Exhibit 2

Hardin District No. 2's Current

Medical Insurance Policies

AN EMPLOYEE-OWNED COMPANY

ADMINISTRATIVE SERVICES AGREEMENT

FOR

HARDIN COUNTY WATER DISTRICT #2

EMPLOYEE BENEFIT PLAN

ASPIRANT, Inc., An Employee-Owned Company
All Rights Reserved

ADMINISTRATIVE SERVICES AGREEMENT

THIS Administrative Services Agreement is made and entered into this 1st day of JANUARY 2022, by and between **HARDIN COUNTY WATER DISTRICT #2** (hereinafter referred to as the "PLAN SPONSOR") a government entity duly organized and existing under the laws of the state of Kentucky with its principal office at:

1951 WEST PARK ROAD
ELIZABETHTOWN, KENTUCKY 42701

And

ASPIRANT, INC (hereinafter referred to as "ASPIRANT") a corporation duly organized and existing under the laws of the state of Kentucky with its principal place of business at:

500 NORTH HURSTBOURNE PARKWAY, SUITE 100
LOUISVILLE, KENTUCKY 40222.

WHEREAS the PLAN SPONSOR is a government entity that sponsors a self-funded employee welfare benefit plan (the "Plan") within the meaning of a non-ERISA Government plan; and

WHEREAS the PLAN SPONSOR desires to make available a program of health care benefits under the Plan; and

WHEREAS the PLAN SPONSOR wishes to contract with an independent third party to perform certain services with respect to the Plan as enumerated below; and

WHEREAS ASPIRANT desires to administer certain elements of the PLAN SPONSOR'S Group Health Plan pursuant to the terms of this Agreement; and

THEREFORE, in consideration of the promises and mutual covenants contained herein, the PLAN SPONSOR and ASPIRANT enter into this Agreement for administrative services for the HARDIN COUNTY WATER DISTRICT #2 Employee Benefit Plan.

ARTICLE I. DEFINITIONS

For the purposes of this Agreement, the following words and phrases have the meanings set forth below, unless the context clearly indicates otherwise and wherever appropriate, the singular shall include the plural and the plural shall include the singular.

1.1 **Administrative Services Fee** means the amount payable to ASPIRANT in consideration of its administrative services and operating expenses as indicated in this Agreement.

1.2 **Affordable Care Act (ACA)** means the Patient Protection and Affordable Care Act of 2010, as amended.

1.3 **Agent of Record** means the person or entity named as the agent and producer for any insurance product, including reinsurance, who accepts responsibility for the insurance product.

1.4 **Agreement Period** means the effective dates as indicated in this Agreement.

1.5 **Anthem (ANTHEM)** means Anthem Blue Cross and Blue Shield of Kentucky, an independent licensee of the Blue Cross and Blue Shield Association.

1.6 **ASPIRANT Affiliate** means an entity controlling, under common control with or controlled by ASPIRANT.

1.7 **Beneficiary** means a person, including a legal entity, such as a trust, who is or may become entitled to receive all or some portion of a participant's plan benefit if that participant dies or another plan benefit upon other specified events.

1.8 **Benefit Plan Design (BPD)** means the document by which ASPIRANT and ANTHEM will interpret the application of plan benefits.

1.9 **Billed Charges** means the amount as the Provider's charge for the services rendered to a Plan Participant, without any adjustment or reduction and irrespective of any applicable reimbursement arrangement with the Provider.

1.10 **BlueCard Program** means the program whereby a Blue Cross Blue Shield Association can process certain Claims for Covered Services received by Plan Participants outside the geographical area served by the contracted Blue Cross Blue Shield association.

1.11 **Blue Cross Blue Shield Association (BCBSA)** means an association of independent Blue Cross and Blue Shield companies.

1.12 **Broker of Record** means the sole person or entity providing consulting services to the Employer and the Plan Sponsor.

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

1.14 **CARES Act** means the Coronavirus Aid, Relief and Economic Security Act of 2020, as amended.

1.15 **Claim** means a written or electronic notice in a format acceptable to the ASPIRANT of a request for payment or reimbursement for Covered Services from the Plan.

1.16 **Claimant** means any person or entity submitting expenses for payment or reimbursement from the Plan.

1.17 **Claims Payment Account** means an account established by and owned by the PLAN SPONSOR for payment or reimbursement for Covered Services, which Account shall be an asset of the PLAN SPONSOR and not the Plan.

1.18 **Claims Runout Services** means the adjudication of Claims that are incurred but unreported and/or unpaid as of the date this Agreement terminates.

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

1.20 **Contract Plan Administrator** means the entity responsible for the execution and management of contracts pertinent to the administration of the Plan including reinsurance contracts.

1.21 **Contract Term** means the effective dates as indicated in this Agreement.

1.22 **Contract Termination Period** means the period of twelve (12) months after the termination of this Agreement during which ASPIRANT shall provide certain services including processing incurred, but not reported or unpaid Claims and any previously processed Claims presented for adjustment.

1.23 **Covered Services** means the care, treatments, services, or supplies described in the Plan Document as eligible for payment or reimbursement from the Plan.

1.24 **Employee** means any individual employed by an employer.

1.25 **Employee Welfare Plan** means any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, pharmacy, or hospital care benefits.

1.26 **Employer** means HARDIN COUNTY WATER DISTRICT #2 and any successor organization or affiliate of such Employer which assumes the obligations of the Plan and this Agreement.

1.27 **Employer Affiliates** means companies affiliated with the Employer that are participating in the Plan and which, along with the Employer constitute a single "control group" as that term is used in the Internal Revenue Code.

1.28 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

1.29 **Fee Schedule & Financial Arrangement** means the listing of administrative services and other fees or charges for services provided under this Agreement. This Fee Schedule may be modified from time to time in writing by the mutual agreement of the parties. A schedule of the base administrative services fees is contained in and is a part of this Agreement. Other fees or charges are detailed elsewhere, as appropriate, in this Agreement.

Exhibit A: Fee Schedule & Financial Arrangement

1.30 **Government Plan** means an employee benefit plan that is established and maintained primarily for the benefit of employees of a government entity.

1.31 **Health Care Providers** means physicians, dentists, hospitals, or other medical practitioners or medical care facilities that are authorized to receive payment or reimbursement for Covered Services provided under the terms of the Plan.

1.32 **Jointly Administered Arrangement (JAA)** means the administrative and operational processes by which ASPIRANT and ANTHEM administer employee benefit plans.

1.33 **Minimum Funding Balance** means the minimum amount required to be maintained by the PLAN SPONSOR in accordance with the Fee Schedule in the Claims Payment Account at all times during the term of this Agreement and the Contract Termination Period.

Exhibit A: Fee Schedule & Financial Arrangement

1.34 **Paid Claim** means the amount charged to the Plan for Covered Services or other services provided during the term of this Agreement. Paid Claims may also include applicable interest and any surcharges assessed by a state or government agency. The original adjudication or process date where payment for Covered Services occurs is the paid date of the claim.

In addition, Paid Claims shall be determined as follows:

Hospital, Provider and Vendor Claims: Except as otherwise provided in this Agreement, Paid Claims shall mean the amount actually paid to the Provider or Vendor (without regard as to whether the provider network reimburses such Provider or Vendor on a percentage of claim basis, fixed payment basis, a global fee basis, single case rate or similar methodology) or whether such amount is more or less than the Provider's or Vendor's actual Billed Charges for a particular service or supply.

Providers or Vendors Reimbursed on a Capitated Basis: Paid Claims shall include the amount per Plan Participant per month the amount actually paid to the Provider or Vendor for Plan Participants who access Covered Services from capitated Providers and Vendors.

Prescription Drug Claims: Paid Claims dispensed by pharmacies shall mean the amount charged to the Plan based upon the rates negotiated with Participating Pharmacy Providers and the Pharmacy Benefit Manager (without regard to whether reimbursements to the participating pharmacy is based on AWP, MAC, dispensing fee or other pricing benchmark or whether such amount is greater or less than the rate actually paid to Participating Pharmacy Providers and the Pharmacy Benefit Manager for particular services, drugs or supplies). Pharmacy Benefit Managers and Contract PLAN ADMINISTRATORs negotiate contracts on their own behalf at various compensation terms and rates; and may retain the difference, if any, between the amounts charged to the Plan and the dispensing fee and/or the drug reimbursement rate actually paid to such Participating Pharmacy Providers which may be greater or less than the amount charged to the Plan.

Performance Payments: If a Provider or Vendor participates in any program in which performance incentives, rewards, or bonuses (Performance Payments) are paid based on the achievement of certain goals, outcomes, or performance standards then Paid Claims shall include the amount of such Performance Payments. Such Performance Payments may be charged to the Plan on a per Claim, lump sum, per Employee, per Plan Participant or a pro-rata apportionment basis. The amount charged to the Plan may be greater or less than the amount actually paid to any one Provider or Vendor pursuant to the terms of the underlying contract(s) with such Provider or Vendor.

Fees Paid to Manage Care: Paid Claim may also include fees paid to Providers or Vendors for managing the care of Plan Participants. In addition, Paid Claims may also include an administrative amount charged to oversee managed care programs.

Claim Payment Pursuant to Judgment, Settlement, Legal or Administrative Proceeding: Paid Claims shall include any Claim amount paid as the result of a judgment, settlement or legal, regulatory, or administrative proceeding brought against the Plan with respect to decisions regarding the coverage of or amounts paid for services under the terms of the Plan. Paid Claims also includes any amount paid as a result of billing dispute resolution procedures with a Provider or Vendor.

Claim Payment Pursuant to the BlueCard, other BCBSA Programs and Supplemental Pricing: Paid Claims shall include any amount paid for Covered Services incurred outside the geographical area served by the contracted Blue Cross Blue Shield association and that are processed through the BlueCard Program or for any amounts paid for Covered Services provided through another BCBSA program or for any Supplemental Pricing which may be required under the terms of the Joint Administration Arrangement.

1.35 **Participating Pharmacy Provider** means those pharmacists and pharmacies contracted and identified by the Pharmacy Benefit Management company as network participating pharmacists or pharmacies.

1.36 **Pharmacy Benefit Management** means the oversight and management of pharmacy benefits offered by the Plan including but not limited to formulary management, clinical management programs, pharmacy network contracting and terms.

Exhibit A: Fee Schedule & Financial Arrangement

1.37 **Pharmacy Rebate Payment Guarantee** means the dollar amount per prescription guaranteed returned to the Plan for rebates received during the term of this Agreement for certain prescriptions dispensed under the pharmacy benefit of the Plan.

Exhibit A: Fee Schedule & Financial Arrangement

1.38 **Plan** means the self-funded employee welfare benefit plan (as defined in Section 3(1) of ERISA if an ERISA plan), which is the subject of this Agreement and which the PLAN SPONSOR has established pursuant to the Plan Document.

1.39 **Plan Administrator** means the person or entity responsible for keeping an employee benefit plan in compliance and managing the plan for the exclusive benefit of Plan Participants and Beneficiaries and as identified in the Plan Document.

1.40 **Plan Document** means the instrument or instruments that set forth and govern the eligibility and benefit provisions of the Plan which provide for the payment or reimbursement of Covered Services.

1.41 **Plan Participant** is any person who is properly enrolled and entitled to benefits from the Plan.

1.42 **Plan Sponsor** means HARDIN COUNTY WATER DISTRICT #2 and any successor organization or affiliate of such Employer which assumes the obligations of the Plan and this Agreement.

1.43 **Plan Year** means the period specified as such in the Plan Document.

1.44 **Prescription Drug** means Insulin and those drugs and drug compounds that are included in the U.S. Pharmacopoeia and that are required to be dispensed pursuant to a prescription or that are otherwise included as Covered (certain over-the-counter drugs).

1.45 **Proprietary/Confidential Information** means systems, information, procedures, methodologies, and practices used by the parties to this Agreement.

PLAN SPONSOR Proprietary Information: The systems, procedures, methodologies, and practices used by the PLAN SPONSOR to run its day-to-day operations and the Plan and other non-public information about the PLAN SPONSOR.

ASPIRANT Proprietary Information: The systems, procedures, methodologies and practices used by ASPIRANT in relation and connection to its underwriting, Claims processing, Claims payment and plan management activities as well as run its day-to-day operations and other non-public information about ASPIRANT. ASPIRANT Proprietary Information shall also include negotiated fees, terms, contractual terms with its vendors of which the PLAN SPONSOR is aware to include, but not limited to, provider and pharmacy network agreements, fee schedules and discount and/or fee-for-service levels.

1.46 **Protected Health Information** (**PHI)** shall have the meaning given such term at 45 C.F.R. 160.103 but limited to that information created or received by ASPIRANT in its capacity as the third-party administrator as outlined in this Agreement on behalf of the Plan.

1.47 **Provider** means a duly licensed physician, health professional, hospital, pharmacy or other individual, organization and/or facility that provides health services, supplies or management within the scope of the applicable license and/or certification.

1.48 **Summary Plan Description** means the document required to be provided that describes the terms and conditions under which the Plan operates.

1.49 **Third-Party Administrator** means an entity duly licensed to perform certain administrative functions for an employee benefit plan.

1.50 **Variable Operating Document** means a separate document outlining certain administrative functions necessary for the performance of obligations outlined in this Agreement.

1.51 **VBAF** means a Value Based Administrative Fee. A Value Based Administrative Fee is a percentage of the Plan Paid Amount of medical Claims that is charged in addition to a Monthly Administrative Fee.

Exhibit A: Fee Schedule & Financial Arrangement

1.52 **Vendor** means a person or entity other than a Provider that provides services and/or supplies pursuant to this Agreement or the Plan Document.

ARTICLE II. RELATIONSHIP OF PARTIES

2.1 The PLAN SPONSOR delegates to ASPIRANT only those powers and responsibilities with respect to development, maintenance, and administration of the Plan which are specifically enumerated in this Agreement. Any function not specifically assigned or delegated to and assumed by ASPIRANT pursuant to this Agreement shall remain the sole responsibility of PLAN SPONSOR.

2.2 The parties enter into this Agreement as independent contractors; not as agents of each other and neither party shall have any authority to act in any way as the representative of the other, or to bind the other to any third party, except as specifically set forth herein. Nothing contained herein shall be deemed or construed by the parties hereto, or by any third party, as creating a relationship of employer and employee, principal and agent, or joint venture of the parties hereto; it being understood and agreed that no provision contained in this Agreement, nor any acts of the parties hereto shall be deemed to place ASPIRANT in any relationship with the PLAN SPONSOR other than as an independent contractor.

2.3 The parties acknowledge that:

- This is a contract for administrative services only as specifically set forth herein and replaces any prior contract for administrative services,

- The Jointly Administered Arrangement (JAA) is a limited-distribution product, and the agent-of-record or consultant-of-record designation is not transferrable without prior permission of ASPIRANT,

- There is an understanding by the PLAN SPONSOR of the administrative processes of the Jointly Administered Arrangement (JAA),

- ASPIRANT shall not be obligated to disburse more in payment for Claims or other obligations arising under the Plan than the PLAN SPONSOR shall have made available in the Claims Payment Account, and

- This Agreement shall not be deemed a contract of insurance under any laws or regulations and that ASPIRANT does not insure, guarantee, make payment for, or underwrite the liability of the PLAN SPONSOR under the Plan. The PLAN SPONSOR has total responsibility for payment of Claims under the Plan and all expenses incidental to the Plan.

2.4 Except as specifically set forth herein, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives and successors; provided, however, neither party may assign this Agreement or any or all its rights or obligations hereunder (except by operation of law) without the prior written consent of the other, which consent may not be unreasonably withheld.

2.5 In the case of disputes as to any issues that may arise in connection with the respective rights and obligations of the parties under this Agreement, mediation will be enjoined. Each party will notify the other, in writing, of the name of its representative(s) who will have primary responsibility for communications with the other party. Each party shall be responsible for their own attorney's fees resulting from the mediation and the parties agree to split the cost of the mediator and associated mediation fees. If through the process of mediation, the parties are unable to resolve the dispute, either party may demand, at their cost, submission of the dispute to arbitration before a single arbitrator in accordance with the rules of the American Arbitration Association with said arbitration to

occur at the principal business office of the arbitrator deemed acceptable by the parties or at another location mutually agreeable to the parties. The parties hereby expressly agree that all costs of the arbitration, including but not limited to the arbitrator's fee, court reporter fee's and both parties' attorney's fees shall be the responsibility of the party initiating the arbitration.

2.6 ASPIRANT will confer with the PLAN SPONSOR at least monthly by written, oral or other forms of communication and more often if circumstances dictate through the term of this Agreement and shall meet either in person or via electronic meeting format no less than quarterly throughout the duration of this Agreement.

2.7 The work to be performed by ASPIRANT under this Agreement will be performed directly by it or wholly or in part through a subsidiary or affiliate of ASPIRANT or under an agreement with a contracted vendor to provide certain services.

2.8 ASPIRANT agrees to be duly licensed as a third-party administrator to the extent required under applicable law and agrees to maintain such licensure throughout the term of this Agreement and will possess throughout the term of this Agreement, an in-force fidelity bond or other insurance as may be required by state and federal laws for the protection of its clients. Additionally, ASPIRANT agrees to comply with any state or federal statutes or regulations regarding its operations and to obtain any additional licenses or registrations which may apply in the future.

2.9 ASPIRANT will indemnify, defend, save, and hold the PLAN SPONSOR harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages, and expenses of any kind including, but not limited to, direct, indirect, consequential, or punitive expenses or fees, including court costs and attorney's fees, with respect to the Plan which directly result from or arise out of the dishonest, fraudulent, grossly negligent, or criminal acts of ASPIRANT and its successors and assigns, except for acts taken at the specific direction of the PLAN SPONSOR.

2.10 The parties acknowledge that certain terms and phrases defined by the Employee Retirement Income Security Act of 1974 (ERISA) are used in the administration of this Plan as a matter of convenience and do not constitute the Plan relinquishing its recognition as a Government plan.

2.11 ASPIRANT shall be entitled to reasonably rely, without investigation or inquiry, upon any written or oral communication of the PLAN SPONSOR or agents or other subcontractors of the PLAN SPONSOR. However, ASPIRANT will not comply with a written or oral communication that it knows is contrary to the rules, regulations, and statutory requirements under which the Plan is administered.

2.12 The PLAN SPONSOR will indemnify, defend, save, and hold ASPIRANT harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages, and expenses of any kind including, but not limited to, direct, expenses or fees, including court costs and attorney's fees, to the extent that such claims, losses, liabilities, damages, and expenses arise out of or are based upon the PLAN SPONSOR'S negligence in the performance of its duties under this Agreement, a release of Claims data by ASPIRANT to:

- The PLAN SPONSOR, or
- If such release is at the request of the PLAN SPONSOR, to any other entity or person, an interpretation of the Plan or this Agreement, or any other written or oral communication by the PLAN SPONSOR or any of its authorized representatives upon which ASPIRANT relies or any breach of this Agreement by the PLAN SPONSOR, including, but not limited to, failure to fund the Claims Payment Account.

Notwithstanding the foregoing, PLAN SPONSOR shall not be liable for any indirect, special, incidental, exemplary, or consequential damages, including but not limited to loss of revenue or anticipated profits, regardless of the form of action, whether in agreement, tort, or otherwise, even if PLAN SPONSOR has been advised of the possibility of the damages.

2.13 The Parties acknowledge that, from time to time, a Claims adjustment may be necessary because of coordination of benefits, subrogation, workers' compensation, other third-party recoveries, payment errors and the like, and that the adjustment will take the form of a debit or a credit. The Parties agree that such Claims adjustment shall be treated as an adjustment to the Claims payment made in the billing period in which the adjustment occurs, rather than as a retroactive adjustment to the Claim in the billing period in which it was initially reported as paid. Any Claims credit may be reduced by a fee charged for recovery or subrogation.

In addition, a credit shall not be provided to the PLAN SPONSOR for the proportionate share of a recovery related to a Claim that was covered under stop loss reinsurance coverage and said recovery shall be returned to the carrier.

2.14 The duties and responsibilities of ASPIRANT as it pertains to the Affordable Care Act (ACA) shall be limited to those required specifically by the legislation or as enumerated in this Agreement.

2.15 The duties and responsibilities of ASPIRANT as it pertains to the Coronavirus Aid, Relief and Economic Security Act (CARES Act) shall be limited to those required specifically by the legislation or as enumerated in this Agreement.

2.16 The duties and responsibilities of ASPIRANT in connection with the requirements imposed by the Health Insurance Portability and Accountability Act ("HIPAA") and the privacy and security regulations promulgated thereunder will be set forth in a separate business associate agreement between the Parties.

In the event the Plan submits Claims or eligibility inquiries, or any other HIPAA covered transaction as defined in 45 CFR Part 160 and 162 to ASPIRANT through electronic means, ASPIRANT and the Plan shall comply with all applicable requirements of HIPAA and ASPIRANT and the Plan shall require any of their respective agents or subcontractors to comply with all applicable requirements of HIPAA.

ARTICLE III. ASPIRANT RESPONSIBILITIES

ASPIRANT will provide the following Plan administrative services for the PLAN SPONSOR:

3.1 Maintain Plan records based on required eligibility information (name and mailing address, telephone number, Social Security number, date of birth, type of coverage, gender, relationship to primary covered member, changes in coverage, date coverage begins or ends, email address, other insurance coverage and any other information necessary to determine eligibility and coverage levels under the Plan) submitted by the PLAN SPONSOR as to the dates on which a Plan Participant's coverage commences and terminates.

3.2 Maintain Plan records of Plan coverage applicable to each Plan Participant based on information submitted by the PLAN SPONSOR.

3.3 Maintain Plan records regarding payments of Claims, denials of Claims, and Claims pended.

3.4 Prepare, post to the ASPIRANT online group portal and provide to the PLAN SPONSOR annual notices that the PLAN SPONSOR may duplicate for distribution to Plan Participants required pursuant to the Women's Health and Cancer Rights Act (WHCRA), Medicare Part D Creditable Coverage and the Children’s Health Insurance Program (CHIP).

Exhibit G: Model Women’s Health and Cancer Rights Act (WHCRA) Notification
Exhibit H: Model Medicare Part D Creditable Coverage Notification
Exhibit I: Model Children’s Health Insurance Program (CHIP) Notification

3.5 Prepare, post to the ASPIRANT online group portal and provide to the PLAN SPONSOR annual notices that the PLAN SPONSOR may duplicate for distribution to Plan Participants, provided benefit information necessary to prepare the same is provided by the PLAN SPONSOR no less than forty-five days prior to the required distribution date, for the Summary of Benefits and Coverage required pursuant to the Patient Protection and Affordable Care Act.

3.6 Prepare and provide enrollment information necessary for the PLAN SPONSOR to complete filings for Patient-Centered Outcomes Research Institute and Reinsurance Fees as required pursuant to the Patient Protection and Affordable Care Act.

3.7 Prepare, post to the group portal at aspirant.us and provide to the PLAN SPONSOR annual notices that the PLAN SPONSOR may duplicate for distribution to Plan Participants the Plan Document and Amendments, Summary Plan Description and Benefit Overview Descriptions.

3.8 Process the enrollment of eligible individuals and termination of Plan Participants as directed by the PLAN SPONSOR subject to the provisions of the Plan Document. Respond to inquiries, with assistance of the PLAN SPONSOR, made by Plan Participants and other persons regarding eligibility in the Plan.

ASPIRANT shall perform the following Claims administrative services:

3.9 Process Claims as outlined in the BPD and the Plan Document with a Claims Incurred Date as indicated in this Agreement and provide member service at a level consistent with industry standards, including investigating and reviewing such Claims to determine what amount, if any, is due and payable according to the terms of the Plan and shall conduct coordination of benefits with other payors, including Medicare.

In processing Claims, ASPIRANT shall utilize medical policies and medical policy exception processes, recognized definition of medical necessity and precertification or preauthorization policies and applicable Claim timely filing limits as established by the Plan and stated in the BPD and/or contracted provider network.

3.10 Facilitate the disbursement to the applicable individuals or entities (including Providers and Vendors) payments that it determines to be due according to the provisions of the Plan.

3.11 Provide an electronic notice when a Claim for benefits has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Plan and shall otherwise satisfy applicable regulatory requirements governing the notice of a denied Claim.

3.12 The PLAN SPONSOR delegates to ASPIRANT limited fiduciary authority to determine claims for benefits under the Plan as well as the authority to act as the appropriate authority to determine appeals of any adverse benefit determinations under the Plan.

3.13 Shall administer complaints and appeals according to the Plan Document and BPD and is delegated full discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan. At all times ASPIRANT shall be deemed to have properly exercised such authority unless a Plan Participant proves that ASPIRANT has abused discretion or that its decision is arbitrary and capricious. ASPIRANT is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement and only to the extent that its performance of such actions constitutes fiduciary action as described in the Plan Document.

Exhibit E: Appeals Process

3.14 Shall not act as the Plan Administrator (as defined by ERISA or the Plan Document) nor shall it have fiduciary responsibility in connection with any other element of the administration of the Plan.

3.15 Shall act as the Contract Plan Administrator and manage and execute agreements necessary for the administration of the Plan and reinsurance where it serves as the agent-of-record for said policy.

3.16 Shall, as clinically required or to meet reinsurance carrier requirements, institute utilization management, case management and chronic condition management services.

3.17 Shall provide subrogation and recovery services for the Plan and shall be entitled to a portion of the recovery not to exceed 20% of the recovered amount in addition to an initial charge of $250 per incident of initiated subrogation and recovery services.

If outside counsel is retained it shall be at the cost of the PLAN SPONSOR, and ASPIRANT shall be entitled to a portion of the recovery not less than 10% of the recovered amount. The PLAN SPONSOR and ASPIRANT shall confer prior to retaining outside counsel and will only be done with the express permission of the PLAN SPONSOR.

ASPIRANT shall apply discretion as to which recoveries to pursue, and in no event will ASPIRANT pursue a recovery if the cost of the collection is likely to exceed the recovery amount or the recovery is prohibited by law or other agreement.

If it is determined by ASPIRANT that there is a potential recovery opportunity, the PLAN SPONSOR grants full authority to ASPIRANT to do the following:

- Determine and take steps reasonably necessary and cost-effective to effect recovery,
- Select and retain outside counsel or other Vendors as appropriate,
- Reduce any recovery obtained on behalf of the Plan by its proportionate share of the outside counsel fees and costs incurred during litigation or settlement activities to obtain such recovery and
- Negotiate and effect any settlement of the PLAN SPONSOR'S and the Plan's rights by, among other things, executing a release waiving the PLAN SPONSOR'S and the Plan's right to take any action inconsistent with the settlement.

ASPIRANT will not be liable for any amount that it does not recover.

The parties acknowledge that a subrogation recovery is a lengthy process where a recovery may take an extended period to realize and which may be impacted by other parties, court orders and similar actions.

3.18 Shall issue one set of printed identification cards to Plan Participants, as applicable, and the content and design of the identification cards shall be in its sole discretion and must comply with contractual obligations.

An electronic version of the card shall also be produced at no additional charge.

Exhibit L: ID Card Template

Replacement of printed identification cards shall be available at an additional cost as outlined in the Fee Schedule & Financial Arrangement.

Exhibit A: Fee Schedule & Financial Arrangement

The contracted Blue Cross Blue Shield Association holds final authority regarding the format and other provisions of identification cards.

3.19 ASPIRANT shall provide a printed Monthly Statement of Utilization to all Plan Participants with an overview of medical and pharmacy utilization.

3.20 ASPIRANT shall provide internet-based services for the PLAN SPONSOR and Plan Participants necessary for the administration of the Plan.

Plan Sponsor Services: Eligibility/Enrollment Maintenance, Enrollment Portal, Electronic ID Card Request, Plan Specific Reports, Pertinent Plan Documents and Participating Provider/Pharmacy Directories.

Plan Participant Services: View Claim/Benefit Information, View Enrollment Information, Electronic ID Card, Electronic Explanation of Benefits, Pertinent Plan Documents and Participating Provider/Pharmacy Directories.

3.21 ASPIRANT reserves the right to make benefit payments to either Providers, Vendors or Plan Participants at its discretion in accordance with the BPD and Plan Document. PLAN SPONSOR agrees that the terms of the Plan will include provisions for supporting such discretion in determining the direction of payment including, but not limited to, a provision prohibiting Plan Participants from assigning their rights to receive benefit payments, unless otherwise prohibited by applicable federal or state law.

3.22 ASPIRANT shall, as clinically required or to meet reinsurance carrier requirements, provide or arrange for the provision of the following managed care services:

Conduct medical necessity review, utilization review and a referral process, which may include, but is not limited to:

- Preadmission Review to evaluate and determine medical necessity of an admission or procedure and the appropriate level of care, and for an inpatient admission, to authorize an initial length of stay,

- Concurrent Case Review throughout the course of the inpatient admission for authorization of additional days of care as warranted by the patient’s medical condition,

- Retrospective Review, and

- Authorizing a referral to a non-network Provider if Applicable. ASPIRANT shall have the authority to waive a requirement if, upon review, such exception is in the best interest of the Plan Participant or the Plan or is in the furtherance of the provision of cost-effective services under this Agreement.

Perform utilization, case, and chronic condition management to identify short-term and long-term treatment programs in cases of severe or chronic illness or injury and as required by the reinsurance carrier. Related professional services charges shall apply as a medical claim to the Plan the same as any other professional service charge.

ASPIRANT may, but is not required to, customize benefits in limited circumstances and seeking the approval of the PLAN SPONSOR for otherwise non-covered services if such exception is in the best interest of the Plan Participant or the Plan. Such requests for approval from the PLAN SPONSOR shall include clinical and other supporting documentation.

3.23 Respond to Claims in accordance with the Plan Claims procedures and applicable Claims regulations, subject to the following provisions:

ASPIRANT shall be responsible for the determination of Urgent Care Claims (as defined under the ERISA Claims regulations) only if the PLAN SPONSOR submits eligibility information as outlined in Section 4.1 and such information is provided one business day during normal hours of operation prior to the effective or termination date.

ASPIRANT shall not be responsible for determining Pre-Service Claims (as defined under the ERISA Claims regulations) if the initial decision on such Claim is decided by a third party other than ASPIRANT. If ASPIRANT is responsible for responding to such Pre-Service Claims, the person or entity who makes the initial decision must provide the necessary information, including any internal rules, guidelines, protocols or similar criteria, and/or any required explanation of the scientific or clinical judgment upon which a denial is based under a Plan exclusion or limitation for medical necessity or experimental treatments, within two business days after the decision is made and in any case not later than five business days before the notice of adverse determination must be provided to the claimant.

Unless Plan Claims procedures clearly provide to the contrary, a Claim will be denied if the claimant fails to respond within the applicable deadline to a request for additional information.

If a Claim cannot be determined by ASPIRANT without an interpretation of the Plan terms by the PLAN SPONSOR, such Claim shall be promptly referred to the PLAN SPONSOR. Upon receipt of the PLAN SPONSOR's response, ASPIRANT shall process payment of the Claim or prepare a notice of adverse determination, as applicable.

3.24 ASPIRANT shall procure and place reinsurance coverage on behalf of the Plan Sponsor and shall serve as the agent-of-record for said coverage and shall perform all the following services and functions:

- Collect and remit required premiums and enrollment reports,
- Provide required carrier reports,
- Execute necessary contracts to bind coverage, and
- Submit any claim that is required to be filed under said stop loss policy.

ASPIRANT shall have no obligation to prepare or file any claim for excess risk or stop loss coverage under a reinsurance policy issued where ASPIRANT does not serve as the agent-of-record unless otherwise agreed to in writing.

ASPIRANT, if it does not act as the agent-of-record for reinsurance coverage, requires a review of the policies, operations, guidelines, and other pertinent items of the reinsurance carrier for the PLAN to ensure that ASPIRANT agrees with those provisions before agreeing to perform any functions related to the servicing of the policy. The reinsurance carrier will be required to accept the payment and similar provisions of the JAA process, including the reimbursement method and definition of a Paid Claim.

ASPIRANT, after review, will determine which, if any, services outlined below it can provide in servicing the policy. An additional interface fee will apply and will be determined after review.

<u>Exhibit A: Fee Schedule & Financial Arrangement</u>

ASPIRANT, to assist the agent-of-record for reinsurance coverage on behalf of the PLAN SPONSOR and after review of the reinsurance carrier by ASPIRANT shall perform all the following services and functions:

- Collect and remit required premiums and enrollment reports (at PLAN SPONSOR discretion),
- Provide required carrier reports,
- Execute necessary contracts to bind coverage, and
- Submit any claim that is required to be filed under said stop loss policy.

ASPIRANT shall assume no responsibility or liability to the PLAN SPONSOR for inconsistencies between the determination of Covered Services under the Plan and the determination of coverage by a reinsurance carrier where the PLAN SPONSOR or agents or other subcontractors of the PLAN SPONSOR authorized an exception to the Plan's benefits.

3.25 ASPIRANT will provide pharmacy benefit management services during the term of this Agreement and as outlined in a separate Pharmacy Benefit Management Agreement between the parties.

If ASPIRANT is not contracted to provide pharmacy benefit management services it reserves the right to review the policies, operations, guidelines, and other pertinent items of the pharmacy benefit manager for the PLAN to ensure that ASPIRANT agrees with those provisions. The contracted pharmacy benefit manager must agree to certain file layout, processing, reporting, access to information, security measures, HIPAA compliance requirements, end user rules, and similar requirements of ASPIRANT. An additional interface fee will apply and will be determined after review.

<u>Exhibit A: Fee Schedule & Financial Arrangement</u>

3.26 Administer the enrollment of Plan Participants during the Open Enrollment period established by the PLAN SPONSOR in the Plan Document. Administration of the Open Enrollment period shall be conducted via the secure online enrollment portal hosted at the aspirant.us website or provided in an electronic format approved by ASPIRANT.

3.27 ASPIRANT will facilitate the processing, issuing, and distribution of Claims checks, or drafts as instructed by the PLAN SPONSOR to Plan Participants, Health Care Providers, or others as may be applicable.

Under the JAA process, the Plan shall reimburse ANTHEM Blue Cross & Blue Shield for payments made directly to Health Care Providers on behalf of the Plan.

3.28 Claims paid in good faith but in error by ASPIRANT shall be chargeable to the Claims Payment Account as any other Claim, but ASPIRANT shall make good faith attempts to recover any overpayments.

3.29 ASPIRANT will maintain information that identifies a Plan Participant in a confidential manner and with data encryption as applicable. ASPIRANT agrees to take all reasonable precautions to prevent disclosure or the use of Claims information for a purpose unrelated to the administration of the Plan.

ASPIRANT will only release this information for certificate of need reviews; for medical necessity determinations; to set uniform data standards; to update relative values scales; to use in Claims analysis; to further cost containment programs; to verify eligibility; to comply with federal, state, or local laws; for coordination of benefits; for subrogation; in response to a civil or criminal action upon issuance of a subpoena; or with the written consent of the Plan Participant or his or her legal representative.

3.30 ASPIRANT will prepare a draft Plan Document and Summary Plan Description for review and final approval by PLAN SPONSOR and the PLAN SPONSOR's legal counsel. ASPIRANT shall not perform any services contemplated in this Agreement until the Plan Document and Summary Plan Description have been approved, in writing, by the PLAN SPONSOR or through a Memorandum of Understanding which shall be valid for no more than forty-five (45) days from the beginning of the contract term.

<u>Exhibit A: Fee Schedule & Financial Arrangement</u>

3.31 ASPIRANT will prepare Plan Document amendments at no additional charge for non-complex amendments requiring no more than two hours of research and composition. Any portion of time exceeding two hours shall be billed at $125 per hour.

Prior to beginning any amendments, ASPIRANT will provide a good faith estimate for amendment preparation for approval by the PLAN SPONSOR.

3.32 ASPIRANT will prepare and maintain a Claim file on every Claim reported to it for the Plan Participants. Such files and all Plan-related information shall be made available to the PLAN SPONSOR for consultation, review, and audit upon reasonable notice and request, during the business day and at the office of ASPIRANT. Any such audit will be at the sole expense of the PLAN SPONSOR. ASPIRANT will charge a separate fee of not less than $250 per hour for its time spent in cooperation with such consultation, review, and audit.

This audit shall be conducted by an auditor mutually acceptable to the PLAN SPONSOR and ASPIRANT and will include, but not necessarily be limited to, a review of procedural controls, a review of system controls, a review of Plan provisions, a review of the sampled Claims, and comparison of results to performance standards and statistical models previously agreed to by the PLAN SPONSOR and ASPIRANT.

Exhibit C: Audit Procedures

3.33 ASPIRANT will capture data for IRS form 5500 filings for Plans it administers and provide that information to the PLAN SPONSOR. Preparation and filing of the IRS form 5500 is the responsibility of the PLAN SPONSOR.

3.34 ASPIRANT, if separately contracted to do so, will administer COBRA continuation coverage to qualified beneficiaries from eligibility information supplied by the PLAN SPONSOR and the parameters of this service are detailed in a separate COBRA Administration Services Agreement. This administration will consist of notification to eligible Employees and/or their Dependents following a qualifying event, billing, collection of money, forwarding of premiums to the PLAN SPONSOR, payment of Claims, ending coverage upon lack of timely payment, or at the end of the COBRA continuation period.

Exhibit A: Fee Schedule & Financial Arrangement

3.35 ASPIRANT will provide standard monthly reports at no additional charge as well as quarterly and annual reports. These reports may change from time-to-time but will always conform to industry standard reports accepted by reinsurance carriers. These reports will be made available at the aspirant.us site on a monthly, quarterly, or annual basis; whichever is applicable.

ASPIRANT will provide, prepared in the standard format used by ASPIRANT, a monthly data file at no additional cost to the PLAN SPONSOR or its designated agent for production of custom reporting. The safe conduct of shared data shall be the responsibility of the PLAN SPONSOR and its designated agent, and the PLAN SPONSOR shall indemnify ASPIRANT for any resulting data or similar breach.

3.36 ASPIRANT will not offer welfare plan consulting services or similar services as part of this Agreement unless specifically requested by the PLAN SPONSOR and upon payment of a separate fee. For the purposes of this Agreement these services shall include, but not be limited to, benefit analysis, development of strategic goals and the development of customized communication materials other than benefit overviews, benefit scenario, custom reporting, or similar analysis.

Exhibit A: Fee Schedule & Financial Arrangement

3.37 Generate a Monthly Invoice for services provided under this Agreement to include service fees and reinsurance premiums. The Monthly Invoice shall be reflective of the enrollment at the close of business on the 25th of the preceding month. Enrollment changes made after the 25th of the preceding month shall be reflected as retroactive changes on a subsequent invoice, but not later than sixty (60) days after the enrollment change.

3.38 ASPIRANT shall issue an annual renewal proposal to the PLAN SPONSOR detailing administrative and related fees no later than one-hundred-twenty (120) days prior to the end of the current Contract Period.

If ASPIRANT does not act as the agent-of-record for reinsurance coverage, the PLAN SPONSOR shall provide a copy of the renewal offer of the current reinsurance carrier and offers from other reinsurance carriers being considered to ASPIRANT no later than ninety (90) days prior to the renewal date.

3.39 ASPIRANT shall maintain or exceed industry standard financial and processing accuracy metrics throughout the contract period, provide Performance Guarantees and report annually metrics for its book of business.

Exhibit D: Performance Guarantees

3.40 ASPIRANT shall maintain a Type II SAS 70/SSAE 16 (SOC 2) certification and shall annually complete an audit of its processes and procedures by an independent auditor. ASPIRANT shall provide a statement of audit findings on an annual basis.

3.41 ASPIRANT will provide 1095 reporting and fulfillment services, if contracted to do so, and charge a separate fee. The intent to contract ASPIRANT for these services must occur no later than August 1st of each year for which the services are requested.

Exhibit A: Fee Schedule & Financial Arrangement

3.42 Upon termination of this Agreement the PLAN SPONSOR it may retain the services of ASPIRANT to maintain all Claim files, reports, filings with governmental entities and plan documentation will be maintained by ASPIRANT at its principal administrative office and/or secure storage facilities for at least seven (7) years following the termination of an Agreement period. The PLAN SPONSOR will pay a separate one-time fee of $2,500 for this storage.

At the end of the seven (7) year period or termination of this Agreement, if earlier, ASPIRANT shall notify the PLAN SPONSOR that these records will be destroyed unless the Employer requests, in writing, that all or some of the records be forwarded to the Employer.

If PLAN SPONSOR opts not to have ASPIRANT store these documents, then an electronic copy of all Claim files, reports, filings with government entities and plan documentation will be prepared in the standard format used by ASPIRANT and provided to the PLAN SPONSOR. The PLAN SPONSOR will pay a separate one-time fee of $4,500 for production and delivery of these electronic files. These files shall be provided forty-five (45) days after the end of the Contract Termination Period.

3.43 If a catastrophic event (whether weather-related, caused by natural disaster, pandemic or caused by war, workplace violence, terrorism or similar event) occurs that prevents or interferes with or interrupts the ability of ASPIRANT to conduct its normal business with respect to its obligations in this Agreement, ASPIRANT reserves the right, without first obtaining the permission of the PLAN SPONSOR, to take reasonable and necessary steps to process Claims and provide other services in a manner that may be inconsistent with the provisions of the Plan. As soon as practicable after a catastrophic event, ASPIRANT shall report its actions to the PLAN SPONSOR.

ARTICLE IV. THE PLAN SPONSOR'S RESPONSIBILITIES

The PLAN SPONSOR will:

4.1 Maintain current, thorough, and accurate Plan eligibility and coverage records, verify Plan Participant eligibility for coverage, verify Plan Participant coordination of benefit coverage and submit this information to ASPIRANT at a frequency that does not impede the administration of the Plan, but not less frequently than monthly.

This information shall be provided in a format acceptable to ASPIRANT and include the following for each Plan Participant: name and mailing address, telephone number, Social Security number, date of birth, type of coverage, gender, relationship to primary covered member, changes in coverage, date coverage begins or ends, email address, other insurance coverage and any other information necessary to determine eligibility and coverage levels under the Plan.

The PLAN SPONSOR assumes the responsibility for the erroneous disbursement or denial of benefits or similar errors by ASPIRANT in the event of error or neglect on the PLAN SPONSOR's part of providing eligibility and coverage information to ASPIRANT, including but not limited to, failure to give timely notification of ineligibility of a former Plan Participant.

4.2 The PLAN SPONSOR shall provide ASPIRANT the most recent Plan Document and Summary Plan Description no later than sixty (60) days prior to effective date of this Agreement. A sixty (60) day notice is required for subsequent plan design changes or modifications.

4.3 Resolve all Plan ambiguities and disputes relating to the Plan eligibility of a Plan Participant, Plan coverage, denial of Claims or decisions regarding appeal or denial of Claims, or any other Plan interpretation questions, within a reasonable time following the request of ASPIRANT. The determination of a reasonable time shall be decided on a case-by-case basis between the parties, with the understanding that ASPIRANT must receive a prompt response to provide a timely response under the Plan's Claims procedures.

ASPIRANT will administer and adjudicate Claims in accordance with Article III if the Plan Document and Summary Plan Description are clear and unambiguous as to the validity of the Claims and the Plan Participants' eligibility for coverage under the Plan but will have no discretionary authority to interpret the Plan or adjudicate Claims. If adjudication of a Claim requires interpretation of ambiguous Plan language, and the PLAN SPONSOR has not previously indicated to ASPIRANT the proper interpretation of the language, then the PLAN SPONSOR will be responsible for resolving the ambiguity or any other dispute.

In any event, the PLAN SPONSOR'S decision as to any Claim (regardless of if it involves a Plan ambiguity or other dispute) shall be final and binding.

If ASPIRANT has a responsibility to determine and respond to Pre-Service Claims decided by other parties, the PLAN SPONSOR will require pursuant to its contracts with such other parties that such other parties must:

- Decide Pre-Service Claims not later than five business days before the notice of adverse determination must be provided to the Claimant, and
- Cooperate with ASPIRANT by providing full and timely responses to any request for information reasonably necessary to permit ASPIRANT to respond to such Claims.

4.4 Conduct and control all enrollment meetings, maintenance of enrollment records, and distribution of enrollment materials. Pertinent enrollment information (name and mailing address, telephone number, Social Security number, date of birth, type of coverage, gender, relationship to primary covered member, changes in coverage, date coverage begins or ends, email address, other insurance coverage and any other information necessary to determine eligibility and coverage levels under the Plan) will be sent to ASPIRANT.

4.5 Provide required COBRA notice to Plan Participants upon initial eligibility to participate in the Plan, maintain COBRA eligibility records, submitting this information to ASPIRANT in a timely manner for administration of the COBRA continuation option. If the PLAN SPONSOR contracts with ASPIRANT to provide COBRA administrative services, the performance of these duties is addressed in the COBRA Administrative Services Agreement and the terms of that agreement shall supersede this section.

4.6 Prospectively fund the Claims Payment Account every week, maintain the Minimum Funding Balance and unless otherwise agreed grant ASPIRANT drafting authority. Failure to fund the Claims Payment Account may result in suspension of services, application of a service fee of $125 per day that the account is not funded as required and/or termination of this Agreement.

<u>Exhibit A: Fee Schedule & Financial Arrangement</u>

4.7 Not require ASPIRANT, under any circumstances, to issue payment(s) for Claims, reinsurance premiums or any other costs arising out of the subject matter of this Agreement, unless the PLAN SPONSOR has so authorized and has previously deposited sufficient funds to cover such payment(s).

4.8 Provide ASPIRANT with copies of all revisions or changes to the Plan within sixty (60) days or the statutory required notification period, whichever is greater, of the effective date of the changes.

4.9 If applicable, acknowledge compliance with the End User rules and security guidelines detailed in the ASPIRANT Type II SAS 70/SSAE 16 (SOC 2) operating standards and guidelines.

4.10 Provide and timely distribute all notices and information required to be given to Plan Participants, maintain and operate the Plan in accordance with applicable law, maintain all recordkeeping, and file all forms relative thereto pursuant to any federal, state, or local law, unless this Agreement specifically assigns such duties to ASPIRANT.

4.11 Acknowledge that it is the PLAN SPONSOR, PLAN ADMINISTRATOR, and NAMED FIDUCIARY, as these terms are defined by ERISA. As such, PLAN SPONSOR retains full discretionary control and authority and discretionary responsibility in the operation and administration of the Plan.

4.12 Pay all taxes, surcharges, licenses, and fees levied, if any, by any local, state, or federal authority in connection with the Plan.

4.13 Hold confidential information obtained that is proprietary to ASPIRANT including, but not limited to, the systems, procedures, methodologies, and practices used by ASPIRANT in relation and connection to its underwriting, Claims processing, Claims payment, plan management activities, its day-to-day operations, negotiated fees, terms, contractual terms with its vendors, provider and pharmacy network agreements, fee schedules and discount and/or fee-for-service levels and any other non-public information about ASPIRANT.

4.14 Provide information necessary to ASPIRANT for timely generation of Certificates of Creditable Coverage to Plan Participants and former Plan Participants.

4.15 Warrant and represent that the only entities that participate, or will participate, in the Plan are in the PLAN SPONSOR's "controlled group of corporations" as that term is used in ERISA.

4.16 Pay to ASPIRANT fees for services rendered under this Agreement. Unless otherwise agreed, ASPIRANT will withdraw from the PLAN SPONSOR's account any fees then due ASPIRANT.

Exhibit A: Fee Schedule & Financial Arrangement

Further, ASPIRANT may withdraw from the Claims Payment Account, prior to application of the funds in the Claims Payment Account to payment of Claims, for any other costs arising out of the Plan or the subject matter of this Agreement.

Late charges will be added for payments received more than five (5) days after the due date as a single charge of $100 and $15 per day for each day of delinquency.

4.17 If the PLAN SPONSOR maintains reinsurance that is not managed by ASPIRANT, the PLAN SPONSOR will promptly notify ASPIRANT of any termination, expiration, lapse, or modification of this coverage.

4.18 Maintain any fidelity bond or other insurance as may be required by state or federal law for the protection of the Plan and Plan Participants.

4.19 Acknowledges it is solely responsible for compliance with the Family and Medical Leave Act.

4.20 Shall give notice to ASPIRANT of the expected occurrence of any of the following events (including a description of the event), with such notice to be given at least sixty (60) days prior to the effective date of the event, unless such advance notice is prohibited by law or contract in which case, notice will be provided as soon as practicable:

- Change of the PLAN SPONSOR'S name,
- Any merger between or consolidation with another entity where, after such merger or consolidation, the PLAN SPONSOR is not the controlling entity,
- The sale or other transfer of all or substantially all the assets of either the PLAN SPONSOR or any of the PLAN SPONSOR'S Affiliates or the sale or other transfer of the equity of the PLAN SPONSOR or any of the PLAN SPONSOR'S Affiliates, or
- Any bankruptcy, receivership, insolvency, or inability of the PLAN SPONSOR to pay its debts as they become due.

ASPIRANT shall not be liable for any regulatory, legal, or other action, including invalidation of reinsurance coverage, for failure by the PLAN SPONSOR to provide the aforementioned information as outlined.

4.21 Shall have the sole responsibility, in accordance with state or federal law, to develop procedures for determining whether a medical child support order is a "qualified" medical child support order and whether a domestic relations order is a "qualified" domestic relations order.

The PLAN SPONSOR shall provide notice to ASPIRANT once it has made such determination.

4.22 May request that ASPIRANT process or pay a claim on an exception basis that was denied by ASPIRANT as not being eligible under the Plan's provisions or the terms of this Agreement. In such situations the PLAN SPONSOR shall provide said direction in writing with the statement that such payment is:

- An exception to the Plan's provisions and/or is not eligible under the terms of this Agreement,
- Understood as not covered by stop loss reinsurance coverage if ASPIRANT is the designated agent-of-record,
- Indemnifying ASPIRANT for any adverse or legal action arising from the exception,
- That a separate fee may be charged for the processing and payment of the claim on an exception basis, and
- Acknowledgement that the exception establishes a precedent, and that the exception is being made solely in the discretion of the PLAN SPONSOR.

4.23 Unless otherwise agreed to by the Parties in writing, the PLAN SPONSOR shall prepare and distribute Summary Plan Descriptions, Summary of Benefits and Coverage, summary annual reports, and all notices or summaries of changes or material modifications to the Plan. The PLAN SPONSOR shall ensure that when it or its designee prepares such documents that they will accurately reflect the terms of the Plan Document.

4.24 Acknowledges that if the services of an independent agent, broker or consultant are retained, that said agent, broker, or consultant:

- Is properly licensed and is in good standing with state and federal regulatory agencies,
- Is the sole provider of welfare benefit plan consulting services to the Plan and ASPIRANT can rely on this distinction to presume that said agent, broker or consultant is acting in this capacity on behalf of the PLAN SPONSOR,
- Has executed a Business Associate agreement with the PLAN SPONSOR, and
- Is solely responsible for the servicing of any product procured by said agent, broker, or consultant other than his or her involvement in assessment of the Plan for which this Agreement pertains.

ARTICLE V. DURATION OF AGREEMENT

5.1 This Agreement shall commence JANUARY 1, 2022, and end DECEMBER 31, 2022, which shall be known as the Contract Term. This Agreement shall automatically renew at the expiration of the initial contract term for another contract term unless a prior ninety (90) day notice is provided and may be modified or terminated as described below.

5.2 At any time during the term of this Agreement, either the PLAN SPONSOR or ASPIRANT may amend or change the provisions of this Agreement. These amendments or changes must be agreed upon in advance in writing by both the PLAN SPONSOR and ASPIRANT. If any such amendment increases the anticipated Claims experience under the Plan or ASPIRANT cost of administering the Plan, the PLAN SPONSOR agrees to pay any increase in Claims expenses, as well as increases in administrative fees or other costs which ASPIRANT reasonably expects to incur as a result of such modification.

5.3 This Agreement may be terminated by either the PLAN SPONSOR or ASPIRANT at any time, either upon giving ninety (90) days advance written notice to the other party or with no notice as outlined in Sections 5.4 and 5.5.

In the event of termination during the contract term that is initiated by the PLAN SPONSOR for any reason other than those outlined in Section 5.5 the PLAN SPONSOR shall be liable for all fees otherwise due to ASPIRANT under the terms of this Agreement through the termination date, in addition to the fees required as outlined in Section 5.6.

5.4 ASPIRANT may, at its option, terminate this Agreement effective immediately upon the occurrence of any one or more of the following events on written notice to the PLAN SPONSOR, and after a reasonable opportunity, not to exceed thirty (30) days, to cure:

- The PLAN SPONSOR fails to maintain the Minimum Funding Balance or to prospectively fund the Claims Payment Account,
- The PLAN SPONSOR is adjudicated as bankrupt, becomes insolvent, a temporary or permanent receiver is appointed by any court for all or substantially all the assets of the PLAN SPONSOR, the PLAN SPONSOR makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to the PLAN SPONSOR and it is not dismissed within forty-five days of such filing,
- The PLAN SPONSOR fails to pay administration fees or other fees for ASPIRANT services upon presentation for payment and in accordance with the Fee Schedule,
- The PLAN SPONSOR engages in any unethical business practice or conducts itself in a manner which in the reasonable judgment of ASPIRANT is in violation of any federal, state, or other government statute, rule, or regulation,
- The PLAN SPONSOR, through its acts, practices, conduct, financial standing, or operations regarding the Plan, exposes ASPIRANT to any existing or potential investigation or litigation, or
- The PLAN SPONSOR permits its stop loss reinsurance to lapse, whether by failure to pay premiums or otherwise.

5.5 The PLAN SPONSOR may, at its option, terminate this Agreement effective immediately upon the occurrence of any one or more of the following events on written notice to ASPIRANT:

- ASPIRANT is adjudicated as bankrupt, becomes insolvent, a temporary or permanent receiver is appointed by any court for all or substantially all of the ASPIRANT assets, ASPIRANT makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to ASPIRANT and it is not dismissed within forty-five days of such filing, or

- ASPIRANT engages in any unethical business practice or conducts itself in a manner which in the reasonable judgment of the PLAN SPONSOR is in violation of any federal, state, or other government statute, rule, or regulation.

5.6 For a period of twelve (12) months after termination of this Agreement, ASPIRANT will process incurred, but not reported or unpaid Claims and any previously processed Claims presented for adjustment. This shall be known as the Contract Termination Period and is subject to the PLAN SPONSOR'S continuing obligation to maintain the Minimum Funding Balance and to prospectively fund the Claims Payment Account.

ASPIRANT shall be due a fee at termination for the processing of these Claims of $200 per enrolled employee/retiree/COBRA continuant based on the average enrollment of the Plan for the most recent six (6) months of the contract term OR the initial enrollment of the contract term; whichever is greater. This fee shall apply strictly to the services provided by ASPIRANT during the Contract Termination Period.

5.7 During the Contract Termination Period ASPIRANT shall provide the following services:

- Processing of all Incurred but not Received (IBNR) Claims during the term of the Agreement,

- Processing of all Adjustment Claims for previously processed Claims during the term of the Agreement,

- Processing of all Incurred but not Received (IBNR) Pharmacy Claims, and

- Processing of all Adjustment Pharmacy Claims for previously processed Pharmacy Claims during the term of the Agreement.

ASPIRANT will produce a Contract Termination Report package consisting of:

- Eligibility Census,

- Claim Detail Report,

- Accumulator Report,

- Precertification and Case Management Report, and

- Reinsurance Detail Report.

The cost of the Contract Termination Report package is $7,500. A Monthly Reinsurance Detail Report package will be produced each month for a period of twelve (12) months post termination at a cost of $1,500 each month.

ARTICLE VI. MISCELLANEOUS

6.1 This Agreement, together with all addenda, exhibits, and appendices supersedes any and all prior representations, conditions, warranties, understandings, proposals, or other agreements between the PLAN SPONSOR and ASPIRANT hereto, oral or written, in relation to the services and systems of ASPIRANT, which are rendered or are to be rendered in connection with its assistance to the PLAN SPONSOR in the administration of the Plan.

6.2 This Agreement, together with the aforesaid addenda, exhibits, and appendices constitutes the entire Administrative Services Agreement of whatsoever kind or nature existing between or among the parties.

6.3 The parties hereto, having read and understood this entire Agreement, acknowledge, and agree that there are no other representations, conditions, promises, agreements, understandings, or warranties that exist outside this Agreement which have been made by either of the parties hereto, which have induced either party or has led to the execution of this Agreement by either party. Any statements, proposals, representations, conditions, warranties, understandings, or agreements which may have been heretofore made by either of the parties hereto, and which are not expressly contained or incorporated by reference herein, are void and of no effect.

6.4 This Agreement may be executed in two or more counterparts, each, and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument.

6.5 Except as provided in Article V, (regarding termination without advance notice), no changes in or additions to this Agreement shall be recognized unless and until made in writing and signed by all parties hereto.

6.6 In the event any provision of this Agreement is held to be invalid, illegal, or unenforceable for any reason and in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice, or disturb the validity of the remainder of this Agreement, which shall be in full force and effect, enforceable in accordance with its terms.

6.7 If either party is unable to perform any of its obligations under this Agreement because of natural disaster, labor unrest, civil disobedience, acts of war (declared or undeclared), or actions or decrees of governmental bodies (any one of these events which is referred to as a "Force Majeure Event"), the party who has been so affected shall immediately notify the other party and shall do everything possible to resume performance.

Upon receipt of such notice, all obligations under this Agreement shall be immediately suspended. If the period of non-performance exceeds ten working days from the receipt of notice of the Force Majeure Event, the party whose ability to perform has not been so affected may, by giving written notice, terminate this Agreement.

6.8 All notices required to be given to either party by this Agreement shall, unless otherwise specified in writing, be deemed to have been given three days after deposit in the U.S. Mail, first class postage prepaid, certified mail, return receipt requested.

6.9 This Agreement shall be interpreted and construed in accordance with the laws of the state of Kentucky except to the extent superseded by federal law.

6.10 No forbearance or neglect on the part of either party to enforce or insist upon any of the provisions of this Agreement shall be construed as a waiver, alteration, or modification of the Agreement.

6.11 No party may assign this Agreement without the prior written consent of the other party, provided such consent will not be unreasonably withheld. However, ASPIRANT may assign this Agreement or delegate the duties to be performed under this Agreement without the consent of the PLAN SPONSOR to any of its subsidiaries, affiliates, or contracted vendor, or as part of a sale of all, or substantially all, of the assets to which this Agreement pertains.

Further, PLAN SPONSOR may assign this Agreement without the consent of ASPIRANT to any of its subsidiaries, affiliates, or as part of a sale of all, or substantially all, of the assets to which this Agreement pertains.

6.12 ASPIRANT is providing administrative services only with respect to the portion of the Plan described in the Plan Document and has only the authority granted it pursuant to this Agreement.

ASPIRANT is not the insurer or underwriter of any portion of the Plan.

ASPIRANT has no responsibility or liability for the funding benefits of the Plan and the PLAN SPONSOR retains the ultimate responsibility and liability for all benefits and expenses incident to the Plan, including but not limited to, any state or local taxes that might be imposed relating to the Plan.

ARTICLE VII. EXHIBITS

7.1 The following Exhibits are hereby incorporated into and made a part of this Agreement:

Exhibit A:	Fee Schedule & Financial Arrangement
Exhibit B:	Business Associate Agreement
Exhibit C:	Audit Procedures
Exhibit D:	Performance Guarantees
Exhibit E:	Appeals Process
Exhibit F:	ERISA Statement [REMOVED NOT APPLICABLE]
Exhibit G:	Model Women's Health and Cancer Rights Act (WHCRA) Notification
Exhibit H:	Model Medicare Part D Creditable Coverage Notification
Exhibit I:	Model Children's Health Insurance Program (CHIP) Notification
Exhibit J:	COBRA Administration Agreement [REMOVED NOT APPLICABLE]
Exhibit K:	Pharmacy Benefit Management Agreement [REMOVED NOT APPLICABLE]
Exhibit L:	ID Card Template

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective this 1st day of JANUARY 2022.

HARDIN COUNTY WATER DISTRICT #2

DocuSigned by:
Shaun Youravich
7ACA5FBA45E34D3...
SIGNATURE

SHAUN YOURAVICH
PRINTED NAME

GENERAL MANAGER
TITLE

ASPIRANT, INC

DocuSigned by:
William O Holton
AE06188B9067454...
SIGNATURE

WILLIAM O HOLTON
PRINTED NAME

PRESIDENT, CHIEF EXECUTIVE OFFICER
TITLE

FULL LEGAL NAME OF EMPLOYER:

HARDIN COUNTY WATER DISTRICT #2

AFFILIATES AND/OR SUBSIDIARIES OF EMPLOYER SUBJECT TO THIS AGREEMENT:

ACKNOWLEDGEMENT OF RECEIPT

DocuSigned by:
7ED5BF71BB8F48D...
SIGNATURE

KATHERINE E NAPIER
PRINTED NAME

EXECUTIVE VICE PRESIDENT, CHIEF FINANCIAL OFFICER
TITLE

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EXHIBIT A

FEE SCHEDULE AND FINANCIAL ARRANGEMENT

All fees, unless otherwise noted, are represented on a Per Covered Employee Per Month (PEPM) basis and are invoiced monthly.

MONTHLY ADMINISTRATIVE FEES		
FEE TYPE	**AMOUNT**	**YES/NO CONTRACTED**
Medical Plan Administration	$26.50	YES
Dental Plan Administration	$1.24	YES
FSA Plan Administration	$6.50	YES
COBRA Administration*		YES
HSA Plan Administration		
HRA Plan Administration		
Vision Plan Administration		
Short Term Disability Plan Administration		
Reinsurance Interface Fee**	$5.00	EFFECTIVE 1/1/2023
Pharmacy Benefit Vendor Interface Fee***	$5.00	YES
Welfare Benefit Plan Consulting****		

* Section 3.34
** Section 3.24
*** Section 3.25
**** Section 3.36

MONTHLY SERVICE FEES – OTHER VENDORS		
FEE TYPE	**AMOUNT**	**YES/NO CONTRACTED**
Joint Administration Fee – Provider Network	$30.38	
Broker Services	$16.00	
MCS Dental Network	$1.51	

Monthly Service Fees – Other Vendors are fees billed by ASPIRANT on behalf of these vendors providing services to the Plan.

OTHER VENDORS	
NAME	**SERVICE PROVIDED**
Anthem Blue Cross & Blue Shield	Joint Administration – Provider Network
Houchens Insurance Group	Broker Services
Anthem Blue Cross & Blue Shield	Dental Provider Network

SERVICE FEES	
SERVICE TYPE	**AMOUNT**
Printed/Mailed Duplicate Coordination of Benefits (COB) Letter Per COB Letter	$3.75
Printed/Mailed Explanation of Benefits (EOB) Per EOB	$1.25
Printed Duplicate Plan Identification Card (ID Card) Per ID Card Packet	$3.75
Value Based Administrative Fee Percentage	0.0%
ASPIRANT Retail Pharmacy Per Script Fee	$0.95
ASPIRANT Mail Order, Specialty Pharmacy Per Script Fee	$1.95
Carve-Out Retail Pharmacy Per Script Fee	$1.25
Carve-Out Mail Order, Specialty Pharmacy Per Script Fee	$2.50
Plan Document/Summary Plan Description^	$750
Medicare Part D Initial Notice Per Notice	$3.75
Medicare Part D Annual Notice Per Notice	$3.75
Medicare Part D New Enrollee Initial Notice Per Notice	$3.75

^ Section 3.30

The PLAN SPONSOR agrees to prospectively fund and maintain a Minimum Funding Balance in the Claims Payment Account of $75,000. ***The Minimum Funding Balance requirement is waived.***

IN WITNESS WHEREOF, the parties acknowledge this Fee Schedule & Financial Arrangement by their duly authorized representatives' signatures, effective this 1st day of JANUARY 2022.

HARDIN COUNTY WATER DISTRICT #2

DocuSigned by:
Shaun Youravich
7ACA5FBA45E34D3...
SIGNATURE

SHAUN YOURAVICH
PRINTED NAME

GENERAL MANAGER
TITLE

ASPIRANT, INC

DocuSigned by:
William O Holton
AE06188B9067454...
SIGNATURE

WILLIAM O HOLTON
PRINTED NAME

PRESIDENT, CHIEF EXECUTIVE OFFICER
TITLE

FULL LEGAL NAME OF EMPLOYER:

HARDIN COUNTY WATER DISTRICT #2

AFFILIATES AND/OR SUBSIDIARIES OF EMPLOYER SUBJECT TO THIS AGREEMENT:

ACKNOWLEDGEMENT OF RECEIPT

DocuSigned by:
7ED5BF71BB8F48D...
SIGNATURE

KATHERINE E NAPIER
PRINTED NAME

EXECUTIVE VICE PRESIDENT, CHIEF FINANCIAL OFFICER
TITLE

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE Agreement (“Agreement”) is made and entered into this 1st day of JANUARY 2022, by and between **HARDIN COUNTY WATER DISTRICT #2,** (hereinafter referred to as the “COVERED ENTITY “) a government entity duly organized and existing under the laws of the state of Kentucky with its principal office at:

1951 WEST PARK ROAD
ELIZABETHTOWN, KENTUCKY 42701

And

ASPIRANT, INC the BUSINESS ASSOCIATE (hereinafter referred to as “ASPIRANT”) a corporation duly organized and existing under the laws of the state of Kentucky with its principal place of business at:

500 NORTH HURSTBOURNE PARKWAY, SUITE 100
LOUISVILLE, KENTUCKY 40222.

WHEREAS the PLAN SPONSOR is a government entity that sponsors a self-funded employee welfare benefit plan (the "Plan") within the meaning of a non-ERISA Government plan; and

WHEREAS COVERED ENTITY has retained BUSINESS ASSOCIATE to provide certain claims administrative services with respect to the Plan which are described and set forth in a separate Administrative Services Agreement among those parties, as amended from time to time; and

WHEREAS COVERED ENTITY is authorized to enter into this agreement on behalf of Plan; and

WHEREAS the parties to this Agreement desire to establish the terms under which BUSINESS ASSOCIATE may use or disclose Protected Health Information (as defined herein) such that the Plan may comply with applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-164) (“HIPAA Privacy Regulation” and/or “HIPAA Security Regulation”) and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the “HITECH Act”), that are applicable to Business Associates, along with any guidance and/or regulations issued by the U.S. Department of Health and Human Services.

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the Plan, COVERED ENTITY and BUSINESS ASSOCIATE hereby agree as follows:

ARTICLE I. BUSINESS ASSOCIATE RESPONSIBILITIES

B1.1 **Privacy of Protected Health Information:**

Confidentiality of Protected Health Information: Except as permitted or required by this Agreement, BUSINESS ASSOCIATE will not use or disclose Protected Health Information without the authorization of the Individual who is the subject of such information or as required by law.

Prohibition on Non-Permitted Use or Disclosure: BUSINESS ASSOCIATE will neither use nor disclose Individuals' Protected Health Information except (1) as permitted or required by this Agreement, or any other agreement between the parties, (2) as permitted in writing by the Plan or its Plan administrator, (3) as authorized by Individuals, or (4) as required by law.

B1.2 **Permitted Uses and Disclosures: BUSINESS ASSOCIATE is permitted to use or disclose Individuals' Protected Health Information as follows:**

Functions and Activities on Plan's Behalf: BUSINESS ASSOCIATE will be permitted to use and disclose Individuals' Protected Health Information:

- For the management, operation, and administration of the Plan,
- For the services set forth in the Administrative Services Agreement, which include (but are not limited to) Treatment, Payment activities, and/or Health Care Operations as these terms are defined in this Agreement and 45 Code of Federal Regulations § 164.501, and
- As otherwise required to perform its obligations under this Agreement and the Administrative Services Agreement, or any other agreement between the parties provided that such use or disclosure would not violate the HIPAA Privacy or Security Regulations if done by the Plan and the HITECH Act.

Business Associate's Own Management and Administration: BUSINESS ASSOCIATE may use Individuals' Protected Health Information as necessary for BUSINESS ASSOCIATE'S proper management and administration or to carry out BUSINESS ASSOCIATE'S legal responsibilities.

Protected Health Information Disclosure: BUSINESS ASSOCIATE may disclose Individuals' Protected Health Information as necessary for BUSINESS ASSOCIATE'S proper management and administration or to carry out BUSINESS ASSOCIATE'S legal responsibilities only:

- If the disclosure is required by law, or
- If before the disclosure, BUSINESS ASSOCIATE obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by written contract, that the entity will:
  - Hold Individuals' Protected Health Information in confidence,
  - Use or further disclose Individuals' Protected Health Information only for the purposes for which BUSINESS ASSOCIATE disclosed it to the entity or as required by law; and
  - Notify BUSINESS ASSOCIATE of any instance of which the entity becomes aware in which the confidentiality of any Individuals' Protected Health Information was breached.

B1.3 **Miscellaneous Functions and Activities: BUSINESS ASSOCIATE is permitted to use or disclose Individuals' Protected Health Information as follows:**

Protected Health Information Use: BUSINESS ASSOCIATE may use Individuals' Protected Health Information as necessary for BUSINESS ASSOCIATE to perform Data Aggregation services, and to create Identity-Removed Information, Summary Health Information and/or Limited Data Sets.

Protected Health Information Disclosure: BUSINESS ASSOCIATE may disclose, in conformance with the HIPAA Privacy Regulation, Individuals' Protected Health Information to make Incidental Disclosures and to make disclosures of Identity-Removed Information, Limited Data Set Information, and Summary Health Information.

Minimum Necessary and Limited Data Set: BUSINESS ASSOCIATE'S use, disclosure or request of Protected Health Information shall utilize a Limited Data Set if practicable. Otherwise, BUSINESS ASSOCIATE will make reasonable efforts to use, disclose, or request only the minimum necessary amount of Individuals' Protected Health Information to accomplish the intended purpose.

B1.4 **Disclosure to Plan and COVERED ENTITY (and their Subcontractors):** Other than disclosures permitted herein BUSINESS ASSOCIATE will not disclose Individuals' Protected Health Information to the Plan, its Plan administrator or COVERED ENTITY, or any BUSINESS ASSOCIATE or subcontractor of such parties except as set forth in this Agreement.

B1.5 **Disclosure to BUSINESS ASSOCIATE'S Subcontractors and Agents:** BUSINESS ASSOCIATE will require its subcontractors and agents to provide reasonable assurance, evidenced by written contract that such other entity will comply with the same privacy and security obligations with respect to Individuals' Protected Health Information as applies to BUSINESS ASSOCIATE.

B1.6 **Reporting Non-Permitted Use or Disclosure, Breaches and Security Incidents:**

Non-Permitted Use or Disclosure: BUSINESS ASSOCIATE will promptly report to the Plan any use or disclosure of Individuals' Protected Health Information not permitted by this Agreement or in writing by the Plan or its Plan administrator, of which BUSINESS ASSOCIATE becomes aware. Such report shall not include instances where BUSINESS ASSOCIATE inadvertently misroutes Protected Health Information to a provider.

Security Incidents: In addition to reporting to Plan any use or disclosure of Protected Health Information not permitted by the Agreement, BUSINESS ASSOCIATE will also report any Breach or security incidents of which BUSINESS ASSOCIATE becomes aware. A security incident is an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system and involves only electronic Protected Health Information that is created, received maintained or transmitted by or on behalf of BUSINESS ASSOCIATE, that is in electronic form. The parties acknowledge and agree that this section constitutes notice by BUSINESS ASSOCIATE to Company of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Company shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on BUSINESS ASSOCIATE'S firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI or NPFI.

Breach: BUSINESS ASSOCIATE will promptly report to Plan any Breach of Unsecured PHI. BUSINESS ASSOCIATE will cooperate with Plan in investigating the Breach and in meeting the Plan's obligations under the HITECH Act and other applicable Security Breach notification laws. In addition to providing notice to Plan of a Breach, BUSINESS ASSOCIATE will provide any required notice to individuals and applicable regulators on behalf of Plan, unless Plan is otherwise notified by BUSINESS ASSOCIATE.

B1.7 **Termination for Breach of Privacy Obligations:** Without limiting the rights of the parties set forth in the Administrative Services Agreement, each party will have the right to terminate this Agreement and the Administrative Services Agreement if the other has engaged in a pattern of activity or practice that constitutes a material breach or violation of their obligations regarding Protected Health Information under this Agreement.

Prior to terminating this Agreement as set forth above, the terminating party shall provide the other with an opportunity to cure the material breach. If these efforts to cure the material breach are unsuccessful, as determined by the terminating party in its reasonable discretion, parties shall terminate the Administrative Services Agreement and this Agreement, as soon as administratively feasible. If for any reason a party has determined the other has breached the terms of this Agreement and such breach has not been cured, but the non-breaching party determines that termination of the Agreement is not feasible, the party may report such breach to the U.S. Department of Health and Human Services.

B1.8 **Disposition of Protected Health Information:**

Destruction or Return Upon Termination of Administrative Services Agreement: The parties agree that upon cancellation, termination, expiration or other conclusion of the Administrative Services Agreement, destruction or return of all Protected Health Information, in whatever form or medium (including in any electronic medium under BUSINESS ASSOCIATE'S custody or control) is not feasible given the regulatory requirements to maintain and produce such information for extended periods of time after such termination. In addition, BUSINESS ASSOCIATE is required to maintain such records to support its contractual obligations with its vendors and network providers. BUSINESS ASSOCIATE shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those consistent with applicable law for so long as BUSINESS ASSOCIATE, or its subcontractors or agents, maintains such Protected Health Information. BUSINESS ASSOCIATE may destroy such records in accordance with applicable law and its record retention policy that it applies to similar records.

Survival: The terms of Section B1.8 shall survive the termination of this Agreement and the Administrative Services Agreement.

B1.9 **Access, Amendment and Disclosure Accounting:**

Access: BUSINESS ASSOCIATE will respond to an Individual's request for access to his or her Protected Health Information as part of BUSINESS ASSOCIATE'S normal customer service function if the request is communicated to BUSINESS ASSOCIATE directly by the Individual. Despite the fact that the request is not made to the Plan, BUSINESS ASSOCIATE will respond to the request with respect to the Protected Health Information BUSINESS ASSOCIATE and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

In addition, BUSINESS ASSOCIATE will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right of access under the HIPAA Privacy Regulation by performing the following functions:

Upon receipt of written notice (includes faxed and emailed notice) from the Plan, BUSINESS ASSOCIATE will make available for inspection and obtaining copies by the Plan, or at the Plan's direction by the Individual (or the Individual's personal representative), any Protected Health Information about the Individual created or received for or from the Plan in BUSINESS ASSOCIATE'S custody or control, so that the Plan may meet its access obligations under 45 Code of Federal Regulations § 164.524, and, where applicable, the HITECH Act. BUSINESS ASSOCIATE will make such information available in an electronic format where required by the HITECH Act.

Amendment: BUSINESS ASSOCIATE will respond to an Individual's request to amend his or her Protected Health Information as part of BUSINESS ASSOCIATE'S normal customer service functions, if the request is communicated to BUSINESS ASSOCIATE directly by the Individual. Despite the fact that the request is not made to the Plan, BUSINESS ASSOCIATE will respond to the request with respect to the Protected Health Information BUSINESS ASSOCIATE and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

In addition, BUSINESS ASSOCIATE will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right to amend under the HIPAA Privacy Regulation by performing the following functions:

Upon receipt of written notice (includes faxed and emailed notice) from the Plan, BUSINESS ASSOCIATE will amend any portion of the Protected Health Information created or received for or from the Plan in BUSINESS ASSOCIATE'S custody or control, so that the Plan may meet its amendment obligations under 45 Code of Federal Regulations §164.526.

Disclosure Accounting: BUSINESS ASSOCIATE will respond to an Individual's request for an accounting of disclosures of his or her Protected Health Information as part of BUSINESS ASSOCIATE'S normal customer service function if the request is communicated to the BUSINESS ASSOCIATE directly by the Individual. Despite the fact that the request is not made to the Plan, BUSINESS ASSOCIATE will respond to the request with respect to the Protected Health Information BUSINESS ASSOCIATE and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

In addition, BUSINESS ASSOCIATE will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right to an accounting of disclosures under the HIPAA Privacy Regulation by performing the following functions so that the Plan may meet its disclosure accounting obligation under 45 Code of Federal Regulations § 164.528:

Disclosure Tracking: BUSINESS ASSOCIATE will record each disclosure that BUSINESS ASSOCIATE makes of Individuals' Protected Health Information, which is not excepted from disclosure accounting under Section II.C.2.b.

The information about each disclosure that BUSINESS ASSOCIATE must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom BUSINESS ASSOCIATE made the disclosure, (c) a brief description of the Protected Health Information disclosed, and (d) a brief statement of the purpose of the disclosure or a copy of any written request for disclosure under 45 Code of Federal Regulations §164.502(a)(2)(ii) or §164.512. Disclosure Information also includes any information required to be provided by the HITECH Act.

For repetitive disclosures of Individuals' Protected Health Information that BUSINESS ASSOCIATE makes for a single purpose to the same person or entity (including to the Plan or COVERED ENTITY), BUSINESS ASSOCIATE may record (a) the Disclosure Information for the first of these repetitive disclosures, (b) the frequency, periodicity, or number of these repetitive disclosures, and (c) the date of

the last of these repetitive disclosures.

Exceptions from Disclosure Tracking: BUSINESS ASSOCIATE will not be required to record Disclosure Information or otherwise account for disclosures of Individuals' Protected Health Information (a) for Treatment, Payment or Health Care Operations, (except where required by the HITECH Act, as of the effective dates of such requirements) (b) to the Individual who is the subject of the Protected Health Information, to that Individual's personal representative, or to another person or entity authorized by the Individual (c) to persons involved in that Individual's health care or payment for health care as provided by 45 Code of Federal Regulations § 164.510, (d) for notification for disaster relief purposes as provided by 45 Code of Federal Regulations § 164.510, (e) for national security or intelligence purposes, (f) to law enforcement officials or correctional institutions regarding inmates, (g) that are incident to a use or disclosure that is permitted by this Agreement or the Administrative Services Agreement, (h) as part of a limited data set in accordance with 45 Code of Federal Regulations §164.514(e), or (i) that occurred prior to the Plan's compliance date.

Disclosure Tracking Time Periods: Unless otherwise provided by the HITECH Act and/or any accompanying regulations, BUSINESS ASSOCIATE will have available for the Plan the Disclosure Information required by Section II.C.2.a above for the six (6) years immediately preceding the date of the Plan's request for the Disclosure Information.

Provision of Disclosure Tracking: Upon receipt of written notice (includes faxed and emailed notice) from the Plan, BUSINESS ASSOCIATE will make available to the Plan, or at the Plan's direction to the Individual (or the Individual's personal representative), the Disclosure Information regarding the Individual, so the Plan may meet its disclosure accounting obligations under 45 Code of Federal Regulations § 164.528 and the HITECH Act.

B1.10 **Confidential Communications:** BUSINESS ASSOCIATE will respond to an Individual's request for a confidential communication as part of BUSINESS ASSOCIATE'S normal customer service function, if the request is communicated to BUSINESS ASSOCIATE directly by the Individual. Despite the fact that the request is not made to the Plan, BUSINESS ASSOCIATE will respond to the request with respect to the Protected Health Information BUSINESS ASSOCIATE and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation. If an Individual's request, made to BUSINESS ASSOCIATE, extends beyond information held by BUSINESS ASSOCIATE or BUSINESS ASSOCIATE'S subcontractors, BUSINESS ASSOCIATE will inform the Individual to direct the request to the Plan, so that Plan may coordinate the request. BUSINESS ASSOCIATE assumes no obligation to coordinate any request for a confidential communication of Protected Health Information maintained by other BUSINESS ASSOCIATEs of Plan.

In addition, BUSINESS ASSOCIATE will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right of confidential communication under the HIPAA Privacy Regulation by performing the following functions:

Upon receipt of written notice (includes faxed and emailed notice) from the Plan, BUSINESS ASSOCIATE will begin to send all communications of Protected Health Information directed to the Individual to the identified alternate address so that the Plan may meet its access obligations under 45 Code of Federal Regulations § 164.524.

B1.11 **Restrictions:** BUSINESS ASSOCIATE will respond to an Individual's request for a restriction as part of BUSINESS ASSOCIATE'S normal customer service function if the request is communicated to BUSINESS ASSOCIATE directly by the Individual. Despite the fact that the request is not made to the Plan, BUSINESS ASSOCIATE will respond to the request with respect to the Protected Health Information BUSINESS ASSOCIATE and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

In addition, BUSINESS ASSOCIATE will promptly, upon receipt of notice from Plan, restrict the use or disclosure of Individuals' Protected Health Information, provided the BUSINESS ASSOCIATE has agreed to such a restriction. Plan and COVERED ENTITY understand that BUSINESS ASSOCIATE administers a variety of different complex health benefit arrangements, both insured and self-insured, and that BUSINESS ASSOCIATE has limited capacity to agree to special privacy restrictions requested by Individuals. Accordingly, Plan and COVERED ENTITY agree that it will not commit BUSINESS ASSOCIATE to any restriction on the use or disclosure of Individuals' Protected Health Information for Treatment, Payment or Health Care Operations without BUSINESS ASSOCIATE'S prior written approval.

B1.12 **Safeguard of Protected Health Information:** BUSINESS ASSOCIATE will develop and maintain reasonable and appropriate administrative, technical and physical safeguards, as required by Social Security Act § 1173(d) and 45 Code of Federal Regulations §164.530(a) and (c) and as required by the HITECH Act, to ensure and to protect against reasonably anticipated threats or hazards to the security or integrity of health information, to protect against reasonably anticipated unauthorized use or disclosure of health information, and to reasonably safeguard Protected Health Information from any intentional or unintentional use or disclosure in violation of this Agreement.

BUSINESS ASSOCIATE will also develop and use appropriate administrative, physical, and technical safeguards to preserve the Availability of electronic Protected Health Information, in addition to preserving the integrity and confidentiality of such Protected Health Information. The "appropriate safeguards" BUSINESS ASSOCIATE uses in furtherance of 45 Code of Federal Regulations §164.530(c), will also meet the requirements contemplated by 45 Code of Federal Regulations Parts 160, 162 and 164, as amended from time to time.

B1.13 **Compliance with Standard Transactions:** BUSINESS ASSOCIATE will comply with each applicable requirement for Standard Transactions established in 45 Code of Federal Regulations Part 162 when conducting all or any part of a Standard Transaction electronically for, on behalf of, or with the Plan.

B1.14 **Inspection of Books and Records:** BUSINESS ASSOCIATE will make its internal practices, books, and records relating to its use and disclosure of Protected Health Information created or received for or from the Plan available to the U.S. Department of Health and Human Services to determine Plan's compliance with 45 Code of Federal Regulations Parts 160-64 or this Agreement.

B1.15 **Mitigation for Non-Permitted Use or Disclosure:** BUSINESS ASSOCIATE agrees to mitigate, to the extent practicable, any harmful effect that is known to BUSINESS ASSOCIATE of a use or disclosure of Protected Health Information by BUSINESS ASSOCIATE in violation of the requirements of this Agreement.

ARTICLE II. PLAN'S RESPONSIBILITIES

B2.1 **Plan's Privacy Notices:**

Preparation of Plan's Notice of Privacy Practice: Plan shall be responsible for the preparation of its Notice of Privacy Practices ("NPP"). To facilitate this preparation, upon Plan's or COVERED ENTITY'S request, BUSINESS ASSOCIATE will provide Plan with its NPP that Plan may use as the basis for its own NPP.

Plan will be solely responsible for the review and approval of the content of its NPP, including whether its content accurately reflects Plan's privacy policies and practices, as well as its compliance with the requirements of 45 C.F.R. § 164.520. Unless advance written approval is obtained from BUSINESS ASSOCIATE, the Plan shall not create any NPP that imposes obligations on BUSINESS ASSOCIATE that are in addition to or that are inconsistent with the NPP prepared by BUSINESS ASSOCIATE or with the obligations assumed by BUSINESS ASSOCIATE hereunder.

Distribution of Notice of Privacy Practice: Plan shall bear full responsibility for distributing its own NPP as required by the Privacy Regulation.

Changes to Protected Health Information: Plan shall notify BUSINESS ASSOCIATE of any change(s) in, or revocation of, permission by an Individual to Use or Disclose Protected Health Information, to the extent that such change(s) may affect BUSINESS ASSOCIATE'S Use or Disclosure of such Protected Health Information.

ARTICLE III. DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE PLAN, COVERED ENTITY AND OTHER BUSINESS ASSOCIATES

B3.1 **Disclosure of Protected Health Information:** The following provisions apply to disclosures of Protected Health Information to the Plan, COVERED ENTITY, and other Business Associates of the Plan.

Disclosure to Plan: Unless otherwise provided in this Agreement, all communications of Protected Health Information by BUSINESS ASSOCIATE shall be directed to the Plan.

Disclosure to COVERED ENTITY: BUSINESS ASSOCIATE may provide Summary Health Information regarding the Individuals in the Plan to COVERED ENTITY upon COVERED ENTITY'S written request for the purpose either:

- To obtain premium bids for providing health insurance coverage for the Plan, or
- To modify, amend or terminate the Plan.

BUSINESS ASSOCIATE may provide information to COVERED ENTITY on whether an individual is participating in the Plan or is enrolled in or has unenrolled from any insurance coverage offered by the Plan.

Disclosure to other Business Associates and Subcontractors: BUSINESS ASSOCIATE may disclose Individuals' Protected Health Information to other entities or Business Associates of the Plan if the Plan authorizes BUSINESS ASSOCIATE in writing to disclose Individuals' Protected Health Information to such entity or BUSINESS ASSOCIATE. The Plan shall be solely responsible for ensuring that any contractual relationships with these entities or Business Associates and subcontractors comply with the requirements of 45 Code of Federal Regulations § 164.504(e) and § 164.504(f).

ARTICLE IV. MISCELLANEOUS

B4.1 **Agreement Term:** This Agreement will continue in full force and effect for as long as the Administrative Services Agreement remains in full force and effect. This Agreement will terminate upon the cancellation, termination, expiration or other conclusion of the Administrative Services Agreement.

B4.2 **Automatic Amendment to Conform to Applicable Law:** Upon the effective date of any final regulation or amendment to final regulations with respect to Protected Health Information, Standard Transactions, the security of health information or other aspects of the Health Insurance Portability and Accountability Act of 1996 applicable to this Agreement or to the Administrative Services Agreement, this Agreement will automatically amend such that the obligations imposed on the Plan, COVERED ENTITY , and BUSINESS ASSOCIATE remain in compliance with such regulations, unless BUSINESS ASSOCIATE elects to terminate the Administrative Services Agreement by providing COVERED ENTITY notice of termination in accordance with the Administrative Services Agreement at least thirty (30) days before the effective date of such final regulation or amendment to final regulations.

B4.3 **Conflicts:** The provisions of this Agreement will override and control any conflicting provision of the Administrative Services Agreement. All other provisions of the Administrative Services Agreement remain unchanged by this Agreement and in full force and effect.

B4.4 **No Third-Party Beneficiaries:** The parties agree that there are no intended third-party beneficiaries under this Agreement. This provision shall survive cancellation, termination, expiration, or other conclusion of this Agreement and the Administrative Services Agreement.

B4.5 **Interpretation:** Any ambiguity in this Agreement or the Administrative Services Agreement or in operation of the Plan shall be resolved to maintain compliance with the Regulations enacted pursuant to HIPAA Administrative Simplification.

B4.6 **Definitions:** Unless otherwise defined in this Agreement, the capitalized terms set forth herein have the meanings ascribed to them under the HIPAA Privacy Regulation and/or HIPAA Security Regulation or the HITECH Act. A reference in this Agreement to the Privacy Regulation, Security Regulation or HIPAA shall mean the section as in effect or as amended.

B4.7 **References:** References herein to statutes and regulations shall be deemed to be references to those statutes and regulations as amended or recodified.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective this 1st day of JANUARY 2022.

HARDIN COUNTY WATER DISTRICT #2

DocuSigned by:
Shaun Youravich
7ACA5FBA45E34D3...
SIGNATURE

SHAUN YOURAVICH
PRINTED NAME

GENERAL MANAGER
TITLE

ASPIRANT, INC

DocuSigned by:
William O Holton
AE06188B9067454...
SIGNATURE

WILLIAM O HOLTON
PRINTED NAME

PRESIDENT, CHIEF EXECUTIVE OFFICER
TITLE

FULL LEGAL NAME OF EMPLOYER:

HARDIN COUNTY WATER DISTRICT #2

AFFILIATES AND/OR SUBSIDIARIES OF EMPLOYER SUBJECT TO THIS AGREEMENT:

ACKNOWLEDGEMENT OF RECEIPT

DocuSigned by:
7ED5BF71BB8F48D...
SIGNATURE

KATHERINE E NAPIER
PRINTED NAME

EXECUTIVE VICE PRESIDENT, CHIEF FINANCIAL OFFICER
TITLE

EXHIBIT C

AUDIT PROCEDURES

An audit of the Services is intended to enable the PLAN SPONSOR to confirm that ASPIRANT has complied with its obligations under the Agreement related to administration of the Plan. To accomplish the review in an efficient and timely manner, the following guidelines will apply to the audit process:

AUDIT NOTIFICATION LETTER

The PLAN SPONSOR's request for an audit of ASPIRANT may be either in writing on the letterhead of the PLAN SPONSOR or via email to the assigned Account Executive.

If by mail:

ASPIRANT, INC
500 N Hurstbourne Parkway, Suite 100
Louisville, Kentucky 40222
Attn: Executive Vice President, Chief Financial Officer

Audits require sixty (60) days prior written notice.

USE OF A THIRD-PARTY AUDITOR

In the event a third-party auditor is used, the auditor shall be a mutually acceptable independent third-party retained by the PLAN SPONSOR. The third-party auditor shall execute a confidentiality agreement with ASPIRANT in a form and substance reasonably acceptable to ASPIRANT prior to conducting an audit.

TELECONFERENCE

Upon receipt of a request of an audit, ASPIRANT will organize and conduct an initial teleconference with the PLAN SPONSOR. This teleconference will address the following:

- Individual audit participants,
- Requirement and purpose of an approved confidentiality agreement (for use with outside audit firms or other PLAN SPONSOR representatives, as applicable),
- Onsite requirements,
- Mutually established timelines,
- Claims tape needs and costs,
- Guidelines for acceptable verification of audit questions,
- ASPIRANT's right to respond within a reasonable time after questions arise and before audit results are disseminated by the auditor to the PLAN SPONSOR.
- Audit Process Confirmation Letter, and
- Other appropriate issues.

MUTUALLY AGREED TIMELINES

PLAN SPONSOR and ASPIRANT will mutually agree upon an audit timeline, taking into consideration individual circumstances and constraints. ~~As~~ An example of a standard timeline is as follows (from the time a signed Confidentiality Agreement is secured):

- Claim tape request – fourteen (14) business days,
- Standard screen prints – fourteen (14) business days, and
- Audit Report reply – thirty (30) business days.

RESPONSE TO SAMPLING QUESTIONS

The PLAN SPONSOR can submit to ASPIRANT questions related to provided claim samples. Answers to sampling questions are normally provided within fourteen (14) business days after the questions have been presented.

CLAIM TAPE REQUESTS

Claims tape specifications shall be clarified during the initial teleconference and processed in the order of receipt of a signed Confidentiality Agreement. Delivery to the specified party normally takes place within fourteen (14) business days.

AUDIT REPORT

In the event of an audit by a third-party, ASPIRANT and the PLAN SPONSOR will be a provided a copy of any proposed audit report and ASPIRANT will have a reasonable opportunity to comment on any such report before it is finalized.

CLOSE OF AUDIT

Upon finalization of audit results and agreement between the PLAN SPONSOR and ASPIRANT on any identified financial discrepancies, the period under review will be considered closed.

AUDIT COSTS

The PLAN SONSOR shall be responsible for all reasonable costs of the Claims audit. Reasonable costs can be expected to include fees due ASPIRANT for audit participation and an hourly fee of $250 for audit participation.

AUDIT PARTICIPATION DOCUMENTS

The PLAN SPONSOR acknowledges that it shall not be entitled to audit documents that either ANTHEM Blue Cross and Blue Shield or ASPIRANT is barred from disclosing by applicable law or pursuant to an obligation of confidentiality to a third party.

IN WITNESS WHEREOF, the parties acknowledge these Audit Procedures by their duly authorized representatives' signatures, effective this 1st day of JANUARY 2022.

HARDIN COUNTY WATER DISTRICT #2

DocuSigned by:
Shaun Youravich
7ACA5FBA45E34D3...
SIGNATURE

SHAUN YOURAVICH
PRINTED NAME

GENERAL MANAGER
TITLE

ASPIRANT, INC

DocuSigned by:
William O Holton
AE06188B9067454...
SIGNATURE

WILLIAM O HOLTON
PRINTED NAME

PRESIDENT, CHIEF EXECUTIVE OFFICER
TITLE

FULL LEGAL NAME OF EMPLOYER:

HARDIN COUNTY WATER DISTRICT #2

AFFILIATES AND/OR SUBSIDIARIES OF EMPLOYER SUBJECT TO THIS AGREEMENT:

ACKNOWLEDGEMENT OF RECEIPT

DocuSigned by:
7ED5BF71BB8F48D...
SIGNATURE

KATHERINE E NAPIER
PRINTED NAME

EXECUTIVE VICE PRESIDENT, CHIEF FINANCIAL OFFICER
TITLE

EXHIBIT D

PERFORMANCE GUARANTEES

Definitions and Limitations Applicable to the Performance Standards

The proposed performance standards are subject to the definitions and limitations set forth in the Definitions and Limitations descriptions below.

Definitions:

For purposes of the performance standards herein:

- Business Day will mean the Normal Business Hours of ASPIRANT on any day other than Saturday or Sunday or a day on which ASPIRANT is closed for general business purposes.

Limitations:

ASPIRANT will diligently attempt to maintain its performance at the levels represented herein, provided that failure to achieve or maintain those levels does not constitute a default for purposes of the termination provisions set forth in the Agreement. The proposed performance standards will be adjusted equitably by the parties to the extent that ASPIRANT has suffered a Force Majeure Event during the applicable measurement period.

ASPIRANT will not be liable to PLAN SPONSOR for any failure to satisfy a performance standard during any time that no agreement existed between PLAN SPONSOR and ASPIRANT as to the applicable Performance Guarantees, even if a subsequent written agreement between the parties provides that the effective date of the Agreement is prior to the time at which the written agreement actually was executed by the parties.

The maximum amount that ASPIRANT will have at risk for any Plan year will be as stated below for PLAN SPONSOR for that calendar year. The total amount at risk will be calculated and allocated as set forth below. Unless otherwise specified.

- Amount at Risk for Ongoing Guarantees: The total amount at risk for PLAN SPONSOR toward applicable performance guarantees will equal the number of Plan Participants within the PLAN SPONSOR multiplied by $5.00.

- Amount at Risk for Implementation Guarantees: The total amount at risk for PLAN SPONSOR toward applicable performance guarantees will equal the number of Plan Participants within the PLAN SPONSOR multiplied by $5.00.

- Determining Number of Plan Participants: For amount at risk calculation purposes, the number of covered lives will be based on the actual number of Plan Participants of the PLAN SPONSOR as of the effective date or the first day of the anniversary being measured (Example: for the period 1/1/2020 – 12/31/2020, total amount at risk available will be $5.00 multiplied by the actual number of covered lives on 1/1/2020).

- Effective Date: Performance guarantees will be based on a calendar year for PLAN SPONSORS with January 1 effective dates when ASPIRANT begins providing services under this Agreement. For those PLAN SPONSORS whose effective date is other than January 1 when ASPIRANT begins providing services

under this Agreement, Performance guarantees will be prorated for the first calendar year and based on a calendar year for any subsequent years.

The obligation of ASPIRANT to meet the performance standards described herein are subject to the terms and conditions set forth in the Agreement. In the event of any conflict between the terms herein and the terms of the Agreement, the terms of the Agreement will control and govern the obligations of the parties regarding such matters.

If ASPIRANT fails to meet the proposed standards, the penalties described herein will be the sole and exclusive remedy available to PLAN SPONSOR for such failure. To the extent permitted by law, any statutory remedies that are inconsistent with the provisions hereof are waived.

If any period covered by the Agreement is less than the period covered by the proposed performance standard, and ASPIRANT has not met such performance standard for such period, the payment associated with such failure will be prorated to reflect the actual period during which the Agreement was in effect.

Unless otherwise indicated with respect to a specific performance standard, ASPIRANT satisfaction of the proposed performance standards will be:

- Monitored internally by ASPIRANT on a quarterly basis for those PLAN SPONSORS who have 5,000 or more card holders and on an annual basis for the remaining PLAN SPONSORS.
- Measured by ASPIRANT on a calendar-year basis for all ASPIRANT customers utilizing the same process platform.

PERFORMANCE STANDARD	GUARANTEE	MEASUREMENT BASIS	MEASUREMENT	AMOUNT AT RISK
Percent of ongoing eligibility updates processed within two (2) business days of receipt of a clean and complete eligibility file in an agreed format.	99%	Measured a percentage of all eligibility and dependent data transmitted on a quarterly basis by the PLAN SPONSOR.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Average time in seconds that inbound calls to toll-free customer services lines shall be answered. Excludes calls routed an IVR.	30 Seconds	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	5% of the at-risk amount for the PLAN SPONSOR.
Minimum percentage of inbound calls to toll-free customer service lines that are abandoned. Excludes calls routed to an IVR and excludes calls abandoned by the participant within the first thirty (30) seconds.	<3%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.

PERFORMANCE STANDARD	GUARANTEE	MEASUREMENT BASIS	MEASUREMENT	AMOUNT AT RISK
Minimum percentage of inbound calls to toll-free customer service lines that will be blocked.	1%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Percent of written inquiries received by Member Services from all Plan Participants will be responded to within ten (10) business days on which such inquiry was received.	99%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Percent of issues that will be resolved at the first point of contact. First call resolution is the number of inquiries completely resolved at the time of the initial contact divided by total inquiries.	90%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Percent of issues that will be resolved within five (5) business days.	98%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Percent of calls returned by Member Service Representative within one (1) business day.	98%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Number of days for a response to a written inquiry.	Two (2) business days.	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Satisfaction Surveys are conducted for all Member Services interactions with Plan Participants. Surveys include a point system ranging from 1 to 10 with 10 indicated Highly Satisfied. Percent of surveys with a score of 6 or better.	90%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.

PERFORMANCE STANDARD	GUARANTEE	MEASUREMENT BASIS	MEASUREMENT	AMOUNT AT RISK
Percent of Claims that are processed accurately from a financial perspective*.	98%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Percent of Claims that are processed accurately from a processing perspective*.	98%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Percent of Claims that are processed within ten (10) business days from date of receipt*.	98%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
All monthly, quarterly, and annual reports will reflect accurate data based upon the information contained within our systems.	100%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
All monthly, quarterly, and annual reports will be issued within fifteen (15) business days from the close of the period.	100%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.
Satisfaction Surveys are conducted for Account Management services. Surveys include a point system ranging from 1 to 10 with 10 indicated Highly Satisfied. Percent of surveys with a score of 7 or better.	100%	Quarterly within sixty (60) days after the end of the quarter. This is measured over the entire book of business.	Quarterly	3% of the at-risk amount for the PLAN SPONSOR.

*Excludes claims received that contain filing or similar errors which originate with the filing provider or systems used by the filing provider. Excludes adjustment claims.

NEW GROUP IMPLEMENTATION PERFORMANCE STANDARDS

PERFORMANCE STANDARD	GUARANTEE	MEASUREMENT BASIS	MEASUREMENT	AMOUNT AT RISK
Group Structure and Benefit Plan Design (BPD)	100%	Within forty-five (45) business days after receipt of an approved BPD the plan and group structure will be built on the appropriate systems and tested for accuracy.	Within sixty (60) days after the effective date.	10% of the at-risk amount for the PLAN SPONSOR.
Eligibility Load	100%	Within fifteen (15) business days after an accurate and complete eligibility file, in an agreed format, is received from the PLAN SPONSOR.	Within sixty (60) days after the effective date.	10% of the at-risk amount for the PLAN SPONSOR.
Initial ID Cards Issued	100%	Within twenty (20) business days after an accurate and complete eligibility file, in an agreed format, is received from the PLAN SPONSOR.	Within sixty (60) days after the effective date.	10% of the at-risk amount for the PLAN SPONSOR.
Communication and Project Management	100%	The assigned Implementation Project Manager will provide weekly updates to the PLAN SPONSOR of the status of the implementation.	Within sixty (60) days after the effective date.	10% of the at-risk amount for the PLAN SPONSOR.
Post Implementation Review Meeting	100%	The assigned Implementation Project Manager will conduct a post implementation meeting with the PLAN SPONSOR within fifteen (15) business days of the effective date.	Within sixty (60) days after the effective date.	10% of the at-risk amount for the PLAN SPONSOR.

IN WITNESS WHEREOF, the parties acknowledge these Audit Procedures by their duly authorized representatives' signatures, effective this 1st day of JANUARY 2022.

HARDIN COUNTY WATER DISTRICT #2

DocuSigned by:
Shaun Youravich
7ACA5FBA45E34D3...
SIGNATURE

SHAUN YOURAVICH
PRINTED NAME

GENERAL MANAGER
TITLE

ASPIRANT, INC

DocuSigned by:
William O Holton
AE06188B9067454...
SIGNATURE

WILLIAM O HOLTON
PRINTED NAME

PRESIDENT, CHIEF EXECUTIVE OFFICER
TITLE

FULL LEGAL NAME OF EMPLOYER:

HARDIN COUNTY WATER DISTRICT #2

AFFILIATES AND/OR SUBSIDIARIES OF EMPLOYER SUBJECT TO THIS AGREEMENT:

ACKNOWLEDGEMENT OF RECEIPT

DocuSigned by:
7ED5BF71BB8F48D...
SIGNATURE

KATHERINE E NAPIER
PRINTED NAME

EXECUTIVE VICE PRESIDENT, CHIEF FINANCIAL OFFICER
TITLE

EXHIBIT E

APPEALS PROCESS

APPEALS FOR PLAN SPONSOR THAT IS GOVERNED BY ERISA

Now, therefore, PLAN SPONSOR and ASPIRANT agree as follows:

1. PLAN SPONSOR represents that its Plan is governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

2. PLAN SPONSOR represents that it will provide ASPIRANT with a current and accurate copy of the Plan Document. The "Plan Document" shall be the written document, as required by ERISA, which sets forth the Plan design and all other information concerning PLAN SPONSOR's prescription drug benefit plan including, but not limited to, eligibility for such benefits, the benefits to be provided, limitations on such benefits and the Plan's Claims and review procedures. Throughout the term of this Addendum, PLAN SPONSOR, at its expense, will provide ASPIRANT with sufficient advance notice of any proposed amendments to the Plan Document.

3. ASPIRANT will provide PLAN SPONSOR with the Appeals Process.

Review of Benefit Coverage. ASPIRANT shall conduct appeals relating to eligibility and coverage of benefit determinations. Such reviews will be based on the Plan Document provisions and criteria approved by the Plan, with respect to coverage of benefits only, and shall not include a review of medical necessity as may be defined under the terms of the Plan Document. With respect to such review of benefit coverage, ASPIRANT shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of ASPIRANT shall be final, subject to External Review under this Exhibit, if applicable to PLAN SPONSOR, or available judicial review. ASPIRANT may, in its sole discretion, consider the opinions of additional medical and/or legal experts with respect to interpretation of the Plan Document. Under the Appeals Program, ASPIRANT agrees to be a fiduciary solely for the purpose of adjudicating appeals relating to the coverage of benefits. ASPIRANT will review appeals in accordance with the rules and procedures established by ASPIRANT to govern appeals from the denials of claims, as may be amended from time to time.

Review of Medical Necessity. ASPIRANT has contracted with an independent vendor or vendors for the processing of appeals resulting from a denial of authorization of benefits where the Plan beneficiary is entitled to obtain a review of the denial by an independent physician specialist. ASPIRANT has entered or will enter into an agreement with the independent vendor(s), which provides for an appeal process consistent with the Appeals Program. With respect to such reviews, the independent vendor shall act as a fiduciary and shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of the independent vendor shall be final, subject to External Review under this Exhibit or available judicial review only for abuse of discretion.

External Review. This shall apply only if PLAN SPONSOR has elected to receive "Independent (External) Appeal Review" in the BPD or other mutually agreed form(s) of documentation. ASPIRANT has contracted with independent review organizations (IRO) to provide External Review of benefit determinations that are subject to external review under the ACA. The decision of the IRO shall be final and binding on the Plan and the Plan Participant, subject only to judicial review. Either party may terminate at any time the External Review services provided under this Exhibit by providing the other party prior written notice.

PLAN SPONSOR agrees to indemnify and hold harmless ASPIRANT for, from and against any and all costs, Losses or damages ASPIRANT may incur as a result of (i) PLAN SPONSOR's breach of this Exhibit, or (ii) any claim by Member as a result of ASPIRANT' denial of an appeal, provided that ASPIRANT followed the procedures set forth in this Exhibit.

APPEALS FOR PLAN SPONSOR THAT IS NOT GOVERNED BY ERISA

Now, therefore, PLAN SPONSOR and ASPIRANT agree as follows:

1. PLAN SPONSOR represents that its Plan is NOT governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). PLAN SPONSOR acknowledges that ASPIRANT will administer Appeals consistent with the requirements of ERISA.

2. PLAN SPONSOR represents and warrants to ASPIRANT that the Appeal process satisfies any and all laws appliable to the Plan with respect to appeals and denials of Claims for covered benefits. PLAN SPONSOR shall promptly notify ASPIRANT in writing in the evet a change in law causes the Appeal process to be in non-compliance with applicable laws. Upon such notice, ASPIRANT shall have the option of revising the Appeal process to be in compliance with such change in law or terminating the service for the PLAN SPONSOR.

ASPIRANT from time to time will modify the Appel process. In the event of any such modification the PLAN SPONSOR will be notified in writing of the modification at least thirty (30) days prior to its implementation. If PLAN SPONSOR determines any such modification would cause the Appeal process to be in non-compliance with applicable laws the PLAN SPONSOR shall notify ASPIRANT prior to the end of the thirty (30) day period. ASPIRANT shall then have the option of further modifying the Appeal process to be in compliance with applicable laws or terminating the modification and shall continue to rely on the representation and warranty set forth above.

PLAN SPONSOR represents that it will provide ASPIRANT with a current and accurate copy of the Plan Document. The Plan Document shall be the written document which sets forth the Plan Design and other information concerning covered benefits including, but not limited to, eligibility for such benefits, the benefits to be provided, limitations on such benefits and the Plan's Claims and review procedures. Throughout the term of this Agreement the PLAN SPONSOR, at its expense, will provide ASPIRANT with sufficient advance notice, not less than thirty (30) days, of any proposed amendments to the Plan Document.

3. ASPIRANT will provide PLAN SPONSOR with the Appeals Process.

Review of Benefit Coverage. ASPIRANT shall conduct appeals relating to eligibility and coverage of benefit determinations. Such reviews will be based on the Plan Document provisions and criteria approved by the Plan, with respect to coverage of benefits only, and shall not include a review of medical necessity as may be defined under the terms of the Plan Document. With respect to such review of benefit coverage, ASPIRANT shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of ASPIRANT shall be final, subject to External Review under this Exhibit, if applicable to PLAN SPONSOR, or available judicial review. ASPIRANT may, in its sole discretion, consider the opinions of additional medical and/or legal experts with respect to interpretation of the Plan Document. Under the Appeals Program, ASPIRANT agrees to be a fiduciary solely for the purpose of adjudicating appeals relating to the coverage of benefits. ASPIRANT will review appeals in accordance with the rules and procedures established by ASPIRANT to govern appeals from the denials of claims, as may be amended from time to time.

Review of Medical Necessity. ASPIRANT has contracted with an independent vendor or vendors for the processing of appeals resulting from a denial of authorization of benefits where the Plan beneficiary is entitled to obtain a review of the denial by an independent physician specialist. ASPIRANT has entered or will enter into an agreement with the independent vendor(s), which provides for an appeal process consistent with the Appeals Program. With respect to such reviews, the independent vendor shall act as a fiduciary and shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of the independent vendor shall be final, subject to External Review under this Exhibit or available judicial review only for abuse of discretion.

External Review. ASPIRANT has contracted with independent review organizations (IRO) to provide External Review of benefit determinations that are subject to external review under the ACA. The decision of the IRO shall be final and binding on the Plan and the Plan Participant, subject only to judicial review. Either party may terminate at any time the External Review services provided under this Exhibit by providing the other party prior written notice.

PLAN SPONSOR agrees to indemnify and hold harmless ASPIRANT for, from and against any and all costs, Losses or damages ASPIRANT may incur as a result of (i) PLAN SPONSOR's breach of this Exhibit, or (ii) any claim by Member as a result of ASPIRANT' denial of an appeal, provided that ASPIRANT followed the procedures set forth in this Exhibit.

IN WITNESS WHEREOF, the parties acknowledge the Appeals Process by their duly authorized representatives' signatures, effective this 1st day of JANUARY 2022.

HARDIN COUNTY WATER DISTRICT #2

DocuSigned by:
Shaun Youravich
7ACA5FBA45E34D3...
SIGNATURE

SHAUN YOURAVICH
PRINTED NAME

GENERAL MANAGER
TITLE

ASPIRANT, INC

DocuSigned by:
William O Holton
AE06188B9067454...
SIGNATURE

WILLIAM O HOLTON
PRINTED NAME

PRESIDENT, CHIEF EXECUTIVE OFFICER
TITLE

FULL LEGAL NAME OF EMPLOYER:

HARDIN COUNTY WATER DISTRICT #2

AFFILIATES AND/OR SUBSIDIARIES OF EMPLOYER SUBJECT TO THIS AGREEMENT:

ACKNOWLEDGEMENT OF RECEIPT

DocuSigned by:
7ED5BF71BB8F48D...
SIGNATURE

KATHERINE E NAPIER
PRINTED NAME

EXECUTIVE VICE PRESIDENT, CHIEF FINANCIAL OFFICER
TITLE

EXHIBIT G

MODEL WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTIFICATION

If you have had or are going to have a 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 consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Therefore, the following deductibles and coinsurance apply:

BENEFIT PLAN NAME		
DEDUCTIBLE	**COINSURANCE**	**COPAYMENT**
BENEFIT PLAN NAME		
DEDUCTIBLE	**COINSURANCE**	**COPAYMENT**
BENEFIT PLAN NAME		
DEDUCTIBLE	**COINSURANCE**	**COPAYMENT**

If you would like more information on WHCRA benefits, please contact us at (855) 981-2583.

EXHIBIT H

MODEL MEDICARE PART D CREDITABLE COVERAGE NOTIFICATION

Important Notice from HARDIN COUNTY WATER DISTRICT #2 About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with HARDIN COUNTY WATER DISTRICT #2 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **HARDIN COUNTY WATER DISTRICT #2 has determined that the prescription drug coverage offered by the HARDIN COUNTY WATER DISTRICT #2 EMPLOYEE BENEFIT PLAN is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current HARDIN COUNTY WATER DISTRICT #2 coverage will (or will not) be affected. (The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance: [available at (http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current HARDIN COUNTY WATER DISTRICT #2 coverage, be aware that you and your dependents will [*or will not*] (Medigap issuers must insert *"will not "*) be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or call [*Insert Alternate Contact*] at *(XXX) XXX-XXXX.*

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through HARDIN COUNTY WATER DISTRICT #2 changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: [MM/DD/YYYY]
Name of Entity/Sender: [Name of Company]
Contact--Position/Office: [Name/Position/Office]
Address: [Street Address, City, State & Zip Code of Entity]
Phone Number: [Entity Phone Number]

EXHIBIT I

MODEL CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTIFICATION

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility:

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

KENTUCKY – Medicaid	NEVADA - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid & CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid & CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OREGON – Medicaid	VERMONT - Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid & CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid & CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA – Medicaid	**WISCONSIN – Medicaid & CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

EXHIBIT J

COBRA ADMINISTRATION AGREEMENT

THIS COBRA ADMINISTRATION Agreement (“Agreement”) is made and entered into this 1st day of JANUARY 2022, by and between **HARDIN COUNTY WATER DISTRICT #2,** (hereinafter referred to as the “EMPLOYER “) a government entity duly organized and existing under the laws of the state of Kentucky with its principal office at:

1951 WEST PARK ROAD
ELIZABETHTOWN, KENTUCKY 42701

And

ASPIRANT, INC (hereinafter referred to as "ASPIRANT") a corporation duly organized and existing under the laws of the state of Kentucky with its principal place of business at:

500 NORTH HURSTBOURNE PARKWAY, SUITE 100
LOUISVILLE, KENTUCKY 40222.

WHEREAS the EMPLOYER is a corporation that sponsors various employee benefit plans for its employees and is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA); and

WHEREAS the EMPLOYER has contracted with ASPIRANT to provide administrative services to the EMPLOYER’S self-funded employee welfare benefit plan (the "Plan") within the meaning of a non-ERISA Government plan; and

WHEREAS the EMPLOYER has contracted with ASPIRANT to provide COBRA administration services to Qualified Beneficiaries of these plans; and

WHEREAS ASPIRANT desires to provide COBRA administration services to Qualified Beneficiaries of these plans; and

THEREFORE, in consideration of the promises and mutual covenants contained herein, the EMPLOYER and ASPIRANT enter into this Agreement for COBRA administrative services for the various plans offered to employees by HARDIN COUNTY WATER DISTRICT #2.

ARTICLE I. THE EMPLOYER'S RESPONSIBILITIES

The EMPLOYER acknowledges and agrees:

C1.1 It is responsible for all aspects of the administration of COBRA with respect to the Qualified Beneficiaries of the various benefit plans it sponsors except as otherwise provided in this Agreement.

C1.2 It is contracting ASPIRANT to perform COBRA administrative services as provided for in this Agreement.

C1.3 It retains responsibility for the following COBRA administration duties:

EMPLOYER shall complete in their entirety and submit to ASPIRANT the necessary forms for newly covered persons within thirty days of the start of coverage. EMPLOYER shall have the option of providing information via paper enrollment forms acceptable to ASPIRANT or through the website maintained by ASPIRANT or electronically in a format acceptable to ASPIRANT.

EMPLOYER shall complete in their entirety and submit to ASPIRANT Qualifying Event Notification Forms within five business days of the Qualifying Event. EMPLOYER shall have the option of providing information via paper enrollment forms acceptable to ASPIRANT or through the website maintained by ASPIRANT or electronically in a format acceptable to ASPIRANT.

EMPLOYER shall provide to ASPIRANT on forms acceptable to ASPIRANT the premium amounts by coverage tier, line of coverage and plan design for all plans no later than thirty business days prior to the date said rates become effective. If ASPIRANT is not notified of premium rates or other changes thirty business days prior to the date said rates become effective, ASPIRANT shall continue to apply the applicable rate from the preceding month in billing EMPLOYER's Qualified Beneficiary(ies) until new rates or other changes are received within the acceptable timeframe.

EMPLOYER shall be responsible for the termination of coverage for active employees and/or dependents at the time of a Qualifying Event.

EMPLOYER shall be responsible for authorizing ASPIRANT to add dependents to COBRA continuants' coverage based on the rules of COBRA and the plans administered by ASPIRANT.

EMPLOYER shall remit premium to the various carriers on behalf of Qualified Beneficiary until such time that EMPLOYER receives notification from ASPIRANT that such beneficiary is no longer entitled to COBRA coverage.

C1.4 It assumes responsibility for a COBRA violation resulting from the failure of EMPLOYER to perform its COBRA administration responsibilities not specifically delegated to ASPIRANT.

C1.5 It is responsible for providing ASPIRANT with all eligibility and premium information related to any additional and/or supplemental plans for which COBRA administrative services are provided by ASPIRANT.

C1.6 It is responsible for providing ASPIRANT all documents relating to eligibility and other rules for the plans for which COBRA administrative services are provided by ASPIRANT.

ARTICLE II. ASPIRANT RESPONSIBILITIES

ASPIRANT acknowledges and agrees:

C2.1 ASPIRANT shall determine application of federal COBRA law to EMPLOYER annually in the quarter prior to the term of this Agreement.

C2.2 To enter, verify and archive its copy of all notices and other information received from EMPLOYER.

C2.3 To receive and review COBRA election forms from beneficiaries for completeness and timeliness of elections and shall make reasonable efforts to correspond with or call EMPLOYER, or Qualified Beneficiary, as necessary for ASPIRANT to provide services. If a Qualified Beneficiary makes a complete and timely election and makes appropriate premium payments for said election, ASPIRANT shall notify EMPLOYER through monthly reporting process.

C2.4 To maintain records of COBRA continuation coverage premiums for all plans in accordance with the provisions of this Agreement.

C2.5 To bill in accordance with applicable rates furnished by EMPLOYER monthly and collect premiums from Qualified Beneficiary(ies) for the cost of COBRA continuation coverage provided to that/those Qualified Beneficiary(ies).

C2.6 To provide notification of nonpayment of COBRA continuation coverage premiums to EMPLOYER and Qualified Beneficiary(ies) within ten days following the end of the grace period for Qualified Beneficiary(ies) that have elected COBRA continuation coverage timely and paid the initial contribution timely within the applicable grace period. Timeliness shall be based upon the postmark or other similar means of determination. COBRA continuation coverage shall terminate at the end of the last coverage period for which payment was received.

C2.7 To forward the applicable premium received from Qualified Beneficiary(ies), less administration charges equal to 2% of COBRA premium to be retained by ASPIRANT, to the EMPLOYER monthly.

C2.8 To provide the EMPLOYER a Monthly Participant Status Report.

C2.9 To make every reasonable attempt to collect on checks with insufficient funds. If, after all reasonable avenues are exhausted, the COBRA continuant has not replaced the returned check. ASPIRANT shall charge EMPLOYER for the amounts previously returned to EMPLOYER.

C2.10 To establish and maintain a record of all Qualified Beneficiaries who elect COBRA continuation coverage and any dependents that are added to the Qualified Beneficiaries' COBRA continuation coverage for EMPLOYER.

C2.11 To provide all forms necessary to EMPLOYER for COBRA compliance to include: (1) New Hire Notification Forms, (2) COBRA Qualifying Event Notification Forms, (3) Premium Notification Forms, and (4) other forms and notices as may be necessary to comply with the provisions of this Agreement.

C2.12 To establish procedures to verify eligibility for COBRA coverage. To assist EMPLOYER in determining and verifying continued eligibility of each Qualified Beneficiary for COBRA continuation coverage, each Premium Remittance Form will contain a statement certifying that the Qualified Beneficiary(ies) continues to meet the eligibility requirements and has not become (1) entitled to Medicare, and/or (2) covered under another group health plan that does not have a limitation of exclusion due to a pre-existing condition.

In addition, Qualified Beneficiaries shall be given the requirements for disability extensions and instructed as to the procedures to submit requests for disability extensions. ASPIRANT shall process only those requests for disability extensions that meet COBRA eligibility requirements.

Dependent additions shall be handled in the same manner as similarly situated active employees of the EMPLOYER. ASPIRANT shall contact EMPLOYER for authorization when a COBRA continuant requests to add a new Dependent. Once EMPLOYER authorizes the addition, the new Dependent will be added as of the appropriate date and the continuant's coverage level shall be changed accordingly.

C2.13 To develop all correspondence and notices referenced herein that will be sent to the Qualified Beneficiary(ies) which reasonably comply with the requirements of COBRA.

C2.14 To provide a reasonable level of customer service with respect to its COBRA administration responsibilities. A toll-free telephone number and email address shall be given to Qualified Beneficiaries which gives a Qualified Beneficiary access to a Customer Service representative during the normal operating hours of ASPIRANT. EMPLOYER shall also be given a toll-free telephone number and email address providing access to a Client Services representative during the normal operating hours of ASPIRANT.

C2.15 To retain records relating to its services for the period as required by law, maintain confidentiality of records, provide an adequate disaster recovery program, and provide reasonable access to EMPLOYER. Any duly authorized representative of EMPLOYER, upon the execution of an appropriate release form to assure the confidentiality of the data and records to be released and to indemnify ASPIRANT from any loss resulting from the misuse of such released data and records, shall have the right to examine or audit such records during the normal business hours of ASPIRANT, upon a seven-day prior written notice to ASPIRANT.

C2.16 To assume responsibility if a violation of COBRA occurs due to the failure of ASPIRANT to materially perform the obligations outlined in this Agreement.

ARTICLE III: GENERAL PROVISIONS

C3.1 This Agreement shall commence JANUARY 1, 2022, and end DECEMBER 31, 2022. This Agreement shall automatically renew each year for an additional one-year period unless a prior ninety-day (90) notice is provided and may be modified or terminated as described below.

C3.2 At any time during the term of this Agreement, either the EMPLOYER or ASPIRANT may amend or change the provisions of this Agreement. These amendments or changes must be agreed upon in advance in writing by both the EMPLOYER and ASPIRANT. If any such amendment increases the cost of administering the Plan, the EMPLOYER agrees to pay any increase in administrative fees or other costs which ASPIRANT reasonably expects to incur because of such modification.

C3.3 This Agreement may be terminated by either the EMPLOYER or ASPIRANT at any time, either upon giving ninety (90) days advance written notice to the other party unless both parties agree to waive such advance notice, or with no notice, as stated below. At the option of the party initiating the termination, the other party may be permitted a cure period (of a length determined by the party initiating the termination) to cure any default.

C3.4 ASPIRANT may, at its option, terminate this Agreement effective immediately upon the occurrence of any one or more of the following events on written notice to the EMPLOYER:

- The EMPLOYER is adjudicated as bankrupt, becomes insolvent, a temporary or permanent receiver is appointed by any court for all or substantially all the EMPLOYER’s assets, the EMPLOYER makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to the EMPLOYER and it is not dismissed within forty-five days of such filing,
- The EMPLOYER fails to pay administration fees or other fees for ASPIRANT services upon presentation for payment and in accordance with the Fee Schedule,
- The EMPLOYER engages in any unethical business practice or conducts itself in a manner which in the reasonable judgment of ASPIRANT is in violation of any federal, state, or other government statute, rule, or regulation, or
- The EMPLOYER, through its acts, practices, conduct, financial standing, or operations, exposes ASPIRANT to any existing or potential investigation or litigation.

C3.5 The EMPLOYER may, at its option, terminate this Agreement effective immediately upon the occurrence of any one or more of the following events on written notice to ASPIRANT:

- ASPIRANT is adjudicated as bankrupt, becomes insolvent, a temporary or permanent receiver is appointed by any court for all or substantially all the ASPIRANT assets, ASPIRANT makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to ASPIRANT and it is not dismissed within forty-five days of such filing,
- ASPIRANT engages in any unethical business practice or conducts itself in a manner which in the reasonable judgment of the EMPLOYER is in violation of any federal, state, or other government statute, rule, or regulation, or
- ASPIRANT, through its acts, practices, conduct, financial standing, or operations, exposes the EMPLOYER to any existing or potential investigation or litigation.

C3.6 Upon termination of this Agreement, at EMPLOYER's discretion, ASPIRANT will perform COBRA administrative services for an additional sixty days only for premiums billed, but not yet collected prior to the date of termination. ASPIRANT, in addition to the COBRA premium fee of 2%, shall be entitled to a fee of $1.75 per covered employee per benefit line for these administrative services as a COBRA Agreement Termination Fee. The computation of the COBRA Agreement Termination Fee shall be based on the average enrollment, per benefit line, for the final three months of the term of this Agreement.

C3.7 Upon termination of this Agreement, all Claim files, reports, filings with governmental entities, and plan documentation will be maintained by ASPIRANT at its principal administrative office or secure storage facilities for at least seven (7) years following the termination of an Agreement period. At the end of the seven (7) year period or termination of this Agreement, if earlier, ASPIRANT shall notify the EMPLOYER that these records will be destroyed unless the EMPLOYER requests, in writing, that all or some of the records be forwarded to the EMPLOYER.

ARTICLE IV. MISCELLANEOUS

C4.1 This Agreement, together with all addenda, exhibits, and appendices supersedes any and all prior representations, conditions, warranties, understandings, proposals, or other agreements between the EMPLOYER and ASPIRANT hereto, oral or written, in relation to the services and systems of ASPIRANT, which are rendered or are to be rendered in connection with its assistance to the EMPLOYER in the administration of the Plan.

C4.2 This Agreement, together with the aforesaid addenda, exhibits, and appendices constitutes the entire COBRA Administrative Services Agreement of whatsoever kind or nature existing between or among the parties.

C3.3 The parties hereto, having read and understood this entire Agreement, acknowledge, and agree that there are no other representations, conditions, promises, agreements, understandings, or warranties that exist outside this Agreement which have been made by either of the parties hereto, which have induced either party or has led to the execution of this Agreement by either party. Any statements, proposals, representations, conditions, warranties, understandings, or agreements which may have been heretofore made by either of the parties hereto, and which are not expressly contained or incorporated by reference herein, are void and of no effect.

C4.4 This Agreement may be executed in two or more counterparts, each, and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument.

C4.5 Except as provided in Article III (regarding termination without advance notice), no changes in or additions to this Agreement shall be recognized unless and until made in writing and signed by all parties hereto.

C4.6 In the event any provision of this Agreement is held to be invalid, illegal, or unenforceable for any reason and in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice, or disturb the validity of the remainder of this Agreement, which shall be in full force and effect, enforceable in accordance with its terms.

C4.7 In the event that either party is unable to perform any of its obligations under this Agreement because of natural disaster, labor unrest, civil disobedience, acts of war (declared or undeclared), or actions or decrees of governmental bodies (any one of these events which is referred to as a "Force Majeure Event"), the party who has been so affected shall immediately notify the other party and shall do everything possible to resume performance.

Upon receipt of such notice, all obligations under this Agreement shall be immediately suspended. If the period of non-performance exceeds ten working days from the receipt of notice of the Force Majeure Event, the party whose ability to perform has not been so affected may, by giving written notice, terminate this Agreement.

C4.8 All notices required to be given to either party by this Agreement shall, unless otherwise specified in writing, be deemed to have been given three days after deposit in the U.S. Mail, first class postage prepaid, certified mail, return receipt requested.

C4.9 This Agreement shall be interpreted and construed in accordance with the laws of the state of Kentucky except to the extent superseded by federal law.

C4.10 No forbearance or neglect on the part of either party to enforce or insist upon any of the provisions of this Agreement shall be construed as a waiver, alteration, or modification of the Agreement.

C4.11 ASPIRANT is providing administrative services only with respect to the portion of the Plan described in the Plan Document and has only the authority granted it pursuant to this Agreement.

ASPIRANT is not the insurer or underwriter of any portion of the Plan.

ASPIRANT has no responsibility or liability for funding benefits provided by the Plan and the EMPLOYER retains the ultimate responsibility and liability for all benefits and expenses incident to the Plan, including but not limited to, any state or local taxes that might be imposed relating to the Plan.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective this 1st day of JANUARY 2022.

HARDIN COUNTY WATER DISTRICT #2

DocuSigned by:
Shaun Youravich
7ACA5FBA45E34D3...
SIGNATURE

SHAUN YOURAVICH
PRINTED NAME

GENERAL MANAGER
TITLE

ASPIRANT, INC

DocuSigned by:
William O Holton
AE06188B9067454...
SIGNATURE

WILLIAM O HOLTON
PRINTED NAME

PRESIDENT, CHIEF EXECUTIVE OFFICER
TITLE

FULL LEGAL NAME OF EMPLOYER:

HARDIN COUNTY WATER DISTRICT #2

AFFILIATES AND/OR SUBSIDIARIES OF EMPLOYER SUBJECT TO THIS AGREEMENT:

ACKNOWLEDGEMENT OF RECEIPT

DocuSigned by:
7ED5BF71BB8F48D...
SIGNATURE

KATHERINE E NAPIER
PRINTED NAME

EXECUTIVE VICE PRESIDENT, CHIEF FINANCIAL OFFICER
TITLE

APPENDIX A

FEE SCHEDULE AND FINANCIAL ARRANGEMENT

All fees, unless otherwise noted, are represented on a per covered employee per month basis.

I. Administrative Services

The EMPLOYER and ASPIRANT hereby agree to the compensation schedules set forth below as being the compensation to ASPIRANT for its COBRA administrative services:

Monthly Administrative Services Fee: $2.25

DocuSign Envelope ID: 4A38E705-CDB2-4320-81E6-037E18BC71B6

DESIGN PREVIEW

Updated By **WHITNEY.NEWTON**
Last Modified **12/07/2021 12:54 PM**

Design Name **Hardwin_Co_Water**

Description **Hardin Co Water**

Card Front | Card Back

X177772932700001

Member Name:
JOHN DOE
Member ID:
HWF123456789

Group #:	000HWF834
Group Name:	Hardin County Water
Plan Name:	PPO
Plan Codes:	834/332
RxBIN:	012882
RxPCN:	KPP
RxGRP:	KT579

Office Visit:	$30 Copay
Specialist Visit:	$60 Copay
Urgent Care:	$100 Copay
Emergency Room:	$300 Copay
In Net Ded Ind/Fam	$1000/$2000
Out of Net Ded Ind/Fam	$3000/$6000
In Net OOP Ind/Fam	$5000/$10000
Out of Net OOP Ind/Fam	$15000/$30000

HCW will utilize ARC Administrators to handle member contact for health plan administration. See back for contact information.

This card intentionally left blank.

X177772932700001

Providers: Please file all claims with the Blue Cross and Blue Shield Plan in the state where services are rendered. If Medicare is primary, file claims to Medicare. Include the 3 digit prefix in addition to the ID number.

Possession of this card does not guarantee eligibility for benefits.

Precertification is required for all hospital admissions and specified outpatient procedures. In the event of an emergency, call within 48 hours of admission or the next business day.

Failure to receive precertification may result in a penalty.

Issue Date: 1/1/2022

anthem.com

Member Services* ARC Administrators	1-855-982-2583
Coverage While Traveling	1-800-810-BLUE
Provider Eligibility/Benefits	1-800-676-BLUE
Rx Provider Pre-Cert (non-onc)	1-833-293-0659
ARC Administrators Precertification*	1-855-984-2583
Kroger (Members)*	1-800-575-7712

*Contracts directly with group

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

*Pharmacy Benefits Administrator, Contracts directly with group

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PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

HARDIN COUNTY WATER DISTRICT NO.2

EMPLOYEE BENEFIT PLAN

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INTRODUCTION

This document is a description of Hardin County Water District No.2 Employee Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Para obtener asistencia en Espanol, llame al (855) 981-2583.

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

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

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Participating Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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

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

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

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

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

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

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

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

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

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

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

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

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

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

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage after completing the Waiting Period that he or she:

(1) Is in a Class of Eligible Employees and is an eligible fulltime Employee and normally working thirty (30) or more hours per week.

(2) Pays any required contribution.

(3) Satisfies the following Waiting Period for the appropriate Class of Eligible Employee:

(a) All Eligible Employees – First of the month following 60 days of continuous employment.

Impact of Breaks in Service:

If you have a Break in Service and then return to work, you will be treated as a New Hire, and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. However, if you are not actively at work for a period and return to work or are otherwise credited with Hours of Service before you incur a Break in Service, you will be treated as a continuous employee and will be eligible for coverage under the Plan upon return if you were enrolled in coverage prior to the start of the period during which you had no Hours of Service. Your coverage will be effective on the first day of the month that coincides with or follows the date you resume Hours of Service, subject to completion of enrollment requirements.

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

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered employee, if they were legally married under the laws of a State or other foreign or domestic jurisdiction.

The Plan Administrator may require documentation proving a legal marital relationship and a certification on the availability of the Employee’s Spouse’s outside group health plan coverage.

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

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

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

(3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include individuals who do not qualify as a Child as defined above, but who are children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years and primarily dependent upon the covered Employee for support and maintenance. When the Employee's Qualified Dependent reaches the applicable limiting age, coverage will end on the last day of the month following the date that the Qualified Dependent reaches age 26.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

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

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

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

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

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

If both parents are Employees, their children will be covered as Dependents of one or the other, but not of both.

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

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

FUNDING

Cost of the Plan. HARDIN COUNTY WATER DISTRICT NO. 2 shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage may include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also, if such coverage is elected.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee is automatically enrolled in this Plan for thirty-one (31) days from date of birth and must be enrolled within this time period and dependent coverage must be elected. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within thirty-one (31) days of birth, any expenses related to the birth or other expenses incurred will not be covered by the Plan. If the child is not enrolled within thirty-one (31) days of birth any subsequent enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

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

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

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

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

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Hardin County Water District No. 2, 360 Ring Road, Elizabethtown, Kentucky, 42701, (270) 737-1056.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

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

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

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

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

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

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

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

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who

no longer reside, live or work in a service area, (whether or not within the choice of the individual).

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

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

(3) **Acquiring a newly eligible Dependent may create a Special Enrollment right.** If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

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

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

The Special Enrollment Period for newly eligible Dependents is a period of 31 days and after the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

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

(a) in the case of marriage, the date of marriage and once the completed request for enrollment is received;

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

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

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

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

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

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

TERMINATION OF COVERAGE

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

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

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

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

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

(5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days'

advance written notice of such action.

Continuation During Periods of Employer-Certified Disability. A person may remain eligible for a limited time if Active, full-time work ceases due to disability. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

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

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

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by applicable law. Unless the rehired Employee has been separated from employment less than six months then the Employee shall not be required to satisfy the new hire Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period.

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

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

- **(a)** The 24 month period beginning on the date on which the person's absence begins; or
- **(b)** The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

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

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

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Hardin County Water District No. 2, 360 Ring Road, Elizabethtown, Kentucky, 42701, (270) 737-1056. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the

Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

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

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

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

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

OPEN ENROLLMENT

Every year, there will be an annual open enrollment period. During this time, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Eligible Employees and their eligible Dependents who are Late Enrollees will also be able to enroll in the Plan during the annual open enrollment period.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect until the next December 31st unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Benefit choices for Late Enrollees made during the open enrollment period will also become effective January 1st.

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

SCHEDULE OF BENEFITS

Verification of Eligibility
ARC Administrators (855) 981-2583

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

MEDICAL BENEFITS

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

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

Note: If claims are not pre-certified they will be denied for no pre-certification. Once information is received claims can be re-opened based on medical information provided.

Inpatient Services:
Hospitalization - Excludes 48/96 hour (legislated timeframe for delivery) maternity admissions
Non-Emergency Inpatient Surgical Procedures
Rehabilitation Facility Stays
Skilled Nursing Facility Stays

Outpatient Services:
Cardiac Rehabilitation Therapy
Outpatient Surgical Procedures (excluding colonoscopies, endoscopies, or surgeries performed in an office setting)
Advanced Imaging Services (MRI/MRA/CAT/PET/SPECT/Diagnostic mammograms)-Excludes preventive low dose CT scans

Behavioral Health Services:
Inpatient Behavioral Health/Substance Abuse
Intensive Outpatient Therapy
Partial Hospitalization (PHO)
Residential Care (RTC)

Other – All Places of Service:
Durable Medical Equipment (over $1,500)
Genetic Testing/Molecular Pathology
Home Health Care
Infusion Therapy
Private Duty Nursing
Prosthetics and Orthotics (over $750)
Radiation Therapy
Sleep Disorder Testing
Transplants

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

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

The Plan is a plan which contains a Participating Provider Organization (PPO) referred to as Network Providers.

If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network

Provider and is available to accept the child as a patient. A Covered Person does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider. However, the health care professional may be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

PPO name: Anthem Blue Cross & Blue Shield
Address: 13550 Triton Park Boulevard
Louisville, KY 40223
Telephone: (800) 810-2583
Fax: (502) 889-2414

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

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

- Professional Services (Radiologist, Pathologist or Anesthesiologist) when services are rendered at an In-Network Facility
- Services are not available at an In-Network Facility/Provider
- Covered Individuals traveling outside the United States
- Medical Emergency Treatment
- Diagnostic Procedures performed in an In-Network Physician's Office and sent to an outside diagnostic facility for evaluation

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers will be given to covered Employees and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Deductibles/Copayments Payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Maximum Out-of-Pocket Payments, per Calendar Year

The Plan will pay the percentage of Covered Charges designated until the following amounts of Out-of-Pocket payments are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The maximums shown in the Schedule of Benefits accumulate jointly for In and Out of Network.

BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard." This program lets the Member get Covered Charges at the Network cost-share when he/she is traveling out of state and needs health care, as long as the Member uses a BlueCard Provider. All the Member has to do is show their Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send the claims to the Claims Administrator.

If a Member is out of state and an Emergency or urgent situation arises, the Member should get care right away. In a non-

Emergency situation, the Member can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of their Identification Card. Members can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care outside the United States – BlueCard Worldwide

Prior to travel outside the United States, Members should check with the Plan Sponsor or call Customer Service at the number on their Identification Card to find out if their Plan has BlueCard Worldwide benefits. Coverage outside the United States may be different and it is recommended:

- Before leaving home, Members should call the Customer Service number on their Identification Card for coverage details.
- Members should always carry the current Identification Card.
- In an emergency, a Member should go directly to the nearest Hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- A Member needs to find a Physician or Hospital or needs medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.
- A Member needs to be hospitalized or needs Inpatient care. After calling the Service Center, the Member must also call the Claims Administrator to obtain approval for benefits at the phone number on their Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information

- Participating BlueCard Worldwide Hospitals. In most cases, when a Member makes arrangements for hospitalization through BlueCard Worldwide, he/she should not need to pay up front for Inpatient care at participating BlueCard Worldwide hospitals except for the Out-of-Pocket costs (non-Covered Charges, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should submit the claim on the Member's behalf.
- Doctors and/or non-participating Hospitals. Members will need to pay up front for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then the Member can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file a Member's claim if the BlueCard Worldwide Service Center arranged the Member's hospitalization. The Member will need to pay the Hospital for the Out-of-Pocket costs he/she would normally pay.
- The Member must file the claim for outpatient and Physician care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. The Member will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

Claim Forms

International claim forms are available from the Claims Administrator, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.

MEDICAL BENEFIT SCHEDULE – PPO PLAN

	TIER 1 LINCOLN TRAIL DIAGNOSTICS HIGH FIELD & OPEN MRI PATH GROUP ZIP CLINIC	TIER 2 ANTHEM IN-NETWORK	TIER 3 NON-NETWORK
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Deductible (Single/Family)[1] The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Deductibles Apply to Out-of-Pocket Maximum Deductible Amounts Accumulate Jointly For Tier 2 and Tier 3.	$0/$0	$1,000/$2,000	$3,000/$6,000
Maximum Out-Of-Pocket (Single/Family)[2] The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Maximum Excludes: • Cost Containment Penalties • Exclusions and Limitations • Charges in Excess of Maximum Allowed Amount • Non-Network Transplant Services Out-of-Pocket Amounts Accumulate Jointly For Tier 2 and Tier 3.	$0/$0	$5,000/$10,000	$15,000/$30,000
COVERED BENEFITS			
PHYSICIAN SERVICES	**YOUR COST SHARE RESPONSIBILITY**		
Physician Office Services Office Visit Copayment (PCP/SCP)	No Cost Share	$30/$60 Copayment, 20% After Deductible	50% After Deductible
• Allergy Injection & Serum Without an Office Visit Charge With an Office Visit Charge		20% After Deductible $30/$60 Copayment, 20% After Deductible	50% After Deductible 50% After Deductible
• Allergy Testing Without an Office Visit Charge With an Office Visit Charge		20% After Deductible $30/$60 Copayment, 20% After Deductible	50% After Deductible 50% After Deductible
• Imaging Services (MRI, MRA, CAT, PET, C-SCAN)		20% After Deductible	50% After Deductible
• Diagnostic Test (Lab and X-Ray)		20% After Deductible	50% After Deductible

COVERED BENEFITS			
PHYSICIAN SERVICES	**YOUR COST SHARE RESPONSIBILITY**		
Preventive Care Services Office Visit Copayment Services include, but are not limited to: • Routine Exams (PCP/SCP) • Colonoscopy • Contraceptives • Mammogram[3](Diagnostic and Preventive) • PAP/PSA Testing • Immunizations • Annual Diabetic Eye Exam • Diabetic Education • PCP Vision/Hearing Screening • Breast Pumps – 1 Pump/Pregnancy[4]	No Cost Share	No Cost Share	Not a Covered Benefit
Live Health Online	Not a Covered Benefit	Not a Covered Benefit	Not a Covered Benefit
COVERED BENEFITS			
FACILITY SERVICES	**YOUR COST SHARE RESPONSIBILITY**		
Behavioral Health & Substance Abuse Covered As Outlined In The Medical Benefits Section • Inpatient Facility Services • Inpatient Professional Services • Other Outpatient Services	No Cost Share No Cost Share No Cost Share	20% After Deductible 20% After Deductible No Cost Share	50% After Deductible 50% After Deductible 50% After Deductible
Emergency Room Covered As Outlined In The Medical Benefits Section Copayment Waived If Admitted To Emergency Room • Emergency Room Services • Emergency Room Physician • Non-Emergent Emergency Room Services	No Cost Share No Cost Share Not a Covered Benefit	$300 Copayment, 20% After Deductible 20% After Deductible Not a Covered Benefit	$300 Copayment, 20% After Deductible 20% After Deductible Not a Covered Benefit
Hospice Care Covered As Outlined In The Medical Benefits Section	No Cost Share	No Cost Share	No Cost Share
Hospital Inpatient Services **Precertification Required** Covered As Outlined In The Medical Benefits Section • Room & Board (Semiprivate or ICU/CCU) • Hospital Services & Supplies **Inpatient Hospital Professional Services** • Assistant Surgeon • Anesthesiologist • Radiologist • Pathologist	No Cost Share No Cost Share No Cost Share No Cost Share No Cost Share No Cost Share	20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible	50% After Deductible 50% After Deductible 50% After Deductible 50% After Deductible 50% After Deductible 50% After Deductible

COVERED BENEFITS			
FACILITY SERVICES	**YOUR COST SHARE RESPONSIBILITY**		
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation			
Inpatient Facility Services (Other Than Hospital) Covered As Outlined In The Medical Benefits Section	No Cost Share	20% After Deductible	50% After Deductible
NOTE: Skilled Nursing Facility 60 Day Annual Limit Combined In-Network/Non-Network. Required to Follow Inpatient Hospital Stay for 3 days.			
Outpatient Surgery/Alternative Care Facility Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Surgery • Administration of General Anesthesia	No Cost Share	20% After Deductible	50% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation			
Urgent Treatment Center • Urgent Treatment Center Services[5]	No Cost Share	$100 Copayment	50% After Deductible
NOTE: The Copayment Applies To The First Claim Received, either the Professional or Institutional.			

COVERED BENEFITS			
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**		
Abortion (Therapeutic) Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30/$60 Copayment, 20% After Deductible	50% After Deductible
• Other Place Of Service	No Cost Share	20% After Deductible	50% After Deductible
Accidental Dental Injury Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30/$60 Copayment, 20% After Deductible	20% After Deductible
• Other Place Of Service	No Cost Share	20% After Deductible	20% After Deductible
Ambulance Services (Land / Air) Covered As Outlined In The Medical Benefits Section	No Cost Share	20% After Deductible	Covered at In-Network Benefit

COVERED BENEFITS			
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**		
Attention Deficit Disorder (ADD) **Attention Deficit Hyperactivity Disorder (ADHD)** Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30/$60 Copayment, 20% After Deductible	50% After Deductible
• Other Place Of Service	No Cost Share	20% After Deductible	50% After Deductible
Autism Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30/$60 Copayment, 20% After Deductible	50% After Deductible
• Other Place Of Service	No Cost Share	20% After Deductible	50% After Deductible
Bariatric Surgery/Morbid Obesity Covered As Outlined In The Medical Benefits Section	Not A Covered Benefit		
Behavioral Health & Substance Abuse Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	No Cost Share	50% After Deductible
• Other Place Of Service	No Cost Share	20% After Deductible	50% After Deductible
Cardiac Rehabilitation Therapy Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30 Copayment, 20% After Deductible	50% After Deductible
• Other Place Of Service	No Cost Share	20% After Deductible	50% After Deductible
NOTE: Phase I & II are covered. Cardiac Rehabilitation Therapy has a 36 Maximum Visit per Calendar Year Combined In-Network & Non-Network.			
Chemotherapy/Infusion Therapy Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30/$60 Copayment, 20% After Deductible	50% After Deductible
• Other Place Of Service	No Cost Share	20% After Deductible	50% After Deductible
Chiropractic/Spinal Manipulation Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30 Copayment	50% After Deductible
• Other Place Of Service	No Cost Share	$30 Copayment	50% After Deductible
NOTE: 20 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network.			

COVERED BENEFITS SPECIALIZED SERVICES	YOUR COST SHARE RESPONSIBILITY		
Clinical Trials Covered For Life Threatening Disease As Outlined In The Medical Benefits Section	No Cost Share	20% After Deductible	50% After Deductible
Hearing Services/Cochlear Implants Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 No Cost Share No Cost Share	 $30/$60 Copayment 20% After Deductible	 50% After Deductible 50% After Deductible
NOTE: Limited to one per hearing impaired ear every 36 months. Hearing aids for members age 18 and above are limited to $2,800 maximum per year.			
Home Health Care Covered As Outlined In The Medical Benefits Section	No Cost Share	20% After Deductible	50% After Deductible
NOTE: Home Health Care has a maximum of 60 Visits Per Year, Combined In-Network & Non-Network.			
Infertility Services/ Treatment Covered As Outlined In The Medical Benefits Section	Not A Covered Benefit	Not A Covered Benefit	Not A Covered Benefit
NOTE: Treatment For Underlying Medical Conditions Are Covered As Medical Benefits.			
Inpatient & Outpatient Professional Services Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • General Medical Care Visit (One Per Day) • Intensive Medical Care • Concurrent Care • Surgery • Anesthesia Administration • Newborn Exams/Care • Consultation, Second Medical Opinion	No Cost Share	20% After Deductible	50% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation			
Maternity/Pregnancy Covered As Outlined In The Medical Benefits Section **Dependent Daughters Are Covered** • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 No Cost Share No Cost Share	 $30 Copayment 20% After Deductible	 50% After Deductible 50% After Deductible
NOTE: Copayment For Tier 2 Applies To Office Visit Only, All Other Covered Expenses Billed During The Same Visit Are Covered at 100%.			
Medical Supplies and Equipment Covered As Outlined In The Medical Benefits Section	No Cost Share	20% After Deductible	50% After Deductible
NOTE: Breast Pumps Electrical And Manual Are Covered At 100%. Limits Apply to 1 Pump Per Pregnancy. Pumps Purchased At A Retail Vendor Are Covered.			

COVERED BENEFITS			
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**		
Nutritional Counseling (Non-Diabetic) Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30/$60 Copayment	50% After Deductible
• Other Place Of Service	No Cost Share	20% After Deductible	50% After Deductible
Occupational Therapy			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30 Copayment	50% After Deductible
• Other Place Of Service	No Cost Share	$30 Copayment	50% After Deductible
• In-Patient	No Cost Share	20% After Deductible	50% After Deductible
NOTE: Occupational Therapy Limited To 25 Visit Maximum Per Year. Combined In-Network & Non-Network.			
Oral Surgery Covered As Outlined In The Medical Benefits Section	Not a Covered Benefit	Not a Covered Benefit	Not a Covered Benefit
Organ Transplant Services	Covered As Outlined In The Transplant Benefit Section		
Orthotic Devices Covered As Outlined In The Medical Benefits Section	No Cost Share	20% After Deductible	50% After Deductible
Physical Therapy			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30 Copayment	50% After Deductible
• Other Place Of Service	No Cost Share	$30 Copayment	50% After Deductible
• In-Patient	No Cost Share	20% After Deductible	50% After Deductible
NOTE: Physical Therapy Limited To 25 Visit Maximum Per Year. Combined In-Network & Non-Network.			
Private Duty Nursing Covered Only With Home Health Care Benefit	No Cost Share	20% After Deductible	50% After Deductible
Respiratory Therapy Covered As Outlined In The Medical Benefits Section			
• Physician Office Visit Copayment (PCP/SPC)	No Cost Share	$30/$60 Copayment, 20% After Deductible	50% After Deductible
• Other Place Of Service	No Cost Share	20% After Deductible	50% After Deductible
• In-Patient	No Cost Share	20% After Deductible	50% After Deductible
NOTE: Respiratory Therapy Limited To 25 Visit Maximum Per Year. Combined In-Network & Non-Network.			
Sleep Disorder Therapy/Sleep Study	No Cost Share	20% After Deductible	50% After Deductible
NOTE: Sleep Studies Are Covered In The Patients Home. Sleep Studies Must Be Rendered In The Patients Home Before Sleep Studies Can Be Preformed In An Overnight Or Outpatient Facility.			

COVERED BENEFITS			
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**		
Speech Therapy • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service • In Patient	 No Cost Share No Cost Share No Cost Share	 $30 Copayment $30 Copayment 20% After Deductible	 50% After Deductible 50% After Deductible 50% After Deductible
NOTE: Speech Therapy is Limited To 25 Visit Maximum Per Year. Combined In-Network & Non-Network. Developmental Delays Are Covered.			
Sterilization (Reversal Excluded) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service **Female Participants Covered At 100% Per ACA Guidelines**	 No Cost Share No Cost Share	 $30/$60 Copayment 20% After Deductible	 50% After Deductible 50% After Deductible
NOTE: Copayment For Tier 2 Applies To Office Visit Only, All Other Covered Expenses Billed During The Same Visit Are Covered At 100%.			
Temporomandibular Joint Dysfunction/Treatment (TMJ) Covered As Outlined In The Medical Benefits Section	No Cost Share	20% After Deductible	50% After Deductible
Tobacco Cessation Programs Covered As A Standard Preventive Care Benefit Through A Network Provider	No Cost Share	No Cost Share	Not A Covered Benefit

COVERED BENEFITS	KROGER PRESCRIPTIONS PHARMACY
PRESCRIPTION DRUGS	**YOUR COST SHARE RESPONSIBILITY**
Retail Pharmacy (90 Day Supply Maximum)	
Generic	$10.00 Per 30 Day Supply
Formulary Brand Name	$35.00 Per 30 Day Supply
Non-Formulary Brand Name	$60.00 Per 30 Day Supply
Medications Recommended by the HRSA/USPSTF	$0.00
Mail Pharmacy (Up to 90 Day Supply) (90 Day Supply Maximum)	
Generic	$25.00 Per 30 Day Supply
Formulary Brand Name	$87.50 Per 30 Day Supply
Non-Formulary Brand Name	$150.00 Per 30 Day Supply
Medications Recommended by the HRSA/USPSTF	$0.00
Specialty Drugs (90 Day Supply Maximum)	$300.00 Per 30 Day Supply
Health Resources and Services Administration (HRSA) United States Preventative Services Task Force (USPSTF)	

COVERED BENEFITS

HUMAN ORGAN TRANSPLANTS

Transplant Services – Human Organ & Tissue Transplant
Covered As Outlined In The Transplant Benefits Section

Any Medically Necessary Human Organ & Stem Cell/Bone Marrow Transplant And Transfusion As Determined By The Claims Administrator, Including Necessary Acquisition Procedures, Harvest And Storage, Including Medically Necessary Preparatory Myeloablative Therapy.

A Blue Distinction Center Requirement Does Not Apply To Cornea Or Kidney Transplants, Or For Any Covered Charges Related To A Covered Transplant Procedure Prior To Or After The Transplant Benefit Period.

NOTE:
Even If A Hospital Is A Network Provider For Other Services, It May Not Be A Network Transplant Provider For These Services. Prior To Seeking Care Please Contact ARC Administrators Care Coordination At (855) 984-2583 To Determine Which Hospitals Are Network Transplant Providers.

TRANSPLANT BENEFIT	TIER 1 LINCOLN TRAIL DIAGNOSTICS HIGH FIELD & OPEN MRI PATH GROUP ZIP CLINIC	TIER 2 ANTHEM IN-NETWORK	TIER 3 NON-NETWORK
	YOUR COST SHARE RESPONSIBILITY		
Transplant Benefit – Non-Blue Distinction Center Facility	No Cost Share	20% After Deductible	Not A Covered Benefit
Transplant Benefit – Blue Distinction Center Facility	Not A Covered Benefit	20% After Deductible	Not A Covered Benefit
Transportation & Lodging Covered As Outlined In The Transplant Benefits Section	Not A Covered Benefit	Not A Covered Benefit	Not A Covered Benefit
Donor Health Services Donor Benefits Are Limited To Benefits Not Available To The Donor From Any Other Source.			
NOTE: Donor Health Services are limited to Medically Necessary charges for procurement of an organ from a live donor. Covered up to the Maximum Allowed Amount including complications form the donor for up to six weeks form the date of procurement.			
All Other Transplant Services Covered As Outlined In The Transplant Benefits Section	Not A Covered Benefit	40% After Deductible	Not A Covered Benefit

Benefit Schedule Notes:

All Copayments and Deductibles Are Included In The Out-Of-Pocket Limits.

Deductible Amounts Accumulate Jointly for Tiers 1, 2, and 3.

Cost Containment Penalties, Non-Network Transplant Services, Services Deemed Not Medically Necessary by Medical Management and/or Anthem, and Charges Over the Allowed Amount are Excluded for the Out-Of-Pocket Limits.

Dependent Coverage to the end of the birthdate month in which Child attains age 26.

No Deductible/Copayment/Coinsurance means No Cost Share up to the Maximum Allowable Amount.

PCP Is a Network Provider who is a Practitioner that specializes in Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics or Any Other Network Provider as allowed by The Plan.

SCP Is a Network Provider, other than a Primary Care Physician (PCP), who provides services within a designated Specialty Area of Practice.

All Specialty Medications must be obtained via the Specialty Pharmacy network in order to receive network level benefits.

Physician Office Visit Copayment is also applicable if the Office Visit is billed with Allergy Injections.

Benefit Period is on a Plan Benefit Year Basis beginning January 1st and ending December 31st.

[1] Charges in excess of the Maximum Allowed Amount do not contribute to the deductible.

[2] Out of Pocket amounts accumulate Jointly for Tiers 1 & 2. Non-Network Accumulate Separately. There is Not a Separate Out of Pocket for Pharmacy.

[3]Diagnostic Mammograms and Preventive Mammograms are covered at 100%.

[4]Must be provided by an in network DME (Durable Medical Equipment) Provider. Member will be reimbursed for a breast pump purchased from a retail store.

[5]Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an Urgent Care Center and billed alone are subject to the Other Outpatient Services Copayment / Coinsurance.

MEDICAL BENEFITS

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

DEDUCTIBLE

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

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

BENEFIT PAYMENT

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

COVERED CHARGES

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

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

Room charges made by a Hospital having only private rooms will be paid at the semi-private room rate, In-Network only. Out-of-Network room charges made by a Hospital having only private rooms will be paid based on the billed charge, or Anthem Out-of-Network rate, if applicable.

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

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

The Usual and Reasonable Charges for the care and treatment of Pregnancy for dependent daughters are covered.- the same as any other Sickness for a covered Employee or covered Dependent.

(3) **Abortion.** Services, supplies, care or treatment in connection with an abortion when performed to save the life or health of the mother.

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

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

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

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

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

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

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

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

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

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

(a) **Inpatient Nursing Care.** Not Covered.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

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

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

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

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

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

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

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

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and (c) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(e) Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

(f) Initial **contact lenses** or glasses required following cataract surgery, limited to 1 occurrence.

(g) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

Durable Medical Equipment includes Hearing Aids and related services. One hearing aid per hearing impaired ear every 36 months for covered members under the age of 18. Ages 18 and older are limited to $2,800 per year.

Breast pumps are covered 100% for Tier 1 and Tier 2. Tier 3 is covered at 50%. Pumps purchased at a retail vendor are covered. Limits Apply to 1 pump maximum per pregnancy.

Temporomandibular Joint Disorder (TMJ) Appliances are covered.

Durable Medical Equipment can also include, but not limited to: Hemodialysis equipment, crutches and replacement of pads and tips, Pressure machines, Infusion pump for IV fluids and medicine, Glucometer, Tracheotomy tube, Cardiac, neonatal and sleep apnea monitors. Augmentative communication devices are covered when approved by the Plan as medically necessary.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the Member’s physical disorder.

(h) **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(i) Diagnostic services for **infertility** up to the maximum shown in the Schedule of Benefits.

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

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

Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

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

Physician's visits are limited to one treatment per day.

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

The following are considered covered charges (this is not a complete list)
Residential Treatment
Detoxification
Inpatient Accommodations and Ancillary charges
Psychological Testing
Medication Management
Applied Behavior Analysis (ABA) Therapy
Eating Disorders
Halfway houses are excluded

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

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

Emergency repair due to Injury to sound natural teeth.

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

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

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

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

(m) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits. All transplants require preauthorization. Benefits will not be paid for transplants unless prior authorization is obtained.

Only the services, care and treatment received for, or in connection with, the pre-approved transplant of the organs identified hereafter, which are determined by the claims administrator to be medically necessary services and which are not experimental, investigational or for research purposes will be covered by this Plan. The transplant includes: pre-transplant services, transplant inclusive of any chemotherapy and associated services, post-discharge services and treatment of complications after transplantation of the following organs or procedures only:

(1) Heart;
(2) Lung(s);
(3) Liver;
(4) Kidney;
(5) Bone Marrow;
(6) Intestine;
(7) Pancreas;
(8) Auto Islet Cell;
(9) Multivisceral;
(10) Any combination of the above listed organs;
(11) An organ not listed above required by federal law.

*The term bone marrow refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppressive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a transplant of bone marrow approved by claims administrator.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular plan benefits and are subject to other applicable provisions of this Plan.

For a transplant to be considered fully approved, prior written approval from plan is required in advance of the transplant. You or your qualified practitioner must notify the claims administrator in advance of your need for an initial transplant evaluation in order for a determination to be made as to whether or not the transplant will be covered. For approval of the transplant itself, the claims administrator must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Once the transplant is approved, the claims administrator will advise the covered person's qualified practitioner. Benefits are payable only if the pre-transplant services, the transplant and post-discharge services are approved.

Exclusions

No benefit is payable for, or in connection with, a transplant if:

(1) It is experimental, investigational or for research purposes as defined in the “Definitions” section;

(2) Claims Administrator is not contacted for authorization prior to referral for evaluation of the transplant;

(3) Claims Administrator does not approve coverage for the transplant, based on its established criteria;

(4) Expenses are eligible to be paid under any private or public research fund, government program, except Medicaid, or another funding program, whether or not such funding was applied for or received;

(5) The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in this Plan;

(6) The expense relates to the donation or acquisition of an organ for a recipient who is not covered by this Plan;

(7) A denied transplant is performed; this includes the pre-transplant evaluation, pre-transplant services, the transplant procedure, post-discharge services, immunosuppressive drugs and complications of such transplant;

(8) The covered person for whom a transplant is requested has not met pre-transplant criteria as established by the plan.

Covered Services

For approved transplants, and all related complications, this Plan will cover only the following expenses:

(1) Hospital and qualified practitioner services, payable as shown on the Medical Schedule of Benefits. If services are rendered at an In-Network facility, covered expenses are paid in accordance to the contracted rates;

(2) Organ acquisition and donor costs. Covered transplant-related expenses incurred by a living donor will be payable as follows:

- If both the recipient and donor are covered under this Plan, all eligible expenses will be payable under the Plan and will be considered expenses of the Recipient.
- If the recipient is covered under this Plan but not the donor, donor expense will be eligible provided such expenses are not covered under any plan covering the donor. Benefits are limited to the maximum stated in the Medical Benefits Schedule.
- If the donor is covered under this Plan but the recipient is not, the donor's expenses are covered provided such expenses are not covered under any plan covering the recipient's expenses. The recipient's expense will not be covered under this Plan.

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

(o) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

Massage Therapy and Aquatic Therapy are covered benefits when rendered as part of a treatment plan.

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

(q) Routine **Preventive Care.** Preventive Care services include Inpatient services, Outpatient services and Physician Home Visits and Office Services. These services may vary based on the age, sex, and personal history of the individual, and as determined appropriate by the Administrator's clinical coverage guidelines. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Some examples of Preventive Care Covered Services are:

- **Routine or periodic exams, including school enrollment physical exams.** (Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.)

  Examinations include, but are not limited to:

(1) Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

(2) Adult routine physical examinations.

(3) Pelvic examinations.

(4) Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.

(5) Annual dilated eye examination for diabetic retinopathy.

- **Immunizations** (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follows the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians.

  These include, but are not limited to:

  (1) Hepatitis A vaccine
  (2) Hepatitis B vaccine
  (3) Hemophilus influenza b vaccine (Hib)
  (4) Influenza virus vaccine
  (5) Rabies vaccine
  (6) Diphtheria, Tetanus, Pertussis vaccine.
  (7) Mumps virus vaccine.
  (8) Measles virus vaccine
  (9) Rubella virus vaccine
  (10) Poliovirus vaccine

- **Screening examinations**:

  (1) Routine vision screening for disease or abnormalities, including, but not limited to, diseases such as glaucoma, strabismus, amblyopia, cataracts.

  (2) Routine hearing screening

  (3) Routine screening mammograms.

  (4) Routine cytologic and chlamydia screening (including pap test).

  (5) Routine bone density testing for women

  (6) Routine prostate specific antigen testing

  (7) Routine colorectal cancer examination and related laboratory tests

Other covered Preventive services include: women's contraceptives, (not including abortifacients), sterilization procedures, and counseling.

The list of services included as Standard Preventive Care may change from time to time depending upon

government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

(r) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(s) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

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

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

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

in a manner determined in consultation with the attending Physician and the patient.

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

(u) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license.

Massage Therapy, Aquatic Therapy and Physical Therapy are covered benefits when rendered as part of a treatment plan.

(v) **Sterilization** procedures. Excludes reversal of sterilization.

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

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

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

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

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

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

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

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

(y) Charges associated with the initial purchase of a **wig after chemotherapy**.

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

(aa) **IV Therapy** in the home is a covered service, and coverage will be provided according to the schedule of benefits.

(bb) **Cochlear Implants** is a covered service, and will be provided according to the schedule of benefits. Medical criteria must be met and precertification must be obtained.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

ARC Administrators Care Coordination (855) 984-2583

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 2 business days after a Medical Emergency.

UTILIZATION REVIEW

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

The program consists of:

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

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

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

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

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

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

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

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

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator ARC Administrators at (855) 984-2583 **at least 48 hours before** services are scheduled to be rendered with the following information:

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

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact ARC Administrators **within 2 business days** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

> If the Covered Person does not receive authorization as explained in this section, the benefit payment may be reduced.

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

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

SECOND AND/OR THIRD OPINION PROGRAM

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

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

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

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

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

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

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

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

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

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Charges for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis, will be paid as outlined in the benefit schedule.

CASE MANAGEMENT

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

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

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

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

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

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

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

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

DEFINED TERMS

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

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

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

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

Brand Name means a trade name medication.

Break in Service means a period of at least 13 consecutive weeks during which the Employee has no Hours of Service. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves.

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

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

Cosmetic Dentistry means dentally unnecessary procedures.

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

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

Covered Transplant Procedure is any Medically Necessary human organ and tissue transplants or transfusions as determined by the Administrator, on behalf of the Employer including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Covered Transplant Services are all Covered Transplant Procedures and all Covered Charges directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any Diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

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

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

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more.

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

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

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used

to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

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

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

Employer is Hardin County Water District No. 2.

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

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

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

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

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

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

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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

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

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

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

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

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

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

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

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

Hospital is an institution which is engaged primarily in providing inpatient diagnostic and therapeutic services at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission, the American Osteopathic Association, or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises which are provided by or under the supervision of a staff of

Physicians; and it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s). The Plan Administrator may accept accreditation of a Hospital by an organization other than those specifically listed, provided that the designation of an alternative accreditation body is consistently applied across institutions.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Hours of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

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

Infertility means incapable of producing offspring.

Initial Measurement Period means the 3 month period beginning on the first day of the Calendar Month coinciding with or next following the Employee's Date of Hire. Notwithstanding the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

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

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of

immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

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

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

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

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

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

New Employee Stability Period means the 6 Calendar Month period that begins on the first day of the Calendar Month following the Calendar Month that begins on or after the Employee's anniversary date.

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

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

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

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

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

Plan means Hardin County Water District No.2 Employee Benefit Plan, which is a benefits plan for certain Employees of Hardin County Water District No.2 and is described in this document.

Plan Benefit Year is the 12-month period beginning on January 1st and ending on the following December 31st.

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

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

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

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

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

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

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

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

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

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.

(7) It is approved and licensed by Medicare.

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

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the Employer).

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

Standard Measurement Period means the 3 month period that begins each year on the first day of April and every 3 months thereafter. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

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

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

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. For Network Provider charges, the Usual and Reasonable Charge will be the contracted rate.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

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

(1) **Administrative Charges.** Charges for any of the following: failure to keep a scheduled visit; completion of claim forms or medical records or reports unless otherwise required by law; for Physician or Hospital's stand-by services; for holiday or overtime rates; membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provider their test results; specific medical reports including those not directly related to the treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

(2) **Administrative Examinations.** Charges for administrative examinations, including, but not limited to, paternity testing, premarital examinations, camp, school, sports or pre-employment physicals, insurance or disability examinations, and examinations to obtain professional licenses

(3) **Alternative Therapies.** Hypnotherapy, acupuncture and acupuncture therapy. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, aquatic therapy, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris. This exclusion also applies to biofeedback, recreational, or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing.

(4) **Bariatric Surgery.**

(5) **Biofeedback.**

(6) **Cold Laser Treatments.**

(7) **Complications of Non-Covered Treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(8) **Cosmetic Services.** Services, supplies, care or treatment provided mainly to improve physical appearance and not to treat Illness or Injury or to restore or improve a physiological function. This includes, but is not limited to, breast implants or enlargements (other than that related to reconstructive mammoplasty after mastectomy), liposuction, electrolysis, breast reduction surgery, and collagen therapy or injections.

(9) **Court Ordered.** Court ordered diagnostic testing or treatment.

(10) **Custodial Care.** Services or supplies provided mainly as a rest cure, half-way houses, maintenance or Custodial Care.

(11) **Dental Care.** Services or supplies in connection with dental care including treatment of congenital anomalies other than those Covered Charges related to the Injury to or care of the mouth, teeth or gums as described in Medical Benefits.

(12) **Dental Hospital Admissions,** unless the patient has another significant medical condition(s) unrelated to the proposed dental procedure(s).

(13) **Dietary Instruction.** Services or supplies for or related to dietary instruction or counseling except for diabetic related instruction or counseling.

(14) **Educational or Vocational Testing.** Services for educational or vocational testing or training.

(15) **Elective Abortion.** Charges for services, supplies and other care provided for elective abortions accomplished by any means as defined by applicable law.

(16) **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Reasonable Charges, or are for services not deemed to be eligible or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

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

(18) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational except as otherwise stated, or not Medically Necessary with the exception of Platelet Injections.

(19) **Eye Care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(20) **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(21) **Functional Therapy.** Charges for functional therapy for learning or vocational disabilities or for speech, hearing and/or occupational therapy, unless specifically covered under another provision by the Plan.

(22) **Genetic Testing.** Services for genetic testing without established Medical Necessity.

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

(24) **Growth Hormone Treatment** except for documented hormone deficiency or as determined by the Plan.

(25) **Gynecomastia.** For the surgical treatment of gynecomastia, except when Medically Necessary.

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

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

(28) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition.

(29) **Illegal Drugs or Medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including

both physical and mental health) condition.

(30) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.

(31) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization, except as otherwise shown in the Schedule of Benefits.

(32) **Marital or Pre-Marital Counseling.** Care and treatment for marital or pre-marital counseling.

(33) **Massage Therapy.** Charges for message therapy or from a massage therapist unless provided as part of a treatment plan by a licensed physical therapist or licensed chiropractor.

(34) **Miscellaneous Services.** Charges for miscellaneous services, including but not limited to, legal fees, travel, mileage, sales tax, telephone conversations, missed appointments, late payment fees, completion of forms, preparation of medical reports, medical testimony and copying of medical records.

(35) **Multifocal Lens Implants for Cataract Surgery.** Unifocal lens is covered.

(36) **Negligence.** For injuries resulting from adjudicated negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

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

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

(39) **Non-Emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if Precertification of the Medical Necessity for non-emergency services is obtained before Medical and/or Surgical services are provided; or if surgery is performed within 24 hours of admission.

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

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

(42) **Not Specified as Covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

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

(44) **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(45) **Plan Design Excludes.** Charges excluded by the Plan design as mentioned in this document.

(46) **Relative Giving Services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(47) **Repeated Services.** Charges for services rendered by more than one Physician or services repeated without Medical Necessity.

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

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

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

(51) **Smoking Cessation.** Care and treatment for Smoking Cessation services including Nicorette or related products, Nicoderm or related products. This exclusion does not apply to a service or supply required by the Patient Protection and Affordable Care Act.

(52) **Specified Counseling.** Care and treatment related to family, child, career, social adjustment, and pastoral or financial counseling.

(53) **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.

(54) **Surrogate Mother.** Charges for, or expenses incurred by, a surrogate mother, or the services of a surrogate mother.

(55) **Telephone consultations.** Charges for treatment or consultation provided via the telephone or the Internet, except as provided under the LiveHealth Online or Onlife Health Benefit.

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

(57) **Vertebral Decompression Therapy.**

(58) **Vitamins.** Megavitamin therapy, herbal supplements, nutritional supplements, vitamins and charges for their administration, except for Medically Necessary use of vitamin B-12 in the treatment of pernicious anemia. Enteral feedings and other nutritional electrolyte supplements, including infant formula and donor breast milk.

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

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Kroger Prescription Plan is the administrator of the pharmacy drug plan.

Prescription Drugs purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used are not covered.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug charge and is shown in the Schedule of Benefits.

Specialty Drugs

Specialty drugs are high-cost specialty medications.

Included in this category are high-cost, genetically engineered injectables (and selected oral drugs) designed to target and treat small populations with chronic, often complex diseases or conditions which require challenging regimens and a high level of expertise.

Mandatory Generic

If you purchase a brand name drug and a generic is available, in addition to the applicable percentage payable as shown in the Schedule of Benefits, you will pay the difference between the cost of the brand name drug and its generic equivalent.

Covered Prescription Drugs

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

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

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

(4) Injectable drugs or any prescription directing administration by injection.

Limits to This Benefit

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

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

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

Expenses Not Covered

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

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

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

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

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

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

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

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

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

(9) **Infertility.** A charge for infertility medication. (See the Schedule of Benefits for limited coverage for infertility.)

(10) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

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

(12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

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

(15) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

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

HOW TO SUBMIT A CLAIM

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

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

(1) Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or Dentist complete the provider's portion of the form.

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

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

(5) Send the above to the Claims Administrator at this address:

ARC Administrators
PO Box 12290
Lexington, Kentucky 40582
(855) 981-2583

WHEN CLAIMS SHOULD BE FILED

Claims from Network Provider should be filed with the Claims Administrator within 180 days of the date charges for the service were incurred. Non-Network providers must file claims within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

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

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

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

CLAIMS PROCEDURE

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

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below.
Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

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

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

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

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	60 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

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

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

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

(5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

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

making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

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

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

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

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

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

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

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

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

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

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

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

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care

professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

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

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

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

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

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

(5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.

(6) A statement that the claimant 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.

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

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

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

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

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

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

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

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

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

(1) The claimant's medical records;

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

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating 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's clinical reviewer.

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

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan. The balance due, if any, is the responsibility of the Covered Person.

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

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

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

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

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

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

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

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

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

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

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

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

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

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

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

Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

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

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

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

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

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

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

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

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

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

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

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

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

through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

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

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

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

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

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

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

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

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

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

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

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

The Covered Person:

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

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

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

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

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

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

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

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

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

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

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

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Hardin County Water District No. 2 Employee Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage under the Plan is administered by the COBRA Administrator. The COBRA Administrator is ARC Administrators, PO Box 12290, Lexington, Kentucky 40582, (855) 981-2583. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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

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

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

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

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

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

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

continuation coverage.

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

(1) The death of a covered Employee.

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

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

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

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

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

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

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the

Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment - related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

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

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

(2) death of the Employee,

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

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the COBRA Administrator at PO Box 12290, Lexington, Kentucky 40582, within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable.

You must mail, fax or hand-deliver your notice to the person, department or firm shown above.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

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

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

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

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

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

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

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

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

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

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

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the **COBRA Administrator at PO Box 12290, Lexington, Kentucky 40582, (855) 981-2583**. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. HARDIN COUNTY WATER DISTRICT NO. 2 Employee Benefit Plan is the benefit plan of HARDIN COUNTY WATER DISTRICT NO. 2, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator. An individual or committee may be appointed by Hardin County Water District No. 2 to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, HARDIN COUNTY WATER DISTRICT NO. 2 shall appoint a new Plan Administrator as soon as reasonably possible.

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

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

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

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

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

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

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

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

(7) To perform all necessary reporting.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified.

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

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

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

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility.

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

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for, or of, employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The

person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Hardin County Water District No. 2 Employee Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 61-0675437

PLAN EFFECTIVE DATE: January 1st

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION

Hardin County Water District No. 2
360 Ring Road
Elizabethtown, Kentucky 42701

PLAN ADMINISTRATOR

Hardin County Water District No. 2
360 Ring Road
Elizabethtown, Kentucky 42701

NAMED FIDUCIARY

Hardin County Water District No. 2
360 Ring Road
Elizabethtown, Kentucky 42701

AGENT FOR SERVICE OF LEGAL PROCESS

Hardin County Water District No. 2
360 Ring Road
Elizabethtown, Kentucky 42701

CLAIMS ADMINISTRATOR

ARC Administrators
PO Box 12290
Lexington, Kentucky 40582
(855) 981-2583

BY THIS AGREEMENT, HARDIN COUNTY WATER DISTRICT NO. 2Employee Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for HARDIN COUNTY WATER DISTRICT NO. 2 on or as of the day and year first below written.

By Shaun Youravich

HARDIN COUNTY WATER DISTRICT NO. 2

Date 4-15-22

Witness Lea Ona Sims

Date 4/15/22

HIPAA PRIVACY AMENDMENT

HARDIN COUNTY WATER COUNTY DISTRICT NO.2 EMPLOYEE BENEFIT PLAN

BY THIS AGREEMENT, HARDIN COUNTY WATER DISTRICT NO. 2 Employee Benefit Plan, the medical, dental, and prescription drug plan(s) (herein called the "Plan") are hereby amended as follows, effective as of January 1, 2019.

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

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the Employer is amending the Plan as follows:

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

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health information that consists of genetic information will not be used for underwriting purposes.

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

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

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

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

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

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

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

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

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

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

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

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

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

Schedule I

The following members of HARDIN COUNTY WATER DISTRICT NO. 2's workforce are designated as authorized to receive Protected Health Information from HARDIN COUNTY WATER DISTRICT NO. 2 Employee Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: HARDIN COUNTY WATER DISTRICT NO. 2 Human Resources staff.

IN WITNESS WHEREOF this Agreement has been executed on behalf of HARDIN COUNTY WATER DISTRICT NO. 2, a corporation on January 1, 2019.

By ______________________

Witness ______________________

AMENDMENT #1 TO THE HARDIN COUNTY WATER DISTRICT NO. 2 EMPLOYEE BENEFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS FIRST AMENDMENT TO THE HARDIN COUNTY WATER DISTRICT NO. 2 EMPLOYEE BENEFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (the "Amendment"), is made and shall take effect as of January 1, 2020. This Amendment is made and entered into by HARDIN COUNTY WATER DISTRICT NO. 2, (the "Plan Sponsor"), with its principal place of business located at 360 Ring Road, Elizabethtown, Kentucky 42701.

WHEREAS, the Plan Sponsor has in effect an existing Plan Document and Summary Plan Description; and

WHEREAS, the Plan Sponsor hereto desires to amend the existing Plan Document and Summary Plan Description to modify the terms;

WHEREAS, the Plan Sponsor hereto desires for this amendment to take effect as of January 1, 2020;

NOW, THEREFORE, the Plan Document and Summary Plan Description for HARDIN COUNTY WATER DISTRICT NO. 2 Employee Benefit Plan is hereby amended as follows:

1. Amendments to existing Plan Document and Summary Plan Description.

   (a) PROVIDER NAME CHANGE. Pg 15 The PPO grids are hereby amended. All references to Lincoln Trail Diagnostics throughout the grids are hereby removed and deleted from the plan document.

   All references to Lincoln Trail Diagnostics throughout the grids are now referring to Heartland Diagnostics.

All sections of the Plan Document and Summary Plan Description not specifically mentioned in this amendment shall remain intact as in the original Plan Document and Summary Plan Description.

BY THIS AGREEMENT, HARDIN COUNTY WATER DISTRICT NO. 2 EMPLOLYEE BENEFIT PLAN is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for HARDIN COUNTY WATER DISTRICT NO. 2 EMPLOLYEE BENEFIT PLAN on or as of the day and year first below written.

By Michael Bell
HARDIN COUNTY WATER DISTRICT NO. 2

Date 12-22-20

Witness LeaOna Sims

Date 12/22/20

AMENDMENT #3 TO THE HARDIN COUNTY WATER DISTRICT NO. 2 EMPLOYEE BENEFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS THIRD AMENDMENT TO THE HARDIN COUNTY WATER DISTRICT NO. 2 EMPLOYEE BENEFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (the "Amendment"), is made and shall take effect as of June 1, 2022. This Amendment is made and entered into by HARDIN COUNTY WATER DISTRICT NO. 2, (the "Plan Sponsor"), with its principal place of business located at 360 Ring Road, Elizabethtown, Kentucky 42701.

WHEREAS, the Plan Sponsor has in effect an existing Plan Document and Summary Plan Description; and

WHEREAS, the Plan Sponsor hereto desires to amend the existing Plan Document and Summary Plan Description to modify the terms;

WHEREAS, the Plan Sponsor hereto desires for this amendment to take effect as of June 1, 2022;

NOW, THEREFORE, the Plan Document and Summary Plan Description for HARDIN COUNTY WATER DISTRICT NO. 2 Employee Benefit Plan is hereby amended as follows:

1. Amendments to existing Plan Document and Summary Plan Description.

   (a) PRESCRIPTION PROGRAM. The Hardin County Water District No. 2 Employee Benefit Plan is hereby adopting the immediately following Prescription Program as part of their Employee Benefit Plan.

All sections of the Plan Document and Summary Plan Description not specifically mentioned in this amendment shall remain intact as in the original Plan Document and Summary Plan Description.

BY THIS AGREEMENT, HARDIN COUNTY WATER DISTRICT NO. 2 EMPLOLYEE BENEFIT PLAN is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for HARDIN COUNTY WATER DISTRICT NO. 2 EMPLOLYEE BENEFIT PLAN on or as of the day and year first below written.

By ___[signature]___
HARDIN COUNTY WATER DISTRICT NO. 2

Date 6/9/22

Witness LeaOna Sims

Date 6/9/22

*For Specialty360 Co-Pay Assistance Program:

Listed Specialty Prescription Drugs

For certain specialty prescription drugs, manufacturer copay assistance may be available under the Specialty360 program administered by Kroger Prescription Plans, Inc. ("KPP"), the pharmacy claims administrator for the Plan, and Kroger Specialty Pharmacy, the Plan's specialty pharmacy provider.

If a [member/participant] is prescribed a specialty drug that qualifies for copay assistance under the Specialty360 program, the [member/participant] may choose to enroll in the drug manufacturer's copay assistance program with KPP's assistance. If a [member/participant] is enrolled in the drug manufacturer's copay assistance program, some or all of the Specialty 360 copays will be offset so that the [member's/participant's] actual cost will be reduced. The copay percentage or dollar amount of the copay varies based on the specialty prescription drug. However, only the amount paid directly by the [member/participant] is credited to the [member/participant's] deductible and out-of-pocket maximum. The portion of the copay paid by the drug manufacturer is not credited to the [member/participant's] annual deductible or out-of-pocket maximum.

If a [member/participant] does not enroll in the drug manufacturer copay assistance program, the [member/participant] will pay the full amount of the copay percentage or dollar amount for the specialty prescription drug required by the plan. In this case, the higher copay amount will be applied to the [member/participant's] annual deductible and out-of-pocket maximum.

Other Prescription Drugs

Manufacturer copay assistance programs or coupons may be available for prescription drugs other than those listed specialty prescription drugs covered by the Specialty360 program. To the extent that any [member/participant] utilizes a drug manufacturer's coupon or enrolls in a drug manufacturer's copay assistance program that pays for all or some of the [member's/participant's] copay for a prescription drug covered by the Plan, the portion of the copay paid by the drug manufacturer will not be credited to the [member's/participant's] annual deductible or out-of-pocket maximum.

HARDIN COUNTY WATER DISTRICT NO.2

Anthem

JOINT ADMINISTRATION ARRANGEMENT PRODUCT

ADMINISTRATION RENEWAL DATE JANUARY 1, 2023

PROPOSAL DATE SEPTEMBER 21, 2022

ENROLLMENT

	MEDICAL
COMPOSITE ENROLLMENT	80

PROPOSAL ISSUED TO HOUCHENS INSURANCE GROUP
UTILIZATION MANAGEMENT ASPIRANT UTILIZATION MANAGEMENT
PHARMACY BENEFIT MANAGEMENT CONSULTANT MANAGED
REINSURANCE ASPIRANT REINSURANCE MANAGEMENT

BLUERE

REINSURANCE OPTIONS THAT OFFER SUPERIOR PROTECTION SUPPORTED BY THE STRENGTH OF THE BLUE CROSS AND BLUE SHIELD NETWORK. ENJOY IMMEDIATE REIMBURSEMENT OF STOP LOSS CLAIMS WITH OUR INCLUSIVE ADMINISTRATIVE SERVICES PRODUCT.*

ADMINISTRATIVE SERVICES

PLAN MANAGEMENT FEES

	CURRENT	RENEWAL (Option 1)	RENEWAL (Option 2)	RENEWAL (Option 3)
COMPOSITE ADMINISTRATIVE SERVICES FEE	31.50	35.00	35.00	35.00
PLAN ADMINISTRATION				
ASPIRANT UTILIZATION MANAGEMENT				
BASE ANTHEM EAP SERVICES				
TOTAL ANNUAL ADMINISTRATIVE SERVICES FEE	30,240	33,600	33,600	33,600
COMPOSITE ANTHEM NETWORK ACCESS FEE	30.38	31.00	31.00	31.00
TOTAL ANNUAL NETWORK ACCESS FEE	29,165	29,760	29,760	29,760
CONSULTANT SERVICES FEE	16.00	16.00	16.00	16.00
REINSURANCE COMMISSION PERCENTAGE	0.0%	0.0%	0.0%	0.0%
CONSULTANT ANNUAL REINSURANCE COMMISSION	-	-	-	-
TOTAL ANNUAL CONSULTANT COMPENSATION	15,360	15,360	15,360	15,360
OPTIONAL ADMINISTRATIVE SERVICES				
DENTAL ADMINISTRATION	2.75	3.75	3.75	3.75
VISION ADMINISTRATION	1.00	1.15	1.15	1.15
STD ADMINISTRATION	1.00	1.15	1.15	1.15
FSA ADMINISTRATION	6.50	6.95	6.95	6.95
HRA/HSA ADMINISTRATION	6.50	6.95	6.95	6.95
COBRA ADMINISTRATION	-	2.25	2.25	2.25

OVERALL PLAN COST SUMMARY

	CURRENT	RENEWAL (Option 1)	RENEWAL (Option 2)	RENEWAL (Option 3)
EXPECTED CLAIM LIABILITY	757,455	719,693	740,621	766,080
EXPECTED CLAIM FUNDING FACTOR	789.02	749.68	771.48	798.00
EXPECTED VALUE BASED ACCESS FEE FACTOR	-	-	-	-
MAXIMUM CLAIM LAIBILITY	946,819	899,616	925,776	957,600
ANNUAL FIXED COSTS	411,341	447,087	425,502	406,767
EXPECTED ANNUAL PLAN COST	1,168,796	1,166,780	1,166,123	1,172,847
MAXIMUM ANNUAL PLAN COST	1,358,160	1,346,703	1,351,278	1,364,367
INITIAL SELECTION		SY		

Shawn Yance[?], General Manager — OFFICER SIGNATURE

9-28-22 — DATE

REINSURANCE COVERAGE

REINSURANCE INFORMATION

BLUERE REINSURANCE SOLUTIONS

	CURRENT	RENEWAL (Option 1)	RENEWAL (Option 2)	RENEWAL (Option 3)
SPECIFIC REINSURANCE	35,000	35,000	40,000	45,000
MEDICAL/RX	15/12	15/12	15/12	15/12
AGGREGATING SPECIFIC DEDUCTIBLE	-	-	-	-
COMPOSITE	336.85	369.97	345.61	324.17
AGGREGATE REINSURANCE	15/12	15/12	15/12	15/12
COMPOSITE	13.75	13.75	15.62	17.55
TERMINAL LIABILITY (TLO) FEE	-	-	-	-
MONTHLY ACCOMMODATION (MA) FEE	-	-	-	-
COMPOSITE	13.75	13.75	15.62	17.55
AGGREGATE CLAIM FUNDING FACTOR				
COMPOSITE	986.27	937.10	964.35	997.50
OVERALL COMPOSITE	1,414.75	1,402.82	1,407.58	1,421.22
MONTHLY AGGREGATE CALCULATION	78,902	74,968	77,148	79,800
ANNUAL AGGREGATE ATTACHMENT POINT	946,819	899,616	925,776	957,600
ANNUAL REINSURANCE PREMIUM	336,576	368,367	346,782	328,047
INDIVIDUAL SPECIFIC DEDUCTIBLE				
CLAIMANT I	70,000	70,000	70,000	70,000
CLAIMANT II	-	90,000	90,000	90,000

CONSULTANT MANAGED PHARMACY BENEFIT MANAGEMENT**

	REBATE	DISCOUNT	PER SCRIPT FEE
RETAIL BRAND			$ 1.15
RETAIL GENERIC			$ 1.15
MAIL/MAINTENANCE AT RETAIL BRAND			$ 2.25
MAIL/MAINTENANCE AT RETAIL GENERIC			$ 2.25
SPECIALTY PHARMACY			$ 2.25

CONSULTANT MANAGED PHARMACY BENEFIT MANAGEMENT

THE PHARMACY BENEFIT MANAGEMENT PROGRAM HAS BEEN DEVELOPED BY YOUR CONSULTANT AND HAS NOT BEEN NEGOTIATED, UNDERWRITTEN OR EVALUATED BY ARC ADMINISTRATORS**

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

*Requires use of Aspirant Pharmacy Benefit Optimization, Aspirant Utilization Management Services & BlueRe Stop Loss Services.

October 19, 2021

RE: 30800-390 Hardin County Water District No. 2

Hello

Thank you for choosing an Avēsis vision plan brought to you by The Dental Care Plus Group (DCPG). Below is your group's current plan information:

Current Plan: 927DCPG-L1
Lens Options Package: L1
Current rates: $6.96 / $12.16 / $13.20 / $16.04

Wholesale Frame Allowance: $50
Contact Lens Allowance: $130

Based on member utilization, we recommend the following packages, which provide more value than your current plan:

Lens Options	927DCPG-L1	Recommendation 1: 050130CYL3S	Recommendation 2: 050130CYL5S
Youth Polycarbonate	✓	✓	✓
Adult Polycarbonate		✓	✓
Standard Scratch		✓	✓
UV Screening		✓	✓
Solid or Gradient Tint		✓	✓
Standard Anti-Reflective		✓	✓
Level 1 Progressives			✓
Level 2 Progressives			
Plan Renewal Pricing	EE $6.96 ES $12.16 EC $13.20 EF $16.04	EE $8.97 ES $16.25 EC $17.69 EF $21.91	EE $10.39 ES $19.03 EC $20.73 EF $25.82
Duration	2-Years	2-Years	
Potential Member Savings		$268	$418
Renewal Selection	☐ 927DCPG-L1	☒ 050130CYL3S	☐ 050130CYL5S

If you wish to renew your plan, as is, for coverage effective January 01, 2022 to December 31, 2023, you do not need to take any action other than to pay your new premium when due. Your payment of the premium is acceptance of the renewal rates.

If you would like one of the new plan recommendations, please check the box of the option above and return this renewal agreement to your broker or DCPG by the 10th of the month prior to your renewal date. If you have questions or need additional information, please contact Jill Schulten at (800) 367-9466 or by email at jschulten@dentalcareplus.com.

Signature: Shan Youmans C Date: 11/17/21

Premium is subject to adjustment in the event of changes in benefits, contributions, or the number of eligible employees, or any future additional tax, fee, or assessment imposed by the federal or state governments with associated administrative costs and expenses.

Effective Date: 1/1/2022

Group Number: 30800-390

Plan Number: 927DCPG-L1

Hardin County Water District No. 2

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Vision Examination (Includes Refraction)	Covered in full after $10 copay	Up to $35
Materials*	$10 copay (Materials copay applies to frame or spectacle lenses, if applicable.)	
Frame Allowance	Members receive a $50 wholesale allowance Up to $150 retail value†	Up to $45
Standard Spectacle Lenses		
Single Vision	Covered in full after $10 copay	Up to $25
Bifocal	Covered in full after $10 copay	Up to $40
Trifocal	Covered in full after $10 copay	Up to $50
Lenticular	Covered in full after $10 copay	Up to $80
Preferred Pricing Options		
Level 1 Option Package		
Polycarbonate (Single Vision/Multi-Focal)	$40/$44 (Covered in full up to age 19)	N/A (Up to $10 for ages up to 19)
Standard Scratch-Resistant Coating	$17	N/A
Ultra-Violet Screening	$15	N/A
Solid or Gradient Tint	$17	N/A
Standard Anti-Reflective Coating	$45	N/A
Level 1 Progressives	$75	Up to $40
Level 2 Progressives	$110	Up to $40
All Other Progressives	$50 allowance + 20% discount	Up to $40
Transitions® (Single Vision/Multi-Focal)	$70/$80	N/A
Polarized	$75	N/A
PGX/PBX	$40	N/A
Other Lens Options	Up to 20% discount	N/A
Contact Lenses‡ (in lieu of frame and spectacle lenses)		
Elective	$130 allowance	Up to $130
Medically Necessary	Covered in full	Up to $250
Refractive Laser Surgery	Onetime/lifetime $150 allowance Provider discount up to 25%	Onetime/lifetime $150 allowance
Frequency		
Eye Examination	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 12 months	

*Discounts are not insured benefits.
†Value may be less depending on the providers retail pricing.
‡Prior authorization is required for medically necessary contacts.

Reliable & Dependable

Avēsis is a national leader in providing exceptional vision care benefits for millions of commercial members throughout the country.

The Avēsis vision care products give our members an easy-to-use wellness benefit that provides excellent value and protection.

Employer Paid Rates Per Month

Please see your H

Department for rates.

Underwritten by: Fidelity Security Life Insurance Company, Kansas City, MO

Policy #: VC-76, Form M-9059

How can we help you?

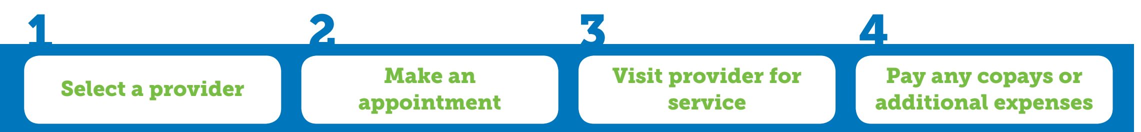
Avēsis Website:
www.avesis.com

Customer Service:
800-828-9341
7 a.m. - 8 p.m. EST

LASIK Provider:
877-712-2010

Here's How It Works

When you need to see an eye care professional, simply visit www.avesis.com or contact Avēsis' Customer Service Monday through Friday, 7 a.m. to 8 p.m. (EST) at 800-828-9341 to receive a listing of providers in your area.



*At participating Walmart/Sam's locations, retail pricing for your plan is $68 . At participating Costco locations, retail pricing is $54.99 .

Using Out-of-Network Providers

Members who elect to use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Avēsis for reimbursement. Reimbursement levels are in accordance with the out-of-network reimbursement schedule previously listed. Out-of-network benefits are subject to the same eligibility, availability, frequency of benefits, and limitation and exclusion provisions of the plan, and are in lieu of services provided by a participating Avēsis provider. Out-of-network claim forms can be obtained by contacting Avēsis' Customer Service Center or your group administrator, or by visiting www.avesis.com.

Limitations and Exclusions

Some provisions, benefits, exclusions, or limitations listed herein may vary depending on your state of residence.

Limitations:

This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the participating Avēsis provider. Benefits are payable only for services received while the group and individual member's coverage is in force.

Exclusions:

There are no benefits under the plan for professional services or materials connected with and arising from:
1) Orthoptics or vision training;
2) Subnormal vision aids and any supplemental testing, aniseikonic lenses;
3) Plano (non-prescription) lenses, sunglasses;
4) Two pair of glasses in lieu of bifocal lenses;
5) Any medical or surgical treatment of eye or supporting structures;
6) Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services;
7) Any eye examination or corrective eyewear required by an employer as a condition of employment and safety eyewear;
8) Services or materials provided as a result of Workers' Compensation Law, or similar legislation, required by any governmental agency whether Federal, State, or subdivision thereof.
9) Services or materials provided by any other group benefit plan providing vision care.

Refractive Surgery Vision Benefit Exclusions:

Benefits are not payable for any of the following:
1) Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames, or contact lenses; or
2) Medical or surgical procedures, services, or treatments:
   a. not specifically covered under this Rider;
   b. provided free of charge in the absence of insurance
   c. payable under any Workers' Compensation law or similar statutory authority
   d. payable under governmental plan or program, whether Federal, state, or subdivisions thereof.

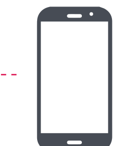
Termination Provisions

Coverage will end on the earliest of: the date the policy ends, the date the employee's employment ends, or the date the employee is no longer eligible.

Notes and Disclaimers

The contact lens allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only, or both contact lenses and professional services (fitting fees). Refractive Laser Surgery is considered an elective procedure, and may involve potential risks to patients. Avēsis is not responsible for the outcome of any refractive surgery. Discounts on materials are not available at Walmart locations. Members may not use their contact lens allowance toward fitting fees at Walmart and are responsible for any out-of-pocket fees associated with fittings there. Discounts on materials are not available at Costco locations. ID cards are not required for services.

Download Our Mobile App



**Please fax or email completed form to eligibility:
Fax: 855-591-3558 Email: eliggroup@avesis.com

PLEASE PRINT LEGIBLY

VISION CARE EMPLOYEE ENROLLMENT FORM

Underwritten by Fidelity Security Life Insurance Company *Kansas City, Missouri*

Policy No. VC-76

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name	Employee First Name	MI

Date of Birth	Social Security Number	Sex
/ /	- -	☐ Male ☐ Female

Street Address	Apartment No.

City	State	Zip Code
		-

Do you wish to cover your eligible dependents? ☐ Yes ☐ No

If yes, complete the following:

	Dependent Name FIRST	LAST	Date of Birth
Spouse / Domestic Partner			/ /
Child			/ /
Child			/ /
Child			/ /
Child			/ /
Child			/ /
Child			/ /

☐ *I would like to cover additional eligible dependents* (PLEASE LIST ON A SECOND ENROLLMENT FORM)

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Signature	Date / /

A-00713KY(4/04) M-9059

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ○ Dependent(s)	☐ **Change** ○ Address ○ Phone ○ Name ○ COBRA	☐ **Cancel Coverage** ○ Policy Holder ○ Dependent(s)

Reason for Change ☐ Employment Status
☐ Qualifying Event: (PLEASE STATE) ____________________

Member Effective Date / /	*Date of Employment* / /

Employer Section

Underwriter Documents

FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

POLICY NUMBER: VC-76

POLICYHOLDER: Hardin County Water District No. 2

STATE OF ISSUE: Kentucky

POLICY EFFECTIVE DATE: 1/1/2022

POLICY ANNIVERSARY DATE: January

The Policy and the attached application form the entire contract between the Policyholder and the Company. Oral statements made by the Policyholder, by an Insured Person, by the Company's agent, or by any other person are not part of the Policy. Only the Company's President or a Vice President may make changes for the Company. Such changes must be in writing and attached to the Policy. The Company reserves the right to amend the Policy from time to time.

The Company will pay, with respect to each Insured Person, the insurance benefits provided in the Policy. Payment is subject to the conditions, limitations and exceptions of the Policy. Eligibility requirements to be insured under the Policy are stated in the attached application. The Policy is governed by the laws of the state shown above. The sections set forth on the following pages are a part of the Policy and take effect on the Policy Effective Date.

PREMIUMS

Premiums are payable in advance by the Policyholder. The first premium is due on the Policy Effective Date. Subsequent premiums are due on the first day of each calendar month thereafter. The required premium due on each premium due date is the sum of the premiums for all Insured Persons and their Dependents covered under the Policy. The premiums due will be determined by applying the premium rates then in effect for each type of insurance provided by the Policy to the number of Insured Persons. All premiums are payable to the Company at the Company's office or to the Company's authorized agent.

While the Policy is in force, changes may be required in the premium payable due to a change in insurance as follows:

1. if an amount of insurance is added or increased during a calendar month and the change is not due to a change in the terms of the Policy, premiums will be changed as of the date the change becomes effective;
2. if an amount of insurance is deleted or decreased during a calendar month and the change is not due to a change in the terms of the Policy, premiums will cease at the end of the calendar month in which the deletion or decrease occurred; or
3. if amounts of insurance are changed during a calendar month due to a change in the terms of the Policy, the premium charge or credit will be computed as of the effective date of the change.

GROUP VISION INSURANCE POLICY
THIS IS A LIMITED BENEFIT POLICY
This Policy is a legal contract between the Policyholder and the Company.
Please read the Policy carefully.

If premiums are due the Company or premium refunds are due the Policyholder as a result of clerical error in the reporting of dates to the Company, all premiums or refunds will be calculated at the current rate of premium payment.

Premium Rate Change. The Company may change the premium rate on any Policy Anniversary Date. The Company will give the Policyholder written notice of any premium rate change at least 31 days prior to the change.

Grace Period. A grace period of 31 days will be allowed to the Policyholder for the payment of each premium due after the first premium. The Policy will remain in force during the grace period. If the required premium is not paid by the end of the 31-day period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

Return of Premium. The Company reserves the right to rescind coverage on one or all employees due to misrepresentation or fraud on the application for the Policy or an employee's enrollment form if such misrepresentation materially affected the acceptance of the risk. If, on the date coverage is rescinded, no claims have been paid under the Policy, the Company will return to the Policyholder all premiums paid for such coverage. If, on the date coverage is rescinded, claims have been paid under the Policy, the Company reserves the right to deduct an amount equal to the amount of such claims paid from the premiums returned to the Policyholder.

TERMINATION OF POLICY

The Policyholder or the Company may terminate or cancel the Policy on any date on or after the first Policy Anniversary Date. Written notice must be provided to the other party at least 31 days prior to termination.

CERTIFICATES

The Company will furnish to the Policyholder a Certificate that will set forth the essential features of the insurance coverage.

ADDITIONAL INSURED PERSONS

Insured Persons may be added at any time if they meet the eligibility requirements stated in the Policyholder's application, complete an enrollment form, if required, and pay any required premium contributions.

INCORPORATION PROVISION

The provisions of the attached Certificate and all Rider(s) issued to amend the Policy after its effective date are made a part of the Policy. The Policy is issued by Fidelity Security Life Insurance Company at Kansas City, Missouri on the Policy Effective Date.

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

FIDELITY SECURITY LIFE INSURANCE COMPANY
3130 Broadway • Kansas City, Missouri 64111-2406 • (800) 648-8624

Group Insurance Certificate Providing Limited Benefits for Vision Care Non-Participating

This Certificate will take the place of any and all Certificates and Riders which may have been issued to You at a prior time under the Policy.

GENERAL INFORMATION

About Your Insurance - This Certificate explains the plan of insurance which is underwritten by Fidelity Security Life Insurance Company. Read it closely to become familiar with Your plan. An individual identification card will be issued to You containing Your Group Number and Your Effective Date.

Important Notice - Benefits are payable only for expenses incurred while this insurance is in force. No agent has the right to change the Policy or to waive any part of it. The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy. The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance. The benefits for Dependents which are described in this Certificate will be applicable to Your Dependents only if You make application to have Your Dependents insured.

DEFINITIONS

The following terms have specific meaning as used in the Policy.

Covered Person means an employee meeting the eligibility requirements of the Policy who is covered for benefits. Covered Person will also include Your Dependents, if enrolled.

Dependent means any of the following persons: 1) Your lawful spouse; 2) Each unmarried child from birth to age 19 who is primarily dependent upon You for support and maintenance; 3) Each unmarried child at least 19 years of age to age 25 who is primarily dependent upon You for support and maintenance and who is a full-time student; or 4) Each unmarried child at least 19 years of age: who is primarily dependent upon You for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is a Covered Person under this Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday. Child includes stepchild, foster child, legally adopted child, child legally placed in Your home for adoption, and child under Your legal guardianship. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 15 or more hours weekly for six or more months.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder on the face of the Policy.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing Optician.

Vision Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Vision Materials means corrective lenses and/or frames or contact lenses.

THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

PLEASE READ THE CERTIFICATE CAREFULLY.

We, Our, Us means Fidelity Security Life Insurance Company.

You, Your, Yours means the employee covered under the Policy.

DEFINITIONS
(PPO and Non-PPO)

Preferred Agreement means an agreement between the PPO and a Provider concerning the rates and reimbursement methods for services and supplies provided by such Provider.

Non-Preferred Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Agreement with the PPO.

Preferred Provider means a Provider who has signed a Preferred Agreement with the PPO.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area who have signed Preferred Agreements with the Company.

PPO Service Area means the geographical area where the PPO is located. An Insured Person who does not have access to a Preferred Provider within 30 minutes or 30 miles of the Insured Person's residence or work may receive services from a Non-Preferred Provider. The Insured Person must pay the full cost at the time the covered service is provided and file a claim with the Company. The Company will reimburse the Insured Person for any costs above the Preferred Provider Co-payments and any cost up to the Preferred Provider allowances as shown in the Schedule of Benefits.

EFFECTIVE DATES

Effective Date of Employee's Insurance - Your insurance will be effective as follows: 1) If the Policyholder does not require You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible; 2) If the Policyholder requires You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible, provided; a) You have given Us Your enrollment form (if required) on, prior to, or within 30 days of the date You became eligible; and b) You have agreed, in writing, to pay the required contributions; 3) If You fail to meet the requirements (a) and (b) within 30 days after becoming eligible, Your coverage will not become effective until We have verified that You have met these requirements. You will then be advised of Your effective date.

Effective Date of Dependent's Insurance - Coverage for Dependents becomes effective on the later of: 1) the date Dependent Coverage is first included in Your coverage; or 2) the premium due date on or after the date the person first qualifies as Your Dependent. If an enrollment form is required, You must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

Newborn Children - If a Dependent is covered under Your Certificate, a Dependent child born while this Certificate is in force shall be covered from the moment of birth for 31 days. In order to continue coverage beyond this 31-day period, You must send Us notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period.

Adopted Children - If a Dependent child is placed with You for adoption while the Certificate is in force, such child will be covered from the date of placement for 31 days. In order to continue coverage beyond this 31-day period, You must send in notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

SCHEDULE OF BENEFITS

Covered Persons have the right to obtain vision care from the Provider of their choice. However, payment of the Benefit varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule:

Benefit	Preferred Provider	Non-Preferred Provider	Benefit Period
Vision Examination:	$10.00 copayment	$35.00	12 Months
Vision Materials:	$10.00	N/A	
Standard Lenses			12 Months
Single	Paid in full after copayment	$25.00	
Bifocal	Paid in full after copayment	$40.00	
Trifocal	Paid in full after copayment	$50.00	
Lenticular	Paid in full after copayment	$80.00	
Standard Progressives	$50.00	$40.00	
Frames	$50.00	$45.00	12 Months
*Contact Lenses**			12 Months
Elective	$130.00	$130.00	
Medically Necessary	Paid in full	$250.00	
Level 1 Lens Option Package			
Basic Polycarbonate	$0 copayment	$10.00	

**Contact Lenses* includes fit, follow-up and Materials.

Any services which cannot be obtained by a Preferred Provider within the PPO Service Area because: 1) due to their specialized nature, there is no Preferred Provider located within the PPO Service Area; 2) are provided by a Provider not in the PPO Service Area; and 3) are specifically authorized in advance by the Covered Person's Provider and approved by the Company, shall be paid in accordance with the Schedule of Benefits for a Preferred Provider, without further deductions, subject to all Policy maximums, limitations, conditions and exclusions.

Benefit Period for Vision Examination is shown in the Schedule of Benefits and begins on Policy Effective Date.

Benefit Period for Vision Materials is shown in the Schedule of Benefits and begins on the Policy Effective Date.

Vision Examination Benefit - A Covered Person is eligible for one Vision Examination in each successive Benefit Period.

Vision Materials Benefit - If a Vision Examination results in a Covered Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials prescribed by Providers will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- Lenses - Up to two lenses provided one time in each successive Benefit Period.
- Frame - One frame provided one time in each successive Benefit Period.
- Contact Lenses - Contact lenses benefit provided in lieu of lenses and/or frame.

LIMITATION

Vision Examination and Vision Materials - Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider. Such fees or materials are not covered under this Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Period, except for Contact Lenses benefit.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: 1) Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes, or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state, or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; or 8) Services or materials provided by any other group benefit plan providing vision care.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

TERMINATION OF INSURANCE

For all Covered Persons - All Covered Persons' insurance will end automatically on the earliest of the following dates: a) The date the Policy ends; b) The end of the last period for which any required contribution agreed to in writing has been made, subject to the Grace Period provision; c) The date You are no longer eligible for insurance; d) The date Your employment with the Employer ends. Your coverage will end on the last day of the month in which employment ends. The Employer may, at its option, continue insurance for individuals whose employment has ended, if it: (i) does so without individual selection between employees; and (ii) if it continues making premium payments for those individuals.

For Dependents - A Dependent's insurance will automatically stop on the earlier of: a) the date Your coverage ends; b) the end of the month in which the Dependent ceases to be Your Dependent; c) the end of the last period for which any required contribution has been made.

A Dependent Child will not cease to be a Dependent solely because of age if the child is: a) not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and b) mainly dependent on You for support.

We may ask for proof of the eligible child's incapacity and dependency two (2) months before the date the Dependent would otherwise cease to be covered.

We may require the same proof again, but We will not ask for it more than once a year after this coverage has been continued for two (2) years. This continued coverage will end: a) on the date the Policy ends; b) the date the incapacity or dependency ends; c) the last day of the month for which required premium for the child is paid; or d) 60 days after the date We request proof which is not given to Us.

CLAIMS

Notice Of Claim. Written notice of claim must be given: (a) within 60 days after a covered loss begins; or (b) as soon as reasonably possible after that. This notice may be given to Us at Our Home Office or to Our Administrator. Notice should include the Covered Person's name and the Policy and Certificate numbers.

Claim Forms. When We receive notice of claim, We will send the claimant forms for filing proof of loss within 15 days. If claim forms are not supplied within this 15-day period, a claimant may submit proof in writing, setting forth the nature and extent of the loss.

Proof Of Loss. Proof of loss must be furnished to Us within 90 days after the date of loss. We will not deny or reduce a claim if it was not reasonably possible to give Us proof within the time allowed. In any event, the Covered Person must give Us proof within one (1) year after it is due unless he is legally incapacitated.

Time Of Payment Of Claims. Immediately after receiving written proof of loss, We will pay all benefits then due a Covered Person.

Payment Of Claims. All claims will be paid to You, unless We have the obligation to pay the facility or Provider directly. However, in the event a benefit becomes payable to Your estate, We may pay such benefit, up to an amount equal to $1,000, to any relative by blood or connection by marriage whom We deem to be equitably entitled thereto. Payment made in good faith fully discharges Us to the extent of any payments made.

Legal Actions. No legal actions may be brought to recover under the Policy: (1) within 60 days after written proof of loss has been furnished as required; or (2) after three years from when written proof of loss is required.

Claim Appeal Procedure. A Covered Person has the right to an internal appeal of a utilization review decision made by or on behalf the Company with respect to the denial, reduction, or termination of a limited health service benefit plan or the denial of payment for a health care service, and the procedure to initiate an internal appeal.

The internal appeals process may be initiated by the Covered Person, an authorized person or a Provider acting on behalf of the Covered Person. The Covered Person, authorized person or Provider acting on behalf of the Covered Person should request on internal appeal within sixty (60) days of receipt of a notice of an adverse determination or coverage denial; and the internal appeal decision must be provided within thirty (30) days.

GENERAL PROVISIONS

Entire Contract. The Policy is a legal contract. It is between the Policyholder and Us. The entire contract consists of: (1) the Policy, the Certificate, endorsements and attachments, if any; (2) the Policyholder's Application; and (3) the employees' enrollment forms, if any. Any statement made by the Policyholder or by a Covered Person in an application will, in the absence of fraud, be deemed a representation and not a warranty. No such statement will void the coverage or reduce the benefits or be used in defense to a claim unless it is in writing and a copy of the application is furnished to the Covered Person.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Additional Insureds. Eligible persons may be added to the original insured group under the Policy, from time to time, according to the terms of the Policy.

Modification Of Policy. The Policy may be modified at any time by agreement between the Policyholder and Us without consent of any employee. No modification will be valid unless approved by one of Our officers: (1) the President; (2) a Vice President; or (3) the Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy or waive any of the Policy's provisions to extend the time for premium payment by making any promise or representation.

Incontestability. The validity of the Policy shall not be contested except for non-payment of premiums, fraudulent misstatements or material misrepresentations after it has been in force for two (2) years. Coverage under this Certificate shall not be contested except for non-payment of premiums or material misrepresentation after it has been in force for two (2) years. No statement, except fraudulent misstatements, made by You relating to: 1) Your insurability; or 2) The insurability of Your Dependents; shall be used in contesting the validity of the coverage of the person about whom the statement was made after coverage has been in force for a period of two (2) years. Any such statement must be contained in a written instrument signed by You, a copy of which has been furnished to You.

Fraud. If You or the Policyholder commits fraud pertaining to an employee against Us, as determined by a court of competent jurisdiction, Your coverage will end automatically without notice.

Misstatement Of Age. If a Covered Person's age has been misstated, the benefits will be those which the premium paid would have bought for the correct age. If a Covered Person's correct age was over the maximum issue age, coverage will be voided and the premiums paid for such Covered Person will be refunded.

Assignment Of Benefits. You may assign Your benefits. However, an assignment is not binding until We have received and acknowledged in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

Grace Period. A grace period of 31 days will be allowed for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. If the premium is not paid within the grace period, coverage will terminate as of the premium due date. The grace period will not apply if the Covered Person gives written notice to Us of his or her intent not to continue this coverage.

FIDELITY SECURITY LIFE INSURANCE COMPANY

President Secretary

FIDELITY SECURITY LIFE INSURANCE COMPANY
3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
A STOCK COMPANY
(Herein Called "the Company")

AMENDMENT RIDER

By attachment of this Rider, the second paragraph of the **PREMIUMS** section in the Policy is amended to add the following:

4. if a government action, including fees, taxes and assessments, or change in law or regulation materially affects the Company's risk, premium may be adjusted and will be effective upon written notification from the Company at least 31 days before the date of change.

This Rider takes effect on the effective date of the Policy to which it is attached. This Rider terminates concurrently with the Policy to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy except as stated.

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REFRACTIVE SURGERY BENEFIT RIDER

This Rider amends the Policy/Certificate to which it is attached. The following refractive surgical benefits are added:

DEFINITIONS

Injury means a bodily Injury sustained directly and independently of all other causes resulting in a covered loss under this Rider.

LASEK (Laser Assisted Epithelium Keratomileusis) means a slight variation of the traditional LASIK procedure as described below. This surgical procedure utilizes a trephine to create an epithelial flap (as opposed to the deeper stromal flap with LASIK) and an alcohol solution to preserve the epithelial cells. Once the epithelial flap is created and lifted, the treatment proceeds as for traditional PRK, with light smoothing at its conclusion. The epithelial flap is then repositioned with a small spatula.

LASIK (Laser Assisted In-Situ Keratomileusis) means a surgical procedure involving the use of a computer-controlled excimer laser to reshape the cornea (epithelium) without invading the adjacent cell layers. An automated microkeratome is used to shave off a thin, hinged layer of the cornea that is lifted, and the exposed surface is reshaped using the laser. After altering the cornea curvature, the flap is replaced and is adhered without stitches. In **IntraLase Initiated LASIK**, a special laser is used instead of a blade to create the flap. In **Custom Wavefront** or **Wavefront-Guided LASIK** procedures, a 3-dimensional measurement of how the eye processes images is used to guide the laser in re-shaping the front part of the eye (cornea).

PRK (Photorefractive Keratectomy) means a surgical procedure involving removal of the surface layer of the cornea by gentle scraping and use of a computer-controlled excimer laser to reshape the stroma.

Physician means an Ophthalmologist or Optometrist licensed under applicable state law to perform the surgical procedures for which benefits are payable under this Rider, and who is acting within the lawful scope of his or her license to render such service. A Physician cannot be the Covered Person or a member of the Covered Person's Immediate Family. "Immediate Family" means the Covered Person or the Covered Person's spouse, parent, child, grandparent, brother, sister, in-law or any person residing with the Covered Person.

Refractive Surgery means a surgical procedure which permanently alters the focusing power of the eye(s) in order to change refractive errors.

BENEFITS

Refractive Surgery Benefit. The Company will pay a one-time surgical indemnity benefit of $150 (per Covered Person) for one of the following refractive surgical procedures to one or both eyes: LASIK (including Custom Wavefront, Wavefront-Guided or IntraLase initiated LASIK), LASEK or PRK, if performed by a Physician on a Covered Person while covered under this Rider, subject to the Exclusions provision.

EXCLUSIONS

Refractive Surgery Vision Benefit Exclusions

Benefits are not payable for any of the following:

1. Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames or contact lenses; or
2. Medical or surgical procedures, services or treatments:
   a. not specifically covered under this Rider;
   b. provided free of charge in the absence of insurance;
   c. if the Covered Person is eligible for benefits under any Workers' Compensation law, or similar statutory authority; or
   d. payable under any governmental plan or program whether Federal, state or subdivisions thereof, except for medical assistance benefits under title XIX of the Social Security Act (Medicaid).

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

FIDELITY SECURITY LIFE INSURANCE COMPANY

President

Secretary

FIDELITY SECURITY LIFE INSURANCE COMPANY

3130 Broadway
Kansas City, Missouri 64111-2406
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A STOCK COMPANY
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AMENDMENT RIDER

By attachment of this Rider, the Policy/Certificate is amended by the following:

> Any provision of the Policy/Certificate that provides coverage for a Dependent child up to a certain age is amended to cover such child to age 26, regardless of financial dependency, residency, student status, or marital status.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

FIDELITY SECURITY LIFE INSURANCE COMPANY

President | Secretary

FACTS	WHAT DOES Fidelity Security Life Insurance Company, Fidelity Security Life Insurance Company of New York (NY Only) and Affiliates DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ■ Social Security number and transaction history ■ medical information and insurance claim information ■ assets and checking account information When you are no longer our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Fidelity Security Life Insurance Company and Affiliates choose to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Fidelity Security Life share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	Call 800-648-8624 or go to www.fslins.com or www.ftj.com

Page 2

Who we are	
Who is providing this notice?	Fidelity Security Life Insurance Company and Affiliates including our Administrative, Insurance and Financial Service Providers.

What we do	
How does Fidelity Security Life Insurance Company and Affiliates protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. These physical, electronic and procedural safeguards were created to protect your information. We also limit employee access as appropriate.
How does Fidelity Security Life Insurance Company and Affiliates collect my personal information?	We collect your personal information, for example, when you ■ apply for insurance or pay insurance premiums ■ file an insurance claim or give us your contact information ■ show your driver's license We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only ■ sharing for affiliates' everyday business purposes – information about your creditworthiness ■ affiliates from using your information to market to you ■ sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ■ *Our affiliates include Fidelity Security Life Insurance Company of New York, Forrest T. Jones & Company, Inc., Forrest T. Jones Consulting Company and National Pension & Group Consultants, Inc.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ■ *Fidelity Security Life Insurance Company does not share with nonaffiliates so they can market to you.*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. ■ *Our joint marketing partners include insurance agencies, broker dealers and investment advisor firms.*

Other important information

Employee Section

Underwriter Documents

Hardin County Water District No. 2
30800-390
927DCPG-L1

**Please fax or email completed form to eligibility:
Fax: 855-591-3558 | Email: eliggroup@avesis.com

VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Fidelity Security Life Insurance Company Kansas City, Missouri

Policy No. VC-76

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name	*Employee First Name*	*MI*

Date of Birth	*Social Security Number*	*Sex*
/ /	- -	☐ Male ☐ Female

Street Address	*Apartment No.*

City	*State*	*Zip Code*
		-

Do you wish to cover your eligible dependents? ☐ Yes ☐ No

If yes, complete the following:

	Dependent Name	*Date of Birth*
Spouse/Domestic Partner		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /

☐ ***I would like to cover additional eligible dependents*** (PLEASE LIST ON A SECOND ENROLLMENT FORM)

By signing below, I agree to receive all documents and correspondence electronically and that I can access the internet or the email address provided. I understand that I may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company {or Administrator} by mail, email, or telephone.

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Signature	*Date* / /

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ○ Dependents	☐ **Change** ○ Address ○ Phone ○ Name ○ COBRA	☐ **Cancel Coverage** ○ Policy Holder ○ Dependent(s)

Reason for Change ☐ Employment Status
☐ Qualifying Event: (PLEASE STATE) ____________________

Requested Effective Date / /	*Date of Employment* / /

FIDELITY SECURITY LIFE INSURANCE COMPANY
3130 Broadway • Kansas City, Missouri 64111-2406 • (800) 648-8624

Group Insurance Certificate Providing Limited Benefits for Vision Care Non-Participating

This Certificate will take the place of any and all Certificates and Riders which may have been issued to You at a prior time under the Policy.

GENERAL INFORMATION

About Your Insurance - This Certificate explains the plan of insurance which is underwritten by Fidelity Security Life Insurance Company. Read it closely to become familiar with Your plan. An individual identification card will be issued to You containing Your Group Number and Your Effective Date.

Important Notice - Benefits are payable only for expenses incurred while this insurance is in force. No agent has the right to change the Policy or to waive any part of it. The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy. The insurance under the Policy does not take the place of nor does it affect any requirements for coverage by Workers' Compensation or a similar type of insurance. The benefits for Dependents which are described in this Certificate will be applicable to Your Dependents only if You make application to have Your Dependents insured.

DEFINITIONS

The following terms have specific meaning as used in the Policy.

Covered Person means an employee meeting the eligibility requirements of the Policy who is covered for benefits. Covered Person will also include Your Dependents, if enrolled.

Dependent means any of the following persons: 1) Your lawful spouse; 2) Each unmarried child from birth to age 19 who is primarily dependent upon You for support and maintenance; 3) Each unmarried child at least 19 years of age to age 25 who is primarily dependent upon You for support and maintenance and who is a full-time student; or 4) Each unmarried child at least 19 years of age: who is primarily dependent upon You for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is a Covered Person under this Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday. Child includes stepchild, foster child, legally adopted child, child legally placed in Your home for adoption, and child under Your legal guardianship. A full-time student is one who is enrolled at least 12 semester hours for credit in the case of an accredited junior college, college or university; and, in the case of a trade school, is enrolled in a course requiring attendance of 15 or more hours weekly for six or more months.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder on the face of the Policy.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing Optician.

Vision Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Vision Materials means corrective lenses and/or frames or contact lenses.

THIS PLAN IS NOT MEDICARE SUPPLEMENT. If you are eligible for Medicare, please review "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," available from the Company.

PLEASE READ THE CERTIFICATE CAREFULLY.

We, Our, Us means Fidelity Security Life Insurance Company.

You, Your, Yours means the employee covered under the Policy.

DEFINITIONS
(PPO and Non-PPO)

Preferred Agreement means an agreement between the PPO and a Provider concerning the rates and reimbursement methods for services and supplies provided by such Provider.

Non-Preferred Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Agreement with the PPO.

Preferred Provider means a Provider who has signed a Preferred Agreement with the PPO.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area who have signed Preferred Agreements with the Company.

PPO Service Area means the geographical area where the PPO is located. An Insured Person who does not have access to a Preferred Provider within 30 minutes or 30 miles of the Insured Person's residence or work may receive services from a Non-Preferred Provider. The Insured Person must pay the full cost at the time the covered service is provided and file a claim with the Company. The Company will reimburse the Insured Person for any costs above the Preferred Provider Co-payments and any cost up to the Preferred Provider allowances as shown in the Schedule of Benefits.

EFFECTIVE DATES

Effective Date of Employee's Insurance - Your insurance will be effective as follows: 1) If the Policyholder does not require You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible; 2) If the Policyholder requires You to contribute towards the premium for this coverage, Your insurance will be effective on the date You became eligible, provided; a) You have given Us Your enrollment form (if required) on, prior to, or within 30 days of the date You became eligible; and b) You have agreed, in writing, to pay the required contributions; 3) If You fail to meet the requirements (a) and (b) within 30 days after becoming eligible, Your coverage will not become effective until We have verified that You have met these requirements. You will then be advised of Your effective date.

Effective Date of Dependent's Insurance - Coverage for Dependents becomes effective on the later of: 1) the date Dependent Coverage is first included in Your coverage; or 2) the premium due date on or after the date the person first qualifies as Your Dependent. If an enrollment form is required, You must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

Newborn Children - If a Dependent is covered under Your Certificate, a Dependent child born while this Certificate is in force shall be covered from the moment of birth for 31 days. In order to continue coverage beyond this 31-day period, You must send Us notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period.

Adopted Children - If a Dependent child is placed with You for adoption while the Certificate is in force, such child will be covered from the date of placement for 31 days. In order to continue coverage beyond this 31-day period, You must send in notice and agree to pay any premium contributions that may be required by the Policyholder within this 31-day period. If proper notice has been given, coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

SCHEDULE OF BENEFITS

Covered Persons have the right to obtain vision care from the Provider of their choice. However, payment of the Benefit varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule:

Benefit	Preferred Provider	Non-Preferred Provider	Benefit Period
Vision Examination:	$10.00 copayment	$35.00	12 Months
Vision Materials:	$10.00	N/A	
Standard Lenses			12 Months
Single	Paid in full after copayment	$250.00	
Bifocal	Paid in full after copayment	$45.00	
Trifocal	Paid in full after copayment	$250.00	
Lenticular	Paid in full after copayment	$250.00	
Standard Progressives	$50.00	$250.00	
Frames	$50.00	$45.00	12 Months
*Contact Lenses**			12 Months
Elective	$250.00	$130.00	
Medically Necessary	Paid in full	$250.00	
Level 1 Lens Option Package			
Basic Polycarbonate	$0 copayment	$10.00	

**Contact Lenses* includes fit, follow-up and Materials.

Any services which cannot be obtained by a Preferred Provider within the PPO Service Area because: 1) due to their specialized nature, there is no Preferred Provider located within the PPO Service Area; 2) are provided by a Provider not in the PPO Service Area; and 3) are specifically authorized in advance by the Covered Person's Provider and approved by the Company, shall be paid in accordance with the Schedule of Benefits for a Preferred Provider, without further deductions, subject to all Policy maximums, limitations, conditions and exclusions.

Benefit Period for Vision Examination is shown in the Schedule of Benefits and begins on Policy Effective Date.

Benefit Period for Vision Materials is shown in the Schedule of Benefits and begins on the Policy Effective Date.

Vision Examination Benefit - A Covered Person is eligible for one Vision Examination in each successive Benefit Period.

Vision Materials Benefit - If a Vision Examination results in a Covered Person needing corrective Vision Materials for their visual health and welfare, those Vision Materials prescribed by Providers will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- Lenses - Up to two lenses provided one time in each successive Benefit Period.
- Frame - One frame provided one time in each successive Benefit Period.
- Contact Lenses - Contact lenses benefit provided in lieu of lenses and/or frame.

LIMITATION

Vision Examination and Vision Materials - Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider. Such fees or materials are not covered under this Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Period, except for Contact Lenses benefit.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: 1) Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes, or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state, or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; or 8) Services or materials provided by any other group benefit plan providing vision care.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

TERMINATION OF INSURANCE

For all Covered Persons - All Covered Persons' insurance will end automatically on the earliest of the following dates: a) The date the Policy ends; b) The end of the last period for which any required contribution agreed to in writing has been made, subject to the Grace Period provision; c) The date You are no longer eligible for insurance; d) The date Your employment with the Employer ends. Your coverage will end on the last day of the month in which employment ends. The Employer may, at its option, continue insurance for individuals whose employment has ended, if it: (i) does so without individual selection between employees; and (ii) if it continues making premium payments for those individuals.

For Dependents - A Dependent's insurance will automatically stop on the earlier of: a) the date Your coverage ends; b) the end of the month in which the Dependent ceases to be Your Dependent; c) the end of the last period for which any required contribution has been made.

A Dependent Child will not cease to be a Dependent solely because of age if the child is: a) not capable of self-sustaining employment due to mental incapacity or physical handicap that began before the age limit was reached; and b) mainly dependent on You for support.

We may ask for proof of the eligible child's incapacity and dependency two (2) months before the date the Dependent would otherwise cease to be covered.

We may require the same proof again, but We will not ask for it more than once a year after this coverage has been continued for two (2) years. This continued coverage will end: a) on the date the Policy ends; b) the date the incapacity or dependency ends; c) the last day of the month for which required premium for the child is paid; or d) 60 days after the date We request proof which is not given to Us.

CLAIMS

Notice Of Claim. Written notice of claim must be given: (a) within 60 days after a covered loss begins; or (b) as soon as reasonably possible after that. This notice may be given to Us at Our Home Office or to Our Administrator. Notice should include the Covered Person's name and the Policy and Certificate numbers.

Claim Forms. When We receive notice of claim, We will send the claimant forms for filing proof of loss within 15 days. If claim forms are not supplied within this 15-day period, a claimant may submit proof in writing, setting forth the nature and extent of the loss.

Proof Of Loss. Proof of loss must be furnished to Us within 90 days after the date of loss. We will not deny or reduce a claim if it was not reasonably possible to give Us proof within the time allowed. In any event, the Covered Person must give Us proof within one (1) year after it is due unless he is legally incapacitated.

Time Of Payment Of Claims. Immediately after receiving written proof of loss, We will pay all benefits then due a Covered Person.

Payment Of Claims. All claims will be paid to You, unless We have the obligation to pay the facility or Provider directly. However, in the event a benefit becomes payable to Your estate, We may pay such benefit, up to an amount equal to $1,000, to any relative by blood or connection by marriage whom We deem to be equitably entitled thereto. Payment made in good faith fully discharges Us to the extent of any payments made.

Legal Actions. No legal actions may be brought to recover under the Policy: (1) within 60 days after written proof of loss has been furnished as required; or (2) after three years from when written proof of loss is required.

Claim Appeal Procedure. A Covered Person has the right to an internal appeal of a utilization review decision made by or on behalf the Company with respect to the denial, reduction, or termination of a limited health service benefit plan or the denial of payment for a health care service, and the procedure to initiate an internal appeal.

The internal appeals process may be initiated by the Covered Person, an authorized person or a Provider acting on behalf of the Covered Person. The Covered Person, authorized person or Provider acting on behalf of the Covered Person should request on internal appeal within sixty (60) days of receipt of a notice of an adverse determination or coverage denial; and the internal appeal decision must be provided within thirty (30) days.

GENERAL PROVISIONS

Entire Contract. The Policy is a legal contract. It is between the Policyholder and Us. The entire contract consists of: (1) the Policy, the Certificate, endorsements and attachments, if any; (2) the Policyholder's Application; and (3) the employees' enrollment forms, if any. Any statement made by the Policyholder or by a Covered Person in an application will, in the absence of fraud, be deemed a representation and not a warranty. No such statement will void the coverage or reduce the benefits or be used in defense to a claim unless it is in writing and a copy of the application is furnished to the Covered Person.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Additional Insureds. Eligible persons may be added to the original insured group under the Policy, from time to time, according to the terms of the Policy.

Modification Of Policy. The Policy may be modified at any time by agreement between the Policyholder and Us without consent of any employee. No modification will be valid unless approved by one of Our officers: (1) the President; (2) a Vice President; or (3) the Secretary. The approval must be endorsed on or attached to the Policy. No agent has authority to modify the Policy or waive any of the Policy's provisions to extend the time for premium payment by making any promise or representation.

Incontestability. The validity of the Policy shall not be contested except for non-payment of premiums, fraudulent misstatements or material misrepresentations after it has been in force for two (2) years. Coverage under this Certificate shall not be contested except for non-payment of premiums or material misrepresentation after it has been in force for two (2) years. No statement, except fraudulent misstatements, made by You relating to: 1) Your insurability; or 2) The insurability of Your Dependents; shall be used in contesting the validity of the coverage of the person about whom the statement was made after coverage has been in force for a period of two (2) years. Any such statement must be contained in a written instrument signed by You, a copy of which has been furnished to You.

Fraud. If You or the Policyholder commits fraud pertaining to an employee against Us, as determined by a court of competent jurisdiction, Your coverage will end automatically without notice.

Misstatement Of Age. If a Covered Person's age has been misstated, the benefits will be those which the premium paid would have bought for the correct age. If a Covered Person's correct age was over the maximum issue age, coverage will be voided and the premiums paid for such Covered Person will be refunded.

Assignment Of Benefits. You may assign Your benefits. However, an assignment is not binding until We have received and acknowledged in writing the original or copy of the assignment before payment of the benefit. We do not guarantee the legal validity or effect of such assignment.

Grace Period. A grace period of 31 days will be allowed for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. If the premium is not paid within the grace period, coverage will terminate as of the premium due date. The grace period will not apply if the Covered Person gives written notice to Us of his or her intent not to continue this coverage.

FIDELITY SECURITY LIFE INSURANCE COMPANY

President	Secretary

FIDELITY SECURITY LIFE INSURANCE COMPANY
3130 Broadway
Kansas City, Missouri 64111-2406
Phone 800-648-8624
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REFRACTIVE SURGERY BENEFIT RIDER

This Rider amends the Policy/Certificate to which it is attached. The following refractive surgical benefits are added:

DEFINITIONS

Injury means a bodily Injury sustained directly and independently of all other causes resulting in a covered loss under this Rider.

LASEK (Laser Assisted Epithelium Keratomileusis) means a slight variation of the traditional LASIK procedure as described below. This surgical procedure utilizes a trephine to create an epithelial flap (as opposed to the deeper stromal flap with LASIK) and an alcohol solution to preserve the epithelial cells. Once the epithelial flap is created and lifted, the treatment proceeds as for traditional PRK, with light smoothing at its conclusion. The epithelial flap is then repositioned with a small spatula.

LASIK (Laser Assisted In-Situ Keratomileusis) means a surgical procedure involving the use of a computer-controlled excimer laser to reshape the cornea (epithelium) without invading the adjacent cell layers. An automated microkeratome is used to shave off a thin, hinged layer of the cornea that is lifted, and the exposed surface is reshaped using the laser. After altering the cornea curvature, the flap is replaced and is adhered without stitches. In **IntraLase Initiated LASIK**, a special laser is used instead of a blade to create the flap. In **Custom Wavefront** or **Wavefront-Guided LASIK** procedures, a 3-dimensional measurement of how the eye processes images is used to guide the laser in re-shaping the front part of the eye (cornea).

PRK (Photorefractive Keratectomy) means a surgical procedure involving removal of the surface layer of the cornea by gentle scraping and use of a computer-controlled excimer laser to reshape the stroma.

Physician means an Ophthalmologist or Optometrist licensed under applicable state law to perform the surgical procedures for which benefits are payable under this Rider, and who is acting within the lawful scope of his or her license to render such service. A Physician cannot be the Covered Person or a member of the Covered Person's Immediate Family. "Immediate Family" means the Covered Person or the Covered Person's spouse, parent, child, grandparent, brother, sister, in-law or any person residing with the Covered Person.

Refractive Surgery means a surgical procedure which permanently alters the focusing power of the eye(s) in order to change refractive errors.

BENEFITS

Refractive Surgery Benefit. The Company will pay a one-time surgical indemnity benefit of $150 (per Covered Person) for one of the following refractive surgical procedures to one or both eyes: LASIK (including Custom Wavefront, Wavefront-Guided or IntraLase initiated LASIK), LASEK or PRK, if performed by a Physician on a Covered Person while covered under this Rider, subject to the Exclusions provision.

EXCLUSIONS

Refractive Surgery Vision Benefit Exclusions

Benefits are not payable for any of the following:

1. Routine vision examinations or corrective vision materials, including corrective eyeglasses, fittings, lenses, frames or contact lenses; or
2. Medical or surgical procedures, services or treatments:
   a. not specifically covered under this Rider;
   b. provided free of charge in the absence of insurance;
   c. if the Covered Person is eligible for benefits under any Workers' Compensation law, or similar statutory authority; or
   d. payable under any governmental plan or program whether Federal, state or subdivisions thereof, except for medical assistance benefits under title XIX of the Social Security Act (Medicaid).

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

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AMENDMENT RIDER

By attachment of this Rider, the Policy/Certificate is amended by the following:

Any provision of the Policy/Certificate that provides coverage for a Dependent child up to a certain age is amended to cover such child to age 26, regardless of financial dependency, residency, student status, or marital status.

This Rider takes effect on the effective date of the Policy/Certificate to which it is attached. This Rider terminates concurrently with the Policy/Certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Policy/Certificate except as stated.

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NOTICE OF ADMINISTRATOR'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the administrator, the policyholder and the insurer:

1. Fidelity Security Life Insurance Company (FSL) has, by agreement, arranged for Avesis Third Party Administrators, Inc. to provide administrative services for your insurance plan. As administrator, Avesis Third Party Administrators, Inc. may be authorized to market, underwrite, bill and collect premiums, process claims payment, and perform other services, according to the terms of its agreement with the insurance company. Avesis Third Party Administrators, Inc. is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Fidelity Security Life Insurance Company is liable for the funds to pay your insurance claims.

If Avesis Third Party Administrators, Inc. is authorized to process claims for the insurance company, they will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against Avesis Third Party Administrators, Inc. than would otherwise be afforded to you by law.

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how we protect personal health information we have about you which relates to our medical, dental, vision and prescription drug coverage. Protected Health Information ("PHI") is individually identifiable information about you. All of the following are examples of PHI: demographic information like your name, address and social security number; medical information that relates to your past, present or future physical or mental health that is collected, created or received from you, a health care provider, a health plan, employer or a health care clearinghouse; the providing of health care; or the past, present or future payment for providing health care to you.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give You this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2013 or the date coverage became effective for you, whichever is later, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our Insureds at the time of change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Your PHI

In conducting our business we will create records regarding you and the insurance services we provide you. The main reasons for which we may use and may disclose your PHI are to evaluate and process any requests for medical coverage and claims for benefits you may make. The following describe these and other uses and disclosures, together with some examples:

Treatment: We may use or disclose your PHI to facilitate medical treatment by providers. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to treat you. We may request the services of a business associate to assist us in these activities.

Payment: We may use and disclose your PHI to facilitate payment of benefits under your insurance coverage. For example, we might disclose your PHI to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain payments and to issue explanations of benefits. We also may use your PHI to obtain payment from third parties that may be responsible for your premium payments, such as family members.

Health Care Operations: We may use and disclose your PHI as necessary, and as permitted by law, to operate our business. Health care operations include: (i) rating our risk and determining our premiums for your insurance; (ii) conducting quality assessment and improvement activities; (iii) conducting or arranging for medical review, legal services, audit services, fraud and abuse detection and compliance programs; and (iv) business planning and development.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We would also need to obtain your prior written authorization if your PHI were to be used for marketing or sales purposes.

To Your Family and Friends: We may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your health care or for payment of your health care. We may use or disclose your name, location and general condition or death to notify, or assist in the notification, of (including identifying or locating) a person involved in your care.

Before we disclose your PHI to a person involved with your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest.

Your Employer or Organization Sponsoring Your Health Plan: We may disclose your PHI and the PHI of others enrolled in your group insurance plan to the employer or other organization that sponsors your group insurance plan to permit the plan administrator to perform plan administration functions. We may also disclose summary information about the enrollees in your group insurance plan to the plan administrator to use to obtain premium bids for the health insurance coverage offered through your group insurance plan or to decide whether to modify, amend or terminate your group insurance plan. The summary information we may disclose will summarize claims history, claims expenses, or types of claims experienced by the enrollees in your group insurance plan. The summary information will be stripped of demographic information about the enrollees in the group insurance plan, but the plan administrator may still be able to identify you or other participants in your group health plan from the summary information. We may also disclose enrollment and disenrollment information to either the plan administrator or plan sponsor of your group insurance plan.

Underwriting: We may receive your PHI for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose your PHI for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us, or where we disclose such information to MIB, Inc., a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. In those cases, our use and disclosure of your PHI will only be as described in this notice. We are also prohibited from using genetic information for underwriting.

Public Benefit: We may use or disclose your PHI without your authorization when required or permitted by law for the following purposes deemed in the public interest or benefit:

- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health and safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker’s compensation laws.

Business Associates: Certain aspects and components of our business are preformed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents, third party administrators, financial auditors, actuarial and underwriting services, reinsurers, legal services, enrollment and billing services, claim payment and medical management services and collection agencies. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our payment or health care operations. In all cases, we disclose only the minimum information necessary for these business associates to perform their responsibilities, and we require them to appropriately safeguard the privacy of your information.

Individual Rights

Access: In most cases, you have the right to inspect and/or obtain an electronic or hard copy of the PHI that we maintain about you. You may also send a written request designating another individual to receive your PHI on your behalf. Written requests must be signed and dated by you or your personal representative using the “Contact Information” provided at the end of this Notice. The request must clearly identify the individual to receive your PHI. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes and PHI collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than for treatment, payment, health care operations or as otherwise authorized by you during the six years prior to the date the accounting is requested. For example, we would account for your PHI or demographic information we disclose during an audit by an insurance department or pursuant to a court order. You must make your request in writing using the “Contact Information” provided at the end of this Notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Restriction: You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing using the "Contact Information" provided at the end of this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

Unauthorized Access: You are entitled to receive notification of unauthorized access to your PHI. We maintain physical, electronic and procedural safeguards that are compliant with applicable federal and state privacy laws. However, if your PHI is ever compromised, we will notify you of the incident.

Confidential Communications: You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing using the "Contact Information" provided at the end of this Notice and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Amendment: If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must provide your request and your reason for the request in writing using the "Contact Information" provided at the end of this Notice. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that: (i) is accurate and complete; (ii) was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment; (iii) is not part of the PHI kept by or for us; or (iv) is not part of the PHI which you would be permitted to inspect and copy.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, submit your complaint using the "Contact Information" provided at the end of this Notice. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

Contact Information: If you have questions regarding this Notice or need further assistance regarding this Notice, please contact us at:

Contact Office: Fidelity Security Life Insurance Company, HIPAA Customer Service
Telephone: 800-648-8624 Fax: 816-968-0660
Address: 3130 Broadway, Kansas City, MO 64111-2406

Options Plus Savings Equals Satisfied Members

Empower groups and their employees to make better choices for their eyes—saving members money while protecting their vision. At renewal time, employees often spend money out-of-pocket for extra options like tints, UV screening, and polycarbonate lenses. Including these popular options in their plans will help limit members' out-of-pocket expenses. Employees with access to these options are positioned to make better choices for their ocular health, which has been shown to improve productivity on the job.[1]

Member's Out-of-Pocket Cost

Benefits	Average Retail Price*	Avēsis Plan with a $130 frame allowance and L1 Package	Avēsis Plan with a $130 frame allowance and L3 Package
Exam	$120	$10 copay	$10 copay
Frame	$150	$10 copay + $20 member responsibility ($150 - $130 allowance = $20)	$10 copay + $20 member responsibility ($150 - $130 allowance = $20)
Single Vision	$86	$0	$0
Adult Polycarbonate	$65	$40	$0
Standard Scratch-Resistant Coating	$38	$17	$0
Ultraviolet Screening	$24	$15	$0
Solid or Gradient Tint	$35	$17	$0
Standard Anti-Reflective Coating	$106	$45	$0
Total	**$624**	**$174**	**$40**
		Savings of $450	**Savings of $584**

Members save money with our lens options.
See for yourself!

Lens Package Options

Lens options not included in the seven standard packages described below are still available for a la carte purchase by members. If we have not identified a lens option with preferred pricing, that lens option would be subject to up to a 20% discount.†

	L1	L2	L3	L4	L5	L6	L7
Youth Polycarbonate	$0	$0	$0	$0	$0	$0	$0
Adult Polycarbonate (single-vision/multi-focal)	$40/$44	$0	$0	$40/$44	$0	$40/$44	$0
Standard Scratch Resistant Coating	$17	$17	$0	$17	$0	$17	$0
Ultraviolet Screening	$15	$15	$0	$15	$0	$15	$0
Solid or Gradient Tint	$17	$17	$0	$17	$0	$17	$0
Standard Anti-Reflective Coating	$45	$45	$0	$45	$0	$45	$0
Level 1 Progressives	$75	$75	$75	$0	$0	$0	$0
Level 2 Progressives	$110	$110	$110	$110	$110	$0	$0
All other Progressives	$50 allowance‡	$50 allowance‡	$50 allowance‡	$120 allowance‡	$120 allowance‡	$140 allowance‡	$140 allowance‡
Transitions®§ (single-vision/multi-focal)	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80
Polarized	$75	$75	$75	$75	$75	$75	$75
PGX/PBX	$40	$40	$40	$40	$40	$40	$40
All other lens options	Up to a 20% discount						

1. https://www.zenefits.com/answers/what-are-the-benefits-of-my-company-offering-vision-insurance-to-employees/ (published January 2017)

*Based on national averages
†Discount not available at all locations
‡Plus up to an additional 20% discount
§You can add Transitions® to any package. Members will pay either $0 or a $40 copay.

Avēsis
10400 N. 25th Ave.
Suite 200
Phoenix, AZ 85021

www.avesis.com

Options Plus Savings Equals Satisfied Members

Empower groups and their employees to make better choices for their eyes—saving members money while protecting their vision. At renewal time, employees often spend money out-of-pocket for extra options like tints, UV screening, and polycarbonate lenses. Including these popular options in their plans will help limit members' out-of-pocket expenses. Employees with access to these options are positioned to make better choices for their ocular health, which has been shown to improve productivity on the job.[1]

Member's Out-of-Pocket Cost

Benefits	Average Retail Price*	Avēsis Plan with a $130 frame allowance and L1 Package	Avēsis Plan with a $130 frame allowance and L5 Package
Exam	$120	$10 copay	$10 copay
Frame	$150	$10 copay + $20 member responsibility ($150 - $130 allowance = $20)	$10 copay + $20 member responsibility ($150 - $130 allowance = $20)
Level 1 Progressives	$150	$75	$0
Adult Polycarbonate	$65	$44	$0
Standard Scratch-Resistant Coating	$38	$17	$0
Ultraviolet Screening	$24	$15	$0
Solid or Gradient Tint	$35	$17	$0
Standard Anti-Reflective Coating	$106	$45	$0
Total	**$688**	**$253**	**$40**
		Savings of $443	**Savings of $648**

Members save money with our lens options. See for yourself!

Lens Package Options

Lens options not included in the seven standard packages described below are still available for a la carte purchase by members. If we have not identified a lens option with preferred pricing, that lens option would be subject to up to a 20% discount.†

	L1	L2	L3	L4	L5	L6	L7
Youth Polycarbonate	$0	$0	$0	$0	$0	$0	$0
Adult Polycarbonate (single-vision/multi-focal)	$40/$44	$0	$0	$40/$44	$0	$40/$44	$0
Standard Scratch Resistant Coating	$17	$17	$0	$17	$0	$17	$0
Ultraviolet Screening	$15	$15	$0	$15	$0	$15	$0
Solid or Gradient Tint	$17	$17	$0	$17	$0	$17	$0
Standard Anti-Reflective Coating	$45	$45	$0	$45	$0	$45	$0
Level 1 Progressives	$75	$75	$75	$0	$0	$0	$0
Level 2 Progressives	$110	$110	$110	$110	$110	$0	$0
All other Progressives	$50 allowance‡	$50 allowance‡	$50 allowance‡	$120 allowance‡	$120 allowance‡	$140 allowance‡	$140 allowance‡
Transitions®§ (single-vision/multi-focal)	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80
Polarized	$75	$75	$75	$75	$75	$75	$75
PGX/PBX	$40	$40	$40	$40	$40	$40	$40
All other lens options	Up to a 20% discount						

1. https://www.zenefits.com/answers/what-are-the-benefits-of-my-company-offering-vision-insurance-to-employees/ (published January 2017)

*Based on national averages
†Discount not available at all locations
‡Plus up to an additional 20% discount
§You can add Transitions® to any package. Members will pay either $0 or a $40 copay.

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Member's Out-of-Pocket Cost

Benefits	Avēsis Plan with a $130 frame allowance and L1 Package	Avēsis Plan with a $130 frame allowance and L3 Package
Exam	$10 copay	$10 copay
Frame	$10 copay + $20 member responsibility ($150 - $130 allowance = $20)	$10 copay + $20 member responsibility ($150 - $130 allowance = $20)
Single Vision	$0	$0
Adult Polycarbonate	$40	$0
Standard Scratch-Resistant Coating	$17	$0
Ultraviolet Screening	$15	$0
Solid or Gradient Tint	$17	$0
Standard Anti-Reflective Coating	$45	$0
Total	**$174**	**$40**
		Savings of $134

Members save money with our lens options. See for yourself!

Lens Package Options

Lens options not included in the seven standard packages described below are still available for a la carte purchase by members. If we have not identified a lens option with preferred pricing, that lens option would be subject to up to a 20% discount.†

	L1	L2	L3	L4	L5	L6	L7
Youth Polycarbonate	$0	$0	$0	$0	$0	$0	$0
Adult Polycarbonate (single-vision/multi-focal)	$40/$44	$0	$0	$40/$44	$0	$40/$44	$0
Standard Scratch Resistant Coating	$17	$17	$0	$17	$0	$17	$0
Ultraviolet Screening	$15	$15	$0	$15	$0	$15	$0
Solid or Gradient Tint	$17	$17	$0	$17	$0	$17	$0
Standard Anti-Reflective Coating	$45	$45	$0	$45	$0	$45	$0
Level 1 Progressives	$75	$75	$75	$0	$0	$0	$0
Level 2 Progressives	$110	$110	$110	$110	$110	$0	$0
All other Progressives	$50 allowance‡	$50 allowance‡	$50 allowance‡	$120 allowance‡	$120 allowance‡	$140 allowance‡	$140 allowance‡
Transitions®§ (single-vision/multi-focal)	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80
Polarized	$75	$75	$75	$75	$75	$75	$75
PGX/PBX	$40	$40	$40	$40	$40	$40	$40
All other lens options	Up to a 20% discount						

1. https://www.zenefits.com/answers/what-are-the-benefits-of-my-company-offering-vision-insurance-to-employees/ (published January 2017)

*Based on national averages
†Discount not available at all locations
‡Plus up to an additional 20% discount
§You can add Transitions® to any package. Members will pay either $0 or a $40 copay.

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Options Plus Savings Equals Satisfied Members

Empower groups and their employees to make better choices for their eyes—saving members money while protecting their vision. At renewal time, employees often spend money out-of-pocket for extra options like tints, UV screening, and polycarbonate lenses. Including these popular options in their plans will help limit members' out-of-pocket expenses. Employees with access to these options are positioned to make better choices for their ocular health, which has been shown to improve productivity on the job.[1]

Member's Out-of-Pocket Cost

Benefits	Avēsis Plan with a $130 frame allowance and L1 Package	Avēsis Plan with a $130 frame allowance and L5 Package
Exam	$10 copay	$10 copay
Frame	$10 copay + $20 member responsibility ($150 - $130 allowance = $20)	$10 copay + $20 member responsibility ($150 - $130 allowance = $20)
Level 1 Progressives	$75	$0
Adult Polycarbonate	$44	$0
Standard Scratch-Resistant Coating	$17	$0
Ultraviolet Screening	$15	$0
Solid or Gradient Tint	$17	$0
Standard Anti-Reflective Coating	$45	$0
Total	**$253**	**$40**
		Savings of $213

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Adult Polycarbonate (single-vision/multi-focal)	$40/$44	$0	$0	$40/$44	$0	$40/$44	$0
Standard Scratch Resistant Coating	$17	$17	$0	$17	$0	$17	$0
Ultraviolet Screening	$15	$15	$0	$15	$0	$15	$0
Solid or Gradient Tint	$17	$17	$0	$17	$0	$17	$0
Standard Anti-Reflective Coating	$45	$45	$0	$45	$0	$45	$0
Level 1 Progressives	$75	$75	$75	$0	$0	$0	$0
Level 2 Progressives	$110	$110	$110	$110	$110	$0	$0
All other Progressives	$50 allowance‡	$50 allowance‡	$50 allowance‡	$120 allowance‡	$120 allowance‡	$140 allowance‡	$140 allowance‡
Transitions®§ (single-vision/multi-focal)	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80	$70/$80
Polarized	$75	$75	$75	$75	$75	$75	$75
PGX/PBX	$40	$40	$40	$40	$40	$40	$40
All other lens options	Up to a 20% discount						

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