review Decision. The IRO will provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for external review. The IRO will deliver the final external review decision to the Covered Person and the Plan.

(9) Contents of Final External Review Decision. The final external review decision will contain:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the reason for the previous denial, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(b) The date the IRO received the request for external review and the date of the IRO's decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching the decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decisions 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 Plan or the claimant;

(f) A statement that judicial review may be available to the Covered Person; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

(10) Maintenance of Records. After a final external review decision, the IRO will maintain all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Covered Person, the Plan, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal law.

(11) Reversal of Claims Administrator's Decision. Upon receipt of an external review decision reversing an Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

C. The following rules shall apply with respect to an expedited external review hereunder:

(1) Request for Expedited External Review. A Covered Person may request an expedited external review at the time the Covered Person receives:

(a) An Adverse Benefit Determination, if that determination involves a medical condition of the Covered Person for which the time frame for the completion of an expedited internal appeal under Section 8.6.A.(1) would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function and the Covered Person has filed a request for an expedited internal appeal; or

(b) A Final Internal Adverse Benefit Determination, if the Covered Person has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the Covered Person's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received emergency services, but has not been discharged from a facility.

(2) Preliminary Review. Immediately upon receipt of a request for external review the Claims Administrator will determine whether the request meets the reviewability requirements set forth in Section 8.6.B.(2) and send a notice that meets the requirements set forth in said Section 8.6.B.(2).

(3) Referral to IRO. Upon a determination that a request is eligible for external review following the preliminary review, the Claims Administrator will assign an IRO

pursuant to the requirements set forth in Section 8.6.B.(3). The Claims Administrator will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO shall review the claim in accordance with the standards set forth in Section 8.6.B.(7).

(4) Notice of Final External Review Decision. The IRO will provide notice of the final external review decision in accordance with Section 8.6.B.(8) as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited review. If the notice is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to the Covered Person and the Plan.

D. Notwithstanding the provisions of Section 8.6. hereof, if a Medical Plan complies with an external review process provided in Department of Labor ("DOL") Technical Releases 2010-01 and 2011-02, as they may be amended by subsequent guidance under Section 2719 of Public Health Services Act, then such Medical Plan shall be deemed to have complied with this Section 8.6.

8.7. Culturally and Linguistically Appropriate Notices. With respect to any Component Benefit Program that is a Medical Plan, all notices described in this Article 8 shall be culturally and linguistically appropriate to the extent required by 45 C.F.R. Section 147.136(e).

8.8. Construction. The provisions of this Article 8 are intended to comply with Section 2719 of the Public Health Services Act and the guidance issued thereunder. If any provision of this Article 8 is subject to more than one interpretation or construction, such ambiguity shall be resolved in favor of the interpretation or construction that is consistent with the provision complying with Section 2719 of Public Health Services Act and the guidance issued thereunder.

8.9. Statute of Limitations for Plan Claims. Except as otherwise specifically stated in a Component Benefit Program, no legal action may be commenced or maintained to recover benefits under this Plan more than 2 years after the determination on appeal by the Third-Party Plan Administrator.

9. GENERAL PLAN PROVISIONS

9.1. **No Guarantee of Employment.** No person shall have any rights under the Plan, except as, and only to the extent, expressly provided for in the Plan. Neither the establishment nor amendment of the Plan, the payment of benefits, nor any action of a Participating Member shall be held or construed to confer upon any person any right to be continued as an employee of the Participating Member, or upon dismissal, any right or interest in any Benefit other than as herein provided. Each Participating Member expressly reserves the right to discharge any Employee at any time and for any reason.

9.2. **Assignment of Benefits.** Except as may otherwise be required by applicable law, or as otherwise specifically provided in the Plan, no amount payable at any time under the Plan shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind, nor in any manner be subject to the debts or liabilities of any person. Any attempt to so alienate or subject any such amount, whether presently or thereafter payable, shall be void. Notwithstanding the foregoing, any Covered Person may request and authorize the Third-Party Plan Administrator to pay benefits directly to a health care provider furnishing services or supplies covered under the Plan, and any such payment, if made, shall constitute a complete discharge of the liability of the Plan therefor.

9.3. **Medical Care Decisions and Treatment.** Certain of the Benefits under the Plan provide for the payment of specified health care expenses. All decisions regarding health care are solely the responsibility of each Covered Person in consultation with the health care providers selected. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed, and whether particular treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of health care reimbursements, or the coverage of a particular health care expense, may be disputed by the Covered Person in accordance with the Plan's claim procedures. Each Covered Person may use any source of care for health treatment and health coverage as selected, and neither the Plan nor the employer will have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Covered Person not to seek or obtain such care, other than the liability of the Plan for the payments of benefits as outlined herein.

9.4. **No Waiver of Terms.** No term, condition or provision of the Plan shall be deemed waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written agreement of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not

constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

9.5. **Limitation of Rights.** Nothing appearing in or done pursuant to the Plan shall be held or construed to give any person any legal or equitable right against a Participating Member, or any person connected therewith, except as expressly provided herein or as provided by applicable law, or to give any person any legal or equitable right to any assets of the Plan. Nothing in this Plan shall be deemed to waive sovereign immunity, official immunity, or any other immunity or defense, or give rise to any cause of action for damages whatsoever against the MEUHP, the Third Party Plan Administrator, the Claims Administrator or any of their Board members, officers, administrators, agents, or employees.

9.6. **Severability.** If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

9.7. **Use of Captions.** The section and subsection numbers and captions used throughout the Plan have been inserted solely as a matter of convenience and in no way define or limit the scope or intent of any provision of the Plan.

9.8. **Plurals and Gender.** Masculine pronouns include the feminine, plural nouns include the singular, and vice versa, except where the context indicates otherwise.

9.9. **No Oral Modifications.** The terms of the Plan cannot be modified except by means of a written amendment duly authorized and adopted by the MEUHP. Any attempted oral modification is not binding on the MEUHP.

9.10. **Tax Consequences.** The MEUHP does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in this Plan. A Covered Person should consult with professional tax advisors to determine the tax consequences of participation.

9.11. **Incapacity.** If a Covered Person is, in the judgment of the MEUHP, legally, physically, or mentally incapable of personally receiving any payment due under the Plan, the MEUHP, in its sole discretion, may direct payments due to such other person or institution who, in the opinion of the MEUHP, are then maintaining or having custody of such covered Employee or Dependent until claim is made by a duly appointed guardian or other legal representative of such covered Employee or Dependent. Such payment

will constitute a full discharge of liability of the Plan to the extent of such payment.

9.12. **Beneficiary Designations.** Unless the Component Benefit Program documentation described in Schedule A with respect to a given benefit expressly provides to the contrary, a covered Employee must designate a beneficiary in the form and manner specified by the MEUHP. If there is no beneficiary designation form on file with the Third-Party Plan Administrator, Benefits will be paid to the Employee's estate.

9.13. **Applicable Law.** This Plan shall be construed in accordance under the laws of the State of Missouri.

IN WITNESS WHEREOF, the undersigned have executed this Plan effective as of July 1, 2017.

By:

Name: Kenneth W. Cook

Title: Board President

By:

Name: Kevin T. Goddard

Title: Board Secretary