CAPE GIRARDEAU
PUBLIC SCHOOLS
District #63

HEALTH CARE PLAN

Revised

Summary Plan and Plan Description with Revisions Through 1-1-23

Accepted changes per emails
dated: 12/14/22 and 10/27/22
Cynthia G. Paul 12/16/22

GENERAL INFORMATION: The Plan Sponsor/Plan Administrator/Agent for Legal Process is Cape Girardeau School District #63, 301 N. Clark Avenue, Cape Girardeau, MO 63701. Phone 573-335-1867. Employer ID # is 43-6000601. The end of the plan year is December 31. The Plan Sponsor reserves the right to amend or discontinue the Plan. You contribute to the Plan in amounts determined by the Plan Sponsor with the balance of costs paid by the Plan Sponsor. The Claim Administrator is Mutual Medical Plans, Inc., 416 Main Street, Peoria, IL 61602. Phone (309) 674-0888 or 1-800-448-4689.

ELIGIBILITY: You and your dependents become eligible on the first of the month following your date of employment as a full time employee (30 or more hours per week). You must apply by the date you become eligible. If you do not apply when first eligible or if you decline coverage, you may enroll at a future date if due to loss of other coverage, marriage, divorce, birth, adoption or placement for adoption provided that you apply within 30 days of the event. Coverage will become effective on the first of the month after your timely request for enrollment due to marriage or loss of other coverage. If the other coverage was COBRA, the COBRA must be exhausted. Non-payment of premium is not considered loss of other coverage. For birth, adoption or placement for adoption, coverage becomes effective on the date of the event, or later if agreed to by you and the Plan Sponsor, assuming you made a timely request for coverage. A person eligible for this Plan may enroll within 60 days of the eligibility date, termination date, or premium assistance date of Medicaid, Mo Health Net, or CHIP. If you do not enter the Plan under the above provisions, you will not be able to enroll in the Plan unless a special enrollment is held by the Plan Sponsor. If you have another health plan that charges your spouse additional fees or contributions or penalizes you or your spouse if you do not enroll in this Plan, then you will not be eligible for this Plan unless an exception is made by the Plan Sponsor.

TERMINATION: Coverage terminates at the earliest of 1) the end of the day – 11:59 PM – on your last day of employment, 2) when any required contributions are not paid, 3) the date a dependent is no longer eligible, 4) the date you have exhausted FMLA leave and/or applicable benefit time defined as vacation, compensatory time, or sick leave, or 5) when the Plan Administrator determines it is in the best financial interest of the plan member.

DEFINITIONS: "You" and "employee" means an employee of Cape Girardeau School District #63. Retirees may continue the coverage in effect at the time of retirement, but must elect retiree coverage within 365 days after the date of retirement.

"Dependent" means your lawful spouse who resides with you in common residence and your under age 26 natural child, adopted child, child placed with you for adoption, or stepchild that you or your spouse have legal guardianship or legal custody or had such guardianship or custody when the child turned age 18, without regard to residence, financial support, or marriage.

"Hospital" means an institution providing care for the sick under supervision of a staff of physicians and nurses on a 24 hour basis. It does not include health resorts or nursing homes, skilled nursing homes, step down units, or long term care facilities, but it does include a state licensed surgery center or a substance abuse treatment center that has an agreement with the Plan or claim administrator.

"Physician" means a duly licensed M.D., D.O., O.D., D.P.M., D.D.S., D.C., Certified Physician's Assistant, Midwife, Nurse Practitioner, and in the case of outpatient mental care, a clinical psychologist, regional mental health center, L.C.S.W., or L.C.P.C.

"Reasonable and customary" means the fee most commonly charged for a service by other health care providers, as determined by the claim administrator. "Maximum Allowable Charge" means 200% of the Medicare allowance or a 100% profit based on the AHD data base cost-to-charge ratio for all services. If a hospital does not accept one of these amounts within 30 days of the offer, the Plan may then consider the admission as a non-covered service and reimburse the member the amount the member owes under that hospital's financial assistance program plus a financial incentive to the plan member as determined by the Plan.

COORDINATION OF BENEFITS

Pursuant to Missouri laws V.A.M.S 476.433, 208.215 and 20CSR400-2.030(2)4F which bestows the same rights on public groups that Medicaid has in regard to paying secondary, this Plan is the payor of last resort and secondary to other health care plans, insurance company policies either individual or group, and other sources of payment, except where contrary to applicable law.

Cynthia Y. Paul 12/14/22

MAJOR MEDICAL PLAN

After a calendar year deductible of $1,500 per person ($3,000 family) and subject to co-pays as listed below, the Plan pays for 80% of covered charges for PPO participating providers as indicated on your ID card, except that hospital or facility charges from Cape Girardeau County hospitals will only be covered at Southeast Health unless the care is not available at Southeast Health or any additional time needed to transport the patient to Southeast Health would jeopardize the patient's health or unless this provision is waived due to extenuating circumstances. Non-PPO providers, subject to the preceding sentence, are covered at 50% of maximum allowable charges. The out-of-pocket expense for services payable at 80%, including the deductible, is $4,500 per person ($9,000 family). The out-of-pocket expense limit does not apply to dental benefits, drug card co-pays, amounts payable at 50%, amounts over reasonable and customary or the maximum allowable charge and other non-covered expenses. Subject to the limitations and exclusions, covered charges are as follows for expenses related to an illness or injury.

Calendar year deductibles apply to the following services in addition to any copayments described unless otherwise noted.

1. Hospital room and board charges up to the hospital's semi-private rate; charges for intensive care, coronary care or similar special care units; and outpatient or inpatient hospital miscellaneous services and supplies when necessary to treat a condition of illness or injury. Inpatient pre-admission and length of stay certification are required from the claim administrator. There is a $250 co-payment applied to hospital emergency room charges that will be waived if admitted.
2. Physician professional fees. Physician office visits, mental health therapy and chiropractic therapy are covered, after a $25 co-pay, at the lower of HealthLink approved pricing or reasonable and customary. Except for group medical or mental therapy, telemedicine visits are paid in full after a $15 copayment per call, the copay is payable by credit card at time of call. Surgery, tests and other services are subject to the deductible and co-insurance, except that lab work to monitor an illness is paid in full when services are received from and billed by a Southeast Medical Group outpatient lab provider or, if outside of Cape Girardeau County, a HealthLink Tier I provider.
3. Services of a registered physical therapist, occupational therapist or speech therapist when prescribed by a physician.
4. Orthotics, leg, arm, neck and back braces. Artificial limbs and other prosthetic appliances for illnesses or accidents. Durable medical equipment rental, or purchase at the claim administrator's option, when such rental type equipment is customarily used only for medical purposes.
5. Professional ground ambulance service when medically necessary to transport a patient to the nearest hospital where required treatment can be provided. The Plan will reimburse an annual subscription fee for your household members to Air Evac or their parent company Air Methods. Mail your itemized receipt to Mutual Medical for reimbursement (normally the annual fee is under $75).
6. Hospice or home health care services when the service provider is not a relative and does not normally reside in the same home as the patient, but only if prescribed by a physician and approved by the Claim Administrator. Clinical trial medical expenses, but not the drug.
7. Oxygen, blood and administration charges. TPN and FDA approved injectable medications that are not excluded by the Plan, when medically necessary and obtained from a vendor designated by the Plan. Specialty drugs including infusions costing over $15,000 per year are not covered unless prior authorization is obtained from the Claim Administrator. Usually these will not be authorized. However, you may get an expensive specialty drug paid in full with either a subsidy from the manufacturer or under the ACP and you can call Mutual Medical for assistance with either at 309-674-0888.
8. Preventative care (not related to an illness or injury) including office visits, exams, tests and immunizations are covered in full without a deductible or co-pay at Southeast Health and PPO physicians, or at the Cape County Health Department, and at 50% of maximum allowable charges at non-PPO providers. Preventative services are only covered if they meet the criteria of ACA legislation. Typical covered services include routine mammogram, pap test, PSA test, colonoscopy and routine blood work. If billed with a medical diagnosis, these services are not considered routine and will be subject to the deductible and co-insurance, if covered.
9. PKU formula and low protein modified food products from birth to age six, newborn hearing screening, necessary rescreening, audiological assessment and follow-up and initial amplification, treatment for autism spectrum disorders, lead testing.
10. Allergy testing, injections and serum are covered at 100% with no deductible at PPO providers and at 50% with no deductible for non-PPO providers. Clinical trials, except for the drug.

HSA PLAN

The HSA plan is the same as the Major Medical except there are no co-pays and it has a $2,000 deductible per person ($4,000 family) in front of all services which are then covered at 100% at PPO providers and 50% of reasonable and customary at non-PPO providers. Prescriptions are covered in full after the $2,000 HSA deductible assuming you use the drug discount card and file an itemized pharmacy receipt to Mutual Medical for reimbursement. HSA enrollees will pay at time of service $65 for Telemed service. Healthlink will forward a claim to Mutual Medical showing the $65 claim in order to have that amount applied to the deductible.

Note that the Maxi Plan, Maxi II, MRP and ACP options all cover emergency care at PPO providers in full, clinical trial related expenses but not the drug, and preventative care from PPO providers in full.

********** SEE PAGE 5 FOR NOTES ON SPECIAL BENEFITS FOR MATERNITY AND LAB. **********

Cynthia Y. Paul 12/16/22

PRESCRIPTION DRUG PLAN
(Only available with the Major Medical and Maxi Plan)

Insulin, insulin syringes, and most other prescription only drugs may be obtained at retail pharmacies - up to a 30 day supply, for co-payments of $10 generic, $30 preferred brand, $50 non-preferred brand. Mail co-pays are double the above for up to a 90 day supply. Generic oral contraceptives are covered in full with no co-payment. If you purchase a brand name drug when the generic is available, you pay the brand co-pay plus the difference in ingredient cost. Only the first 3 refills at retail pharmacies are covered by this Plan. If you require more than 3 refills please use the mail order program. Certain non-preferred brand name drugs are only covered if the preferred brand name drug has been used unsuccessfully as determined by your physician and Express Scripts. The co-pays and the deductible are not covered under the Major Medical Benefits and do not count towards the Major Medical Plan deductible or out-of-pocket expense limit, but are covered under the Maxi Plan.

Specialty drugs or injectable drugs, other than insulin, not receiving special authorization from the Claim Administrator will not be covered providing that any drug that cost over $15,000 per year will not be covered or authorized, but you may call Mutual Medical if you need assistance with a manufacturer's subsidy or for possible ACP enrollment. Drugs not approved by the FDA for the condition being treated, infertility, weight loss, hair growth, cosmetic purposes, Retin-A for individuals over 26 years old, contraceptive devices, and any drug determined to be abused or otherwise misused by you are not covered under this prescription drug benefit. Formulary drug lists are available at www.express-scripts.com or call Express Scripts 800.282.2881. The calendar year out-of-pocket limit on covered prescription drugs is $1,500 per person ($3,000 family). Note that a few generic drugs are covered in full as required by the ACA.

MAXI PLAN and MAXI PLAN II

If you have other coverage that is secondary to this Plan you may elect the Maxi Plan. The Maxi Plan covers the same scope of eligible expenses as Major Medical Benefits without a deductible or co-insurance. All covered services are payable at 100% except that inpatient hospital billed charges are paid up to a maximum of $2,000 per admission. The Maxi Plan also pays in full for routine medical exams and the co-pays under any drug plan. A person may change from the Major Medical Plan to the Maxi Plan, or vice-versa, at any time. Except for inpatient hospital billed charges, the same PPO provisions apply that are in the Major Medical Benefits. The Maxi II is the same as the Maxi Plan except that Maxi II does not cover hospital charges, prescription drugs or oncology expenses. ACA required benefits are covered. Preventative, ER and clinical trial medical expenses, but not the drug, are covered in full.

MEDICAL REIMBURSEMENT PLAN (MRP)

Employees covered by Tri-Care or another employer sponsored health plan may elect only this plan, unless an exception is approved by the Plan Sponsor. This plan can significantly increase your overall benefits. Deductibles, co-pays and co-insurance (but not co-insurance for using your other plan's non-PPO hospitals unless approved by this Plan) under a medical or prescription plan not sponsored by Cape Girardeau Schools are covered in full. If not a covered benefit of your other plan under any circumstances, reasonable charges will be paid in full for office visits, routine exams, and up to 20 chiropractic visits incurred in a calendar year. Benefits are paid directly to you when you send a copy of your other plan's explanation of benefits, or a copy of your prescription receipt showing your co-pay, to Mutual Medical. Write the health care provider's name and phone number on the explanation of benefits. ACA required benefits are covered. Preventative, ER and clinical trial medical expenses, but not the drug, are covered in full.

THE AFFORDABLE CARE PLAN (ACP)
*** No deductible, no co-pays, no co-insurance**
*** No overall annual or lifetime dollar limits * No pre-existing condition limits**

The ACP is designed for individuals whose benefits are expected by the Claim Administrator to exceed $35,000 or more in a year. Each year, if you qualify, you may remain in the ACP, or elect to come back to your group major medical plan at any time. Here is how it works. You may select the carrier of your choice on the Exchange market without having to answer health questions or being subject to pre-existing limits. The ACP will pay your premiums, minus any federal government subsidy for which you may be eligible under PPACA. The ACP will also reimburse you for all deductibles, co-pays and co-insurance for both medical and prescriptions under your chosen fully insured health plan with the Exchange carrier of your choice, and these same expenses under the Major Medical both the year you enter and year you leave the ACP option. Clinical trial expenses except for the drug, and preventative and ER expenses are covered in full. Arrangements can be made to qualify the first of any month with a three day notice. While not everyone can qualify, everyone in the group benefits because of reduced claims that affect employee contributions. To determine if you qualify, contact Mutual Medical at 1-800-448-4689, or consult with the individual in your HR department that handles health insurance. If you do not qualify for all of the features of the Affordable Care Plan, you may qualify for a modified version of the plan as determined by you and the Plan Sponsor. The following are eligible for the ACP: knee or hip replacements, neck, back and shoulder surgery, and any treatment that is likely to exceed charges of $35,000.

Cynthia Y. Paul 12/16/22

DENTAL BENEFITS

The plan will pay reasonable and customary fees of licensed dentists up to a maximum of $1,000 per person for expenses incurred in a calendar year.

100% No Deductible

- Oral exams and cleanings up to twice per calendar year
- Bite-wing x-rays once per calendar year
- Sealants to age 19
- Fluoride treatment once per calendar year to age 19
- Full mouth x-rays once in a consecutive 24 month period

70% (Deductible $75 per person per calendar year)

- Denture repair and relining
- Recementing of inlays, onlays, and crowns
- Extractions, dental tests, oral surgery and related anesthesia except for general anesthesia for 3 or less simple extractions
- Fillings consisting of amalgam, silicate and plastic restorations
- Space maintainers, periodontics (diseases of the gum), endodontics, and apicoectomy
- Emergency treatment including prescriptions

50% (Deductible $75 per person per calendar year)

- Implants, gold foil restorations, inlays and onlays, and crowns or crown build-ups
- Dentures, full or partial
- Bridges, fixed or removable

Orthodontics are not covered. The placement of dentures, bridges or crowns is limited to once in a consecutive five year period for the same tooth or teeth. The date an appliance is placed shall be the date the claim is incurred. General limitations and exclusions of the Plan apply.

LAB SERVICES

Preventive and non-preventative labs when completed by SoutheastHealth, the Cape County Health Department, or by a SoustheastHealth PPO physicians and the lab test is on the list of required ACA preventives services are covered at 100%.

Preventive labs performed at Labcorp, Quest or other in-network labs and the lab test is on the list of required ACA preventives services are covered at 100%. Non-preventative labs performed at Labcorp, Quest or other in-network labs will apply to deductibles and coinsurance.

Beware of lab schemes where the provider ordering the lab work has a financial tie-in with a lab and thousands of dollars are billed out for general diagnoses such as fatigue. Such lab charges will not be paid by the Plan, and you may or may not be balance billed.

MATERNITY BENEFITS

A newborn baby is not automatically covered under the mother's insurance for the hospital stay. While in the hospital, your baby will incur both delivery and nursery charges along with individual charges.

What to do if you have an individual health policy for your newborn:
If you have an individual health policy on the baby, it will pay primary for delivery, nursery and individual charges. Our plan will be considered secondary.

What to do if you do not have an individual policy for your newborn:
If you do not have an individual health policy on the baby, please contact the Benefits Specialist to complete a new enrollment card. This must be completed within 30 days from the date of delivery. The monthly child premium will be required at the time of the enrollment change.

Our self-funded plan will process your claim as follows:
If a newborn is discharged with the mother and is considered a "well baby" the delivery and nursery charges will be included as part of the mother's hospital bill and is covered under her insurance.

Sick babies and individual charges including, but not limited to pediatrician visits, labs, circumcision, etc. will be processed under the baby's insurance. These charges are subject to the individual deductible and coinsurance for the child.

Cynthia Y. Paul
12/16/22

LIMITATIONS AND EXCLUSIONS

The Plan will not pay for:

1. Hospital or related physician charges during inpatient admissions primarily for care which can be provided safely on an outpatient basis as determined by the claim administrator. Charges exceeding reasonable and customary or the maximum allowable charge as determined by the claim administrator. Job related injuries or illnesses covered by or pending under Worker's Compensation or similar legislation, or for which a final decision has not been made by the Division of Worker's Compensation on a claim filed under Worker's Compensation. Expenses payable by Medicare, or which would have been payable if the person had properly enrolled in Medicare, except where contrary to law. Custodial care primarily for assistance with activities of daily living. Care that is provided or can be provided at home, by a nursing home, skilled nursing facility, step-down unit, or long-term care facility. Education or training not specifically mentioned as a benefit of the Plan. Expenses for which you, the employee, are not liable for payment including expenses on adult dependents where you have not assumed legal liability for medical bills.
2. Routine foot care such as trimming nails or callouses, except for diabetics. Orthopedic shoes and orthotics. IQ testing. Hearing aids or eyeglasses and tests for the fitting thereof. Expenses denied by an HMO or other health care plan for (a) lack of pre-treatment approval, (b) use of non-network providers, or (c) failure to follow claim procedures.
3. Hospital admissions commencing or other services or appliances received before an individual's effective date of coverage or after termination of coverage. Personal comfort or convenience items such as television rental, barber services, special or guest meals, telephone calls, travel expenses, stair lifts, van lifts, or medical complications related to a non-covered service. Services or supplies not specifically listed as a benefit of the Plan. Expenses not related to the diagnosis or treatment of an illness or injury unless specifically included as a benefit. Genetic testing unless necessary to treat an illness.
4. Cosmetic surgery unless necessary to correct congenital deformity of a dependent child or repair traumatic injuries incurred while covered under the Plan. Expenses related to dependent daughter pregnancy, sex changes, penile implants, reverse sterilization, infertility, sexual dysfunction, radial keratotomy or a similar procedure, weight reduction, or exercise or fitness programs except for phase 1 or 2 cardiac rehabilitation following cardiac surgery or a heart attack. Mastectomy in the absence of a malignancy. Breast reduction or enlargement except for post mastectomy reconstruction of a covered mastectomy. Wigs and hair transplants. Growth hormones. Hospital or physician charges for non-surgical inpatient admissions for back pain. Steroid epidurals for back pain.
5. Rhinoplasty or any nose surgery except for tumors or cysts or to repair nasal injury incurred while covered under the Plan. Hospital charges for a vasectomy or other surgery that can be performed in a physician's office. Home uterine monitoring devices.
6. Services of a dentist except surgery to correct facial injuries incurred while covered under the Plan. Treatment for TMJ or to alter vertical dimension.
7. Injury or illness due to war or act of war or while serving on active military duty. Services not authorized by a physician as necessary treatment, or services (including organ transplants) which are considered experimental, investigational or not medically necessary by Medicare criteria. Expenses related to kidney dialysis beyond 150% of the Medicare National Fee of the Physician's Fee Reference.
8. Marriage counseling or sexual therapy. Services or supplies received when a person travels to another country primarily for the purpose of obtaining such services or supplies.
9. Expenses covered by or pending under auto, property and casualty, or liability insurance or for which another party is liable. Self-inflicted injury or illness.
10. Expenses related to a hospital admission, course of treatment, or chronic condition (a condition that has lasted or expected to last 3 or more months) beyond $35,000 provided that the Plan may elect to ignore this limit when there were no better financial options available. This limit does not apply to the ACP or MRP.

LEGISLATION AND OTHER PROVISIONS

If provisions of the Plan conflict with applicable State or Federal laws, present or future, such legislation shall prevail. You should rely upon this document to estimate or determine benefits available. Information you receive from any source will not be valid if it conflicts with the language of this Plan. If the Plan determines that provisions herein are incompatible with another health care plan, the Plan may take any action it deems appropriate to best serve the interest of the Plan and the individual Plan member. Any retroactive termination of coverage must be approved by the Plan. If claims on an individual are expected by the Plan to exceed $35,000 in a consecutive 12 month period, the Plan reserves the right to determine the health care provider. If a provider is not approved, benefits will be paid at zero. If necessary to avoid financial hardship to the employee, the Claim Administrator may elect to negotiate additional payments for kidney dialysis related expenses or a kidney transplant. Where it is to the financial benefit of the Plan and an individual, the Plan may assist an individual financially in retaining or obtaining alternate health plan coverage.

Cynthia Y. Paul
12/16/22

CLAIM PROCEDURES

ALWAYS PRESENT YOUR HEALTH PLAN ID CARD WHEN RECEIVING COVERED MEDICAL SERVICES because the card contains billing instructions for your hospital and doctor. Benefits may be paid directly to the provider of service, the Plan reserves the right and option of paying benefits directly to you, or in the event of your death to a relative determined by the claim administrator (does not apply to care received in Missouri). Claims must be filed within 180 days after the end of the calendar year in which the expense is incurred.

You may contact the Claim Administrator for additional clarification on how a claim was paid or denied. If you do not agree with the Claim Administrator's reason for denying a claim or issuing a rescission of coverage, you may file a written appeal to the Plan Administrator within 180 days after the claim is denied or rescission issued. The appeal should indicate: Employee Name and Social Security Number, Patient Name, name of Plan Sponsor, Claim Number of Denied Claim, Date(s) of Service, Provider(s) of Service, Specific reason(s) you feel the claim should be paid including reference to Plan provisions, Relevant documents or other information. When reviewing your appeal, the Plan Administrator will take into account all information you submit without regard to whether the information was considered when the claim was denied. If the denial was due to medical judgment, the Plan Administrator will consult with an appropriate medical professional who was not, directly or indirectly, involved with the claim denial. You may obtain information relevant to a denied claim, including the name of any medical expert who gave advice relative to the denial, free of charge. The Plan will provide you, free of charge, with any new or additional evidence considered or generated in connection with the claim or new or additional rationale, for the Plan's decision as soon as possible in advance of the appeal decision date for your response, prior to that date. A written response to the appeal will be made within 60 days after the Plan Administrator receives the above necessary information. The response will be sent to the employee's address currently on file, or to a different address at your request. Any claim denial or appeal denial will sufficiently identify the claim involved, the diagnosis code, the treatment code, the denial code, and their corresponding meanings; the Plan's applicable standards; and, if an appeal, a discussion of the Plan's decision.

If the appeal is denied because of medical necessity or because coverage was rescinded, you may file a request for an external appeal of the decision within 123 days of receipt of notice of the decision (or the first business day following that date if a weekend or legal holiday). Within 5 days of the receipt of this request the Plan will determine if you (1) were covered under the Plan at the relevant time, (2) met the requirements for eligibility under the Plan, (3) exhausted the Plan's internal appeal procedures, and (4) have provided the Plan all information and forms to process the external review. Within 1 day of determining the above, the Plan will notify you whether you are eligible for external review or the information needed to be eligible for external review and the reasons for the plan determination. If eligible, the Plan will randomly assign your appeal to an independent review organization (IRO) in accordance with the requirements of, and in compliance with, DOL Technical Release 2010-01. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. The IRO will timely notify you in writing of your eligibility and acceptance for external review. You may submit additional information to the IRO as allowed by the IRO in the notice. The Plan will provide the IRO all related documents within 5 days of assignment of the IRO. If the Plan fails to do so the IRO may terminate the external review and reverse the claim denial and notify you within one business day after making that decision. The IRO must provide the Plan with any information you submit within one business day. The external review may be terminated if the Plan reverses its denial based on this information. The Plan will notify you within one business day after reversing the denial upon reconsideration. The IRO will decide the external appeal after reviewing all information and will review the claim de novo and not bound by any decisions or conclusions reached during the Plan's internal claims and appeal processes. In addition, the IRO will consider, as appropriate: (1) your medical records, (2) the attending provider's recommendation, (3) reports by health care professionals and other documents submitted by you, the Plan, or your provider, (4) the terms of the Plan, (5) appropriate practice guidelines, (6) any applicable clinical review criteria developed and used by the Plan, and (7) the opinion of the IRO clinical reviewers, all in accordance with the requirements of DOL Technical Release 2010-01. The IRO will provide written notice of its decision within 45 days of its receipt of your appeal. The IRO's notice of decision will comply with the requirements of DOL Technical Release 2010-01 and will contain: (1) a general description of the reason for the request for external review, including information sufficient to identify the claim; (2) the date the IRO received the assignment to conduct the external review and the date of the IRO decision; (3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision; (4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; (5) 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 to you; (6) a statement that judicial review may be available to you; and (7) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by you, plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws. Upon receipt of a notice of a final external review decision reversing the denial, the Plan immediately must provide coverage or payment for the claim. If your external appeal is denied, you have a right to file a civil action under Section 502 of ERISA provided you file it within 90 days after the appeal is denied.

Cynthia Y. Paul
12/16/22

PRIVACY INFORMATION

The Claims Administrator may release to, or obtain from any party, without consent of or notice to any person, any information the Plan Administrator or Claims Administrator deems necessary to carry out the provisions of the Plan. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, et seq., or other applicable law, the Plan Administrator or Claims Administrator may only use or disclose such information when related to treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Claims Administrator such information as may be necessary to carry out this provision.

Only individuals, and their clerical support staff, who are involved with Plan administration, supervision or management, shall be given protected health information, and only to the extent necessary to perform duties assigned by the Plan Administrator. In addition, the Plan Sponsor hereby certifies and agrees that it will: (a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law; (b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan; (c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor; (e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) Make available protected health information in accordance with 45 C.F.R. 164.524; (g) Make available health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526; (h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528; (i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.; (j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

STATEMENT OF RIGHTS UNDER THE NEWBORN'S AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital lengths of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your plan administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a covered mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis, and;
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same exclusions, deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore the following deductibles and coinsurance apply: See pages 3 and 4 for your benefit package. If you would like more information on WHCRA benefits, call your plan administrator at 573-335-1867.

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12/16/22

NOTIFICATION OF COBRA RIGHTS AND REQUIREMENTS

Coverage may continue in certain instances where coverage under the Plan would normally end. The information below advises you of your rights and obligations under this continuation coverage, made possible under federal legislation commonly referred to as COBRA. A person who is eligible for continuation is called a "qualified beneficiary." Each qualified beneficiary, or the parent or legal guardian of a minor qualified beneficiary, has a right to make a separate election for a qualified beneficiary or for such minor. The events making a person eligible are called "qualifying events." Questions may be directed to the plan administrator. This notice describes your rights under this continuation coverage under the Plan and you may contact the Plan Administrator with questions or for more information.

Eligibility for Continuation The following qualifying events make a Plan participant eligible as a qualified beneficiary. If an employee's medical coverage terminates because of termination of employment (other than for gross misconduct) or reduction of hours, the employee is a qualified beneficiary and may elect to continue the medical coverage. If you are a spouse/dependent of an employee, and were covered under the Plan at the time of the qualifying event, or born of the employee or adopted by the employee during the period of COBRA continuation and qualify as a "dependent" under the Plan, you have the right to continuation coverage if medical coverage terminated for any of the following events: (1) Death of an employee (2) Termination of the employee's employment (other than for gross misconduct) or reduction in hours worked (3) Divorce or legal separation (4) Employee becomes covered under Medicare (5) Dependent child no longer meets the definition of an eligible dependent under the Plan (6) Substantial reduction in retiree coverage due to employer bankruptcy reorganization.

Notice of Qualifying Event/Election Period The Plan Sponsor will provide notice of the availability of continuation coverage when the following qualifying events occur: (1) Employee's death (2) Loss of coverage due to employee's termination of employment (other than for gross misconduct) or reduction of work hours (3) Loss of coverage due to Medicare entitlement (4) Substantial reduction in retiree coverage due to employer bankruptcy reorganization. Plan participants must notify the Plan Sponsor in writing within 60 days of a divorce, separation, child losing dependent status in order to arrange for continuation coverage. The Plan Administrator will then provide the plan participants an election notice. An election for continuation coverage must be made within the 60-day election period beginning on the later of the date the coverage would end because of one of the qualifying events described above or the date the participant(s) is sent COBRA notice. In order for the Plan Administrator to notify you of your COBRA rights, it is important for you to keep the Plan Administrator advised of your current address.

Period of Continuation will terminate on the earliest of the following dates: (1) The end of: (a) 18 months, in the case where the coverage ended because of termination of employment (other than for gross misconduct) or reduction of hours (b) 36 months total, for dependents of the plan participant who have other including second qualifying events (c) 29 months, for employees and dependents if either the employee or a qualified dependent beneficiary is classified as disabled under the terms Title II or XVI of the Social Security Act within 60 days of the time of termination of employment or reduction of hours provided you notify the Plan Sponsor in writing within 60 days after you receive notice of disability from the Social Security Administration, and providing that you provide such notice to the Plan Sponsor before the end of the initial 18 months of COBRA continuation (2) The date after the COBRA election on which the person first becomes: (a) covered under any other group health plan, as an employee or otherwise (NOTE: Qualified beneficiaries, i.e., employee, spouse and/or dependents, who become covered by another group insurance program, are allowed to continue COBRA coverage only if the other group insurance plan has a pre-existing condition limitation or exclusion clause that applies to that individual's coverage. COBRA coverage will continue only to the time period specified above, or if earlier, when the pre-existing conditions restriction no longer applies) (b) entitled to benefits under Medicare (3) The date the premium is not paid (4) The date the Plan Sponsor no longer provides group health coverage to any of its employees (5) In the case where continuation of coverage is extended to 29 months, this extended coverage will be terminated the first day of the month following 30 days after the final determination that the individual is no longer disabled. You are required to notify the Plan Sponsor within 30 days of any event described above which would cause COBRA coverage to end.

Election and Premium Payment If continuation coverage is chosen, this coverage will be identical to the coverage provided under the Plan prior to the qualifying event. Qualified beneficiaries choosing to continue coverage under COBRA must pay the entire premium amount (plus a 2% administration charge, or plus 50% during an 11 month disability extension) to the Plan Sponsor on a monthly basis. (Monthly premium rates are subject to change annually.) Payroll deduction is not available to COBRA participants. Checks should be made payable to the Plan Sponsor. The qualified beneficiary's first payment deadline is 45 days after the date of their continuation election. The subsequent payment due date is the first day of the month for which coverage is purchased with a deadline of 30 days after the due date. Failure to pay premiums by these deadlines will result in termination of coverage. Information on current premiums is available by contacting the Plan Sponsor. Failure to elect COBRA coverage may cause you to avoid having pre-existing conditions apply to you in other group plans if you have more than a 63-day gap in health coverage, and will cause you to lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition if you do not exhaust COBRA coverage. You have a right to request special enrollment under certain plans that you are eligible for if you (a) apply within 30 days of coverage termination related to the initial qualifying event or (b) apply within 30 days of exhaustion of COBRA continuation coverage, If you reject COBRA coverage before the deadline for election, you may still elect COBRA before the election deadline by completing a new election form and your coverage will be effective on the date the form is received by the Plan Administrator or its designee.

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12/16/22