Kentucky Rural Electric Cooperative Employers Benefit Plan – Kenergy

Medical Benefit Plan -PPO

Revised: January 1, 2020

SUMMARY PLAN DESCRIPTION

SELF-FUNDED MEDICAL PLAN FOR

KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY

EFFECTIVE DATE: JANUARY 1, 2020

It is the intention of the Employer to hereby establish a program of benefits constituting an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code of 1986, and any amendments thereto.

IN WITNESS WHEREOF, the employer has executed this Summary Plan Description as of the Plan Effective Date shown.

By: Keith Ellis — Date: 2.4.2020

Authorized Representative

Title: V.P. – Adm Services

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IMPORTANT MESSAGE

CHANGES IN ELIGIBILITY

You should report **ANY CHANGE IN ELIGIBILITY** to *your employer* as soon as possible. Changes in eligibility include:

1. Marriage or divorce
2. Death of any *dependent*
3. Birth or adoption of a *child*
4. *Dependent child* reaching the limiting age
5. IRS ineligible *dependent child*
6. Total disability
7. Retirement
8. *Medicare* eligibility

For specific details on maintaining coverage under the *plan*, refer to SECTION 3 - ELIGIBILITY.

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SCHEDULE OF BENEFITS

CLAIMS AUDIT

In addition to the *plan*'s medical record review process, the *plan administrator* may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the *plan administrator* has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not *usual and customary* and/or *medically necessary* and *reasonable*, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the *plan administrator* or its agent to identify the charges deemed in excess of the *usual and customary* and *reasonable* amounts or other applicable provisions, as outlined in this plan document.

Despite the existence of any agreement to the contrary, the *plan administrator* has the discretionary authority to reduce any charge to a *usual and customary* and *reasonable* charge, in accord with the terms of this plan document.

PRIOR AUTHORIZATION REQUIREMENTS

The Utilization Management company (UM) shown on your ID card will handle the authorization requirements of *your plan*. *You* or *your* provider should call the UM for authorization as soon as possible to receive proper care coordination. However, *you* or *your* provider must call within the time frames shown below. The UM toll-free number is shown on the back of *your* ID card.

PPO BENEFIT PROVISION

PPO benefits will be payable for Non-*PPO* provider services up to the *plan's usual and customary and reasonable* limits **only** if:

1. *You* receive treatment that is a *covered expense* from a *PPO* provider and as a result of that treatment, a *covered expense* is incurred from a Non-*PPO* hidden provider that is a pathologist; anesthesiologist; radiologist; *emergency* room physician; or assistant surgeon;

2. *You* do not have access to a *PPO* provider within 30 miles of *your* place of residence;

3. *You* are treated for an *injury* or receive treatment for an *emergency*, including treatment received if *you* are admitted to the *hospital* directly from the *emergency* room;

4. *You* are inpatient confined in a *PPO* facility and receive a consultation from a Non-*PPO* hidden provider;

5. *You* received a referral from a *PPO* provider to a Non-*PPO* hidden provider for diagnostic laboratory or pathology services; or

6. The required medical services are not available from a *PPO* provider.

PREFERRED PROVIDER ORGANIZATION PLAN (PPO PLAN)

PRIOR AUTHORIZATION REQUIRED	NON-COMPLIANCE PENALTY	SUMMARY

• Inpatient
  ○ Inpatient Behavioral Health/Substance Abuse
  ○ Skilled Nursing Facility Admissions
 	
• Outpatient:
  ○ Adenoidectomy
  ○ Arthroscopy Any Joint
  ○ Blepharoplasty
  ○ Cardiac Catheterization
  ○ Cochlear Implants
  ○ Cholecystectomy
  ○ Deviated Septum/Nasal
  ○ Durable Medical Equipment (in excess of $500)
  ○ Endoscopic Procedures
  ○ Epidural/Facet & Trigger Point Injections
  ○ Excision of Mass
  ○ Genetic Testing/Molecular Pathology
  ○ High End Radiology - MRI/CT/PET
  ○ Laminectomy/Spinal Surgery
  ○ Laparoscopy
  ○ Lung Perfusion Study
  ○ Mammoplasty
  ○ Occupational Therapy
  ○ Orthopedic Surgery With Implants
  ○ Physical Therapy After 10 Visits
  ○ Surgery
  ○ Tonsillectomy
  ○ Varicose Vein Stripping & Ligation
	PPO: $100 per occurrence.
	
	Non-*PPO*: $100 per occurrence.
	
	The penalty is taken prior to applying the deductible and coinsurance provisions of the *plan*. The penalty is not applied to the out-of-pocket limit.
		***PPO*: <u>Your PPO provider</u>** is required to handle the *prior authorization* requirements with UM.
		
		Non-PPO: ***<u>You</u>*** must call UM for authorization at least 24 hours in advance of any non-*emergency* inpatient admission. All inpatient admissions, except maternity admissions that do not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section delivery, require *prior authorization*. If *you* do not obtain *prior authorization*, benefits will be payable after the non-compliance penalty. If admission is on an *emergency* basis, UM must be notified within 48 hours or the first business day following *your* admission.

Medical Bill Review	None	If *you* discover a provider billing error (your doctor billing for treatment not received, for example), report it to the *plan*. As a reward, *you* will receive 50% of the error amount, but not more than $1,000 per bill.

MEDICAL BENEFIT SCHEDULE
PPO PLAN

	NETWORK	NON-NETWORK
Lifetime Maximum Benefit	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	$600/$1,800	$1,200/$3,600
Maximum Out-Of-Pocket Coinsurance Limits (Single/Family)	Medical: $1,900/$3,800	$4,500/$9,000
Maximum Out-Of-Pocket[2] **(Single/Family)** The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Maximum Includes: • Copayments • Prescription Costs Maximum Excludes: • Cost Containment Penalties • Exclusions and Limitations • Charges in Excess of Maximum Allowed Amount	Medical: $7,150/$14,300	Unlimited
COVERED BENEFITS		
PHYSICIAN SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Physician Office Services		
• Office Visit Copayment (PCP/SPC)	$30 Copay per visit	30% After Deductible
• Allergy Injection/Serum	$30 Copay per visit with office visit, + 10% After Deductible	30% After Deductible
• Allergy Testing	$30 Copay per visit with office visit	30% After Deductible
• Imaging Services (MRI, MRA, CAT, PET, SPECT)	10% After Deductible	30% After Deductible
• Diagnostic Test (Lab & X-Ray)	No Cost Share if billed alone	30% After Deductible
• Office Surgery/Eye Care/Hearing Care	$30 Copay per visit with office visit No Cost Share if billed alone	30% After Deductible
• Prescription Dispensed In Physician's Office	10% After Deductible	30% 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/SPC) • Colonoscopy • Contraceptives • Mammogram[3] • PAP/PSA Testing • Immunizations • Annual Diabetic Eye Exam • Diabetic Education • PCP Vision/Hearing Screening • Breast Pumps – 1 Pump/Pregnancy[4]	No Cost Share	First $500 per calendar year is covered at 100%. Anything in excess of $500 member is responsible for 30% with deductible waived.
Behavioral Health Office Services	$30 Copayment per visit	30% After Deductible
Live Health Online/Telehealth Consultation	$30 Copayment per visit	30% After Deductible
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	 10% After Deductible 10% After Deductible 10% After Deductible	 30% After Deductible 30% After Deductible 30% After Deductible
NOTE: Methadone Clinics And Halfway Houses Are Excluded.		
Emergency Room Covered As Outlined In The Medical Benefits Section Copayment Waived If Admitted To Hospital, If Placed In Observation Copayment Will Apply • Emergency Room Services • Emergency Room Physician • Non-Emergent Emergency	 $100 Copayment No Cost Share $100 Copayment	 $100 Copayment Covered at In-Network Level $100 Copayment
Hospice Care Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
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** • Surgeon • Anesthesiologist • Radiologist • Pathologist	 10% After Deductible 10% After Deductible 10% After Deductible 10% After Deductible 10% After Deductible 10% After Deductible	 30% After Deductible 30% After Deductible 30% After Deductible 30% After Deductible 30% After Deductible 30% 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 • Skilled Nursing Facility • Extended Care Facility	10% After Deductible	30% After Deductible
NOTE: Precertification Required. Limited To 60 days Per Sickness Or Injury.		
Outpatient Surgery/Alternative Care Facility Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Surgery • Administration of General Anesthesia	10% After Deductible, If Billed With An Office Visit $30 Copayment applies.	30% 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	$30 Copayment	30% After Deductible
COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Abortion Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Inpatient Services • Outpatient Services	 $30 Copayment 10% After Deductible 10% After Deductible	 30% After Deductible 30% After Deductible 30% After Deductible
NOTE: Abortion Services Only Covered If The Life Of The Mother Is Endangered.		
Accidental Dental Injury Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Inpatient Services • Outpatient Services	 $30 Copayment 10% After Deductible 10% After Deductible	 30% After Deductible 30% After Deductible 30% After Deductible
NOTE: Covered For Accidental Dental Injuries To Sound And Natural Teeth Only If The Treatment Is Completed Within 12 Months Of The Accident.		
Ambulance Services (Land / Air) Covered As Outlined In The Medical Benefits Section	10% After Deductible	10% After Deductible
NOTE: If Related To An Inpatient Admission The Deductible Will Be Waived. All Other Services And Providers Are Paid At The In Network Benefit Level. Ground Ambulance Transport Between Hospital And Skilled Nursing Facilities Are Covered.		
Attention Deficit Disorder (ADD) **Attention Deficit Hyperactivity Disorder (ADHD)** Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Inpatient Services • Outpatient Services	 $30 Copayment 10% After Deductible 10% After Deductible	 30% After Deductible 30% After Deductible 30% After Deductible
Autism Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Inpatient Services • Outpatient Services	 $30 Copayment 10% After Deductible 10% After Deductible	 30% After Deductible 30% After Deductible 30% After Deductible
NOTE: Limited To $500 Paid Per Month. ABA Therapy, PT, ST, OT Visits Are Included In This $500 Limit Per Month.		

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Behavioral Health & Substance Abuse Covered As Outlined In The Medical Benefits Section • Inpatient Professional Services • Outpatient Professional Services	 10% After Deductible 10% After Deductible	 30% After Deductible 30% After Deductible
Cardiac Rehabilitation Therapy Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
Chiropractic/Spinal Manipulation Covered As Outlined In The Medical Benefits Section	$30 Copayment	30% After Deductible
NOTE: $1,000 Maximum Benefit Combined In-Network And Non-Network Per Plan Year. X-Rays Are Not Included In The $1,000 Maximum.		
Approved Clinical Trials Routine patient costs of items and services furnished in connection with participation in an approved clinical trial are covered for qualified individuals.		
NOTE: If The Covered Person Is Part Of An FDA-Approved Clinical Trial For A Life-Threatening Disease Medical Expenses That Are Currently Covered Under The Plan That Occur During The Trial Will Be Covered Benefits.		
Contacts or Glasses Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: Covered following Cataract Surgery or Eye Injury. Limited to $50 for eyeglasses, including frames, $75 for one contact lens, $150 for two contact lenses.		
Durable Medical Equipment (DME) Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: Precertification Is Required If the Cost To Purchase Or Rent Such Equipment Exceeds $500.00.		
Hearing Services/Cochlear Implants Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: 1 Hearing Aid per ear only if necessary, by impairment of hearing following ear surgery or traumatic injury.		
Home Health Care Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: 60 Visit Plan Year Maximum Benefit Combined In-Network And Non-Network		
Infertility Diagnosis Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: Covered For Services To Diagnose Infertility Only. Any Artificial Means To Achieve Pregnancy Including, But Not Limited To, In Vitro Fertilization, GIFT, ZIFT, Artificial Insemination And All Related Fertility Testing, Treatment And Drugs Are Not Covered Benefits On The Plan.		
Inpatient & Outpatient Professional Services Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Medical Care Visit (One Per Day) • Intensive Medical Care • Concurrent Care • Surgery • Anesthesia Administration • Newborn Exams	10% After Deductible	30% 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		

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Maternity/Pregnancy Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Hospital • Birthing Center	 $30 Copayment 10% After Deductible 10% After Deductible	 30% After Deductible 30% After Deductible 30% After Deductible
NOTE: The Following Stipulations Apply: • Once Delivered, The Claim For The Newborn Will Apply To The Benefit Plan Of The Newborn • Pregnancy Of Dependent Daughter Is **NOT** Covered		
Nutritional Counseling Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Outpatient Services	 $30 Copayment 10% After Deductible	 30% After Deductible 30% After Deductible
NOTE: Counseling Must Be Rendered By A Licensed Nutritionist Or Dietician And Must be Medically Necessary. When Part Of PPACA Services Refer To Preventative Care Benefits. Diagnosis Of Obesity Will Be Covered If Organic In Nature. Eating Disorders Are Covered.		
Occupational Therapy Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: Prior Authorization Is Required for Occupational Therapy.		
Oral Surgery Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
Organ Transplant Services(Non-Blue Distinction Center Facility) Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
Organ Transplant Services	Consult The Transplant Benefit Section Plan Includes Blue Distinction Transplant Center	
Orthotic/Prosthetic Devices Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: Wigs are covered following chemotherapy limited to 1 wig per calendar year, up to a maximum of $300. Custom molded Orthotic Devices, Diabetic shoes, Orthopedic shoes, or shoe inserts are not covered.		
Physical Therapy Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: Prior Authorization Is Required After 10 Physical Therapy Visits.		
Private Duty Nursing Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
Reconstructive Surgery Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: Covered For The Correction Of Abnormal Congenital Conditions And/Or Performed As A Result Of Injury Or Illness		
Sleep Disorder Therapy Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: Sleep Studies are Covered in The Patients Home.		
Speech Therapy Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible
NOTE: Speech Therapy To Treat A Developmental Delay Is Not Covered.		
Sterilization (Reversal Excluded From Coverage) Covered As Outlined In The Medical Benefits Section **Female Participants Covered At 100% Per ACA Guidelines.**	10% After Deductible	30% After Deductible
Temporomandibular Joint Dysfunction (TMJ) Covered As Outlined In The Medical Benefits Section	10% After Deductible	30% After Deductible

COVERED BENEFITS	
PRESCRIPTION DRUGS	**YOUR COST SHARE RESPONSIBILITY**
Retail Pharmacy Limited to a 34-day supply (a 90-day supply can be purchased at certain retail pharmacies at the Mail Order Co-pay Level shown below).	
Tier I Member Payment Amount Tier II Member Payment Amount Tier III Member Payment Amount Tier IV – Specialty Medications Member Payment Amount	$15 Copayment $30 Copayment $60 Copayment 20% to $100
Prescription Drug Benefit shall include Specialty Medications Included in Copay Assistance program. Manufacturer assistance program covers most if not all of the coinsurance amount. Your out-of-pocket cost per 30-day supply will not exceed the maximum copayment.	30% Copayment per 30-day fill
Direct Mail Service Limited up to a 90-day supply.	
Tier I Member Payment Amount Tier II Member Payment Amount Tier III Member Payment Amount	$30 Copayment $60 Copayment $120 Copayment
Medicare Eligible Retirees, Disabled and Survivors If eligible for this plan you MUST be enrolled in Medicare parts A, B and D to be eligible for Prescription Drug coverage under this plan. Retirees over age 65 are not eligible for the Mail Order benefit.	
Specialty Medication You must obtain pre-authorization through the drug card or benefits will not be payable.	20% Copayment ($100 maximum) Per Drug/Refill.
Over-the-Counter Drugs (OTC) OTC proton pump inhibitors OTC non-sedating anti-histamines	$0 Copayment 20% Copayment
You must still obtain a prescription for your qualified practitioner.	
Step Therapy: PPI Class Not all PPI Class drugs are covered by the plan. Some require Step Therapy. Step Therapy requires that you first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, KREC may not cover Drug B unless you try Drug A first. If Drug A does not work for you, KREC will then cover Drug B.	
If you are prescribed certain generic drugs in this class, you may not be subject to clinical review due to the generic drug representing STEP A in the Step Therapy program.	
If you are prescribed certain brand name drugs in this class you may be subject to clinical review by the Prescription Drug Card vendor. Experts in conjunction with your physician will determine if you can advance through the step tiers. STEP B will represented by the preferred PPI medications and STEP C will be represented by the non-preferred PPI medications.	

NOTE:
The Covered Individual's Prescription Drug Copayments will apply to the Plan's Maximum Annual Out-Of-Pocket Limit per Calendar Year.[1]
Member may be responsible for additional cost when not selecting the available generic drug.
Specialty Medications must be obtained via the Specialty Pharmacy Network.
Specialty Medications are limited to a 30-day supply regardless of whether obtained via retail or Mail Order.

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	**BLUE DISTINCTION CENTER IN-NETWORK**	**NON-NETWORK**
	YOUR COST SHARE RESPONSIBILITY	
Transplant Benefit Period	Starts One Day Prior To A Covered Transplant Procedure And Continues For The Applicable Case Rate/Global Time Period.	Starts One Day Prior To A Covered Transplant Procedure And Continues For The Applicable Case Rate/Global Time Period.
Plan Deductible – Transplant Services	Applicable Unless A BDCT/CME Is Used And Then Services Are Paid In Full	Applicable Unless A BDCT/CME Is Used And Then Services Are Paid In Full
Transplant Benefit	During The Transplant Benefit Period The Member Pays Coinsurance And Deductible. If A BDCT/CME Facility Is Used Services Are Covered 90% With 10% Member Cost Share. Prior To And After The Transplant Benefit Period, Covered Charges Will Be Covered Based On The Place Of Service.	During The Transplant Benefit Period The Member Pays Coinsurance And Deductible. If A Non-Network Facility Is Used Services Are Covered 70% With 30% Member Cost Share. Prior To And After The Transplant Benefit Period, Covered Charges Will Be Covered Based On The Place Of Service.
Transportation & Lodging The Plan Will Provide Assistance With Reasonable And Necessary Travel Expenses As Determined By The Plan When You Obtain Prior Approval And Are Required To Travel More Than 75 Miles From Your Residence To Reach The Facility Where The Covered Transplant Procedure Will Be Performed. Assistance With Travel Expenses Includes Transportation To And From The Facility And Lodging For The Transplant Recipient And One Adult Companion For An Adult Transplant Recipient Or Two Adult Companions For A Child Transplant Recipient Under Age 18. The Member Must Submit Itemized Receipts For Transportation And Lodging Expenses In A Form Acceptable To The Plan. Internal Revenue Service (IRS) Guidelines Will Be Applied In Determining Which Expenses May Be Paid By The Plan. There Is A Maximum Lodging Allowance Of $50 Per Day For Double Occupancy.	Not A Covered Service	Not A Covered Service

TRANSPLANT BENEFIT	BLUE DISTINCTION CENTER IN-NETWORK	NON-NETWORK
	YOUR COST SHARE RESPONSIBILITY	
Unrelated Donor Searches	Unrelated Donor Services Are Covered at 90% With 10% Member Cost Share.	Unrelated Donor Services Are Covered at 70% With 10% Member Cost Share.
Live Donor Health Services Donor Benefits Are Limited To Benefits Not Available To The Donor From Any Other Source.	During The Transplant Benefit Period Covered At 90% After Deductible with 10% Member Cost share. Medically Necessary Charges For Procurement Of An Organ From A Live Donor Are Covered To The Maximum Allowable Amount Including Complications From The Donor Procedure For Up To Six Weeks From The Date Of Procurement.	During The Transplant Benefit Period Covered At 70% After Deductible with 30% Member Cost share. Medically Necessary Charges For Procurement Of An Organ From A Live Donor Are Covered To The Maximum Allowable Amount Including Complications From The Donor Procedure For Up To Six Weeks From The Date Of Procurement.
All Other Transplant Services	During The Transplant Benefit Period Member Pays 10% After Deductible.	During The Transplant Benefit Period Member Pays 30% After Deductible.

Benefit Schedule Notes for PPO:

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

Cost Containment Penalties are excluded from the Out-Of-Pocket Limits.

Network and Non-Network Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximums are separate and accumulate separately.

Dependent Coverage to end of the Calendar 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.

SPC 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 Calendar Year Basis beginning January 1st and ending December 31st.

[1] Charges in excess of the Maximum Allowed Amount do not contribute to the deductible. Deductible Amounts accumulate separately for In Network and Out of Network.

[2]Out of Pocket amounts accumulate separately for In Network and Out of Network Charges.

[3]Preventive Mammograms are covered at 100%.

[4] Breast Pumps are Covered at 100% by an In Network or Out of Network DME (Durable Medical Equipment) Provider as well as retail stores. Members are reimbursed for any breast pumps at purchase price, including sales tax.

PPO NETWORK INFORMATION

PPO networks negotiate contracts with health care providers to provide services at a discounted price. In return, the provider receives a higher volume of patients due to the *plan's* incentives to use *PPO* providers. These contracts establish a fair market value for health care services, which in most cases will reduce *your* costs. When using a *PPO* provider, *you* will generally receive a higher level of benefits.

Your employer has contracted one or more *PPO's* to provide services to this *plan* in the areas it has *employees*. Each *PPO* network consists of physicians, *hospitals* and other medical care providers. The *PPO* that is applicable to *you* is shown on *your* ID card. The *PPO* network is comprised of a broad range of provider specialties, including *hospitals* and all types of medical *qualified practitioners* who are contracted to provide services for pre-negotiated, contracted rates.

You can access *network* provider information on the *network's* website that is listed on the back of *your* ID card at no charge.

Any *plan* limits on access to specialist or emergency care, use of primary care physicians, or pre-authorization of benefits are shown on the Schedule of Benefits.

This *plan* also offers *you* the choice of obtaining care from health care providers who are outside *your PPO* network. When *you* obtain *covered expenses* from Non-*PPO* providers, the *plan* will generally pay a lower level of benefits and *your* out-of-pocket expenses will be more. *Covered expenses* received from Non-*PPO* providers are subject to the *usual and customary and reasonable* limits.

HOW TO FILE A MEDICAL CLAIM

You will receive a *plan* identification (ID) card. It will show *your* name and group number.

Medicare primary claims must be mailed to ARC Administrators with the corresponding Explanation of Benefits provided by Medicare:

Attention: Claim Department
ARC Administrators
333 West Vine Street, Suite 900
Lexington, Kentucky 40507

All other claims must be sent directly to *your* local BCBS Plan.

Be sure each bill shows the group number and participant number found on *your* ID card. The *employee's* name and the patient's name should also be included on each bill.

MISCELLANEOUS MEDICAL CHARGES

Bills for medical items *you* purchased yourself should be sent to ARC Administrators at least once every three months (quarterly). Make sure each receipt includes: the group number, participant number, *employee* name, patient name, name of prescribing *qualified practitioner*, provider address, Tax Identification Number, procedure codes, diagnosis codes, amount charged for each service, and date purchased.

PAYMENT OF CLAIMS

The *plan* will make direct payment to the service provider. If *you* have paid the bill, please indicate on the original bill "paid by *employee*" and payment will be made to *you*. *You* will receive a written explanation of payment or reason for denial of any portion of a claim. The *plan* reserves the right to request any information required to determine benefits or process a claim. *You* or the service provider will be contacted if additional information is needed to process *your* claim.

CLAIM FILING LIMITS

You must provide the *plan* with written proof of *your* claim. Proof should be provided within 15 months after the date the claim was incurred. *Your* claim will not be denied if it was not reasonably possible to give such proof. However, unless *you* were legally incapacitated during the period, any claim received by the *plan* more than 15 months after the date the claim was incurred will not be covered under the *plan*.

If the *plan* is terminated, written proof of any claims incurred prior to the termination must be given to the *plan* within 90 days of its termination. Any claim received by the *plan* more than 90 days after it is terminated will not be covered under the *plan*.

MEDICAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

Deductible

The deductible applies to each *covered person*, each *calendar year*. Only charges that are a *covered expense* will be used to satisfy the deductible. The amount of the deductible is shown on the Schedule of Benefits.

Maximum Family Deductible

The maximum deductible per family is shown on the Schedule of Benefits. No further deductibles will be taken during a *calendar year* once this maximum has been met.

Common Accident Deductible

When more than one *covered person* in a family is involved in the same *accident*, only one deductible per *calendar year* will be applied to all *covered expenses* resulting from that *accident*.

Coinsurance

The deductible must be satisfied each *calendar year*. Benefits are then payable at the percentage rate shown on the Schedule of Benefits. Benefits are payable up to any *plan* maximums on a *usual and customary and reasonable* basis.

Coinsurance Limit

The amount *you* must pay is the coinsurance limit. The coinsurance limit is shown on the Schedule of Benefits. The coinsurance limit is made up of the coinsurance. The deductible is in addition to this amount. When the coinsurance limit has been met for a *covered person* or family, the coinsurance reverts to 100%.

This limit does not apply to:

1. Penalties for failure to comply with the *Prior Authorization*; or
2. Benefit specific copays under the *plan* (if applicable),
3. Exclusions and Limitations,
4. Charges in Excess of Maximum Allowed Amount.

Maximum Annual Out-of-Pocket Limit

The amount *you* must pay is the maximum annual out-of-pocket limit. The maximum-out-of-pocket limit is shown on the Schedule of Benefits. The maximum-out-of-pocket limit is made up of deductibles, coinsurances, and copays (if applicable) for both medical and prescription drug benefits. When the maximum annual out of pocket limit has been met for a *covered person* or family, the coinsurance reverts to 100%.

PRIOR AUTHORIZATION REQUIREMENTS

HOW THE PROGRAM WORKS

When *you* call UM for authorization, *you* will be asked the following questions:

1. Group name and number
2. Name of *employee*
3. *Employee's* participant number
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting facility and phone number, if applicable
8. Physician's name and phone number
9. Reason for admission or treatment
10. Admission or treatment date

Once *prior authorization* is provided, it is valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new *prior authorization* must be obtained if: you do not receive the treatment within 30 days of the scheduled date; *you* use a different facility or physician; or *you* are admitted for a different reason.

PRIOR AUTHORIZATION REQUIREMENTS

You, or *your qualified practitioner,* are required to obtain authorization from UM prior to receiving certain types of health care. The services that require *prior authorization* are listed on the Schedule of Benefits. **If** *you* **are required to obtain *prior authorization* and fail to do so, benefits may be reduced or denied.**

PRIOR AUTHORIZATION DOES NOT GUARANTEE BENEFIT PAYMENT. BENEFITS ARE SUBJECT TO ALL *PLAN* PROVISIONS.

The following procedures require pre-certification:

- Adenoidectomy
- Arthroscopy Any Joint
- Blepharoplasty
- Cardiac Catheterization
- Cochlear Implants
- Cholecystectomy
- Deviated Septum/Nasal
- Durable Medical Equipment (in excess of $500)
- Endoscopic Procedures
- Epidural/Facet & Trigger Point Injections
- Excision of Mass
- Genetic Testing/Molecular Pathology
- High End Radiology - MRI/CT/PET
- Inpatient Behavioral Health/Substance Abuse
- Laminectomy/Spinal Surgery
- Laparoscopy
- Lung Perfusion Study
- Mammoplasty
- Occupational Therapy
- Orthopedic Surgery With Implants
- Physical Therapy After 10 Visits
- Skilled Nursing Facility Admissions
- Surgery
- Tonsillectomy
- Varicose Vein Stripping & Ligation

NON-COMPLIANCE PENALTY

If the provider is required to obtain *prior authorization* and it is not obtained, *you* will not be subject to the non-compliance penalty. *Your* treatment will be reviewed when a claim is received.

If *you* are required to obtain *prior authorization* and it is not obtained, *your* treatment will be reviewed when a claim is received. If it is determined to be a *covered expense*, benefits that are otherwise payable may be reduced by $100 per occurrence. This penalty is applicable to both *PPO* and Non-PPO charges. The penalty may be taken from any charges relating to the treatment. The penalty is taken before subtracting any deductible and coinsurance. The penalty is not applied to the out-of-pocket limit.

If *your* treatment is not a *covered expense*, no benefits will be payable under the *plan*.

SECONDARY COVERAGE WAIVER

If this *plan* is secondary to another medical plan that also covers you, *prior authorization* will not be required.

CASE MANAGEMENT

Case management services help *you* use *your* benefits wisely during periods of treatment due to a serious *sickness* or *injury*. This is done through early identification of the need for case management in UM. Followed by on-going work with *you* and *your* provider to plan health care alternatives to meet *your* needs. The case manager will try to conserve *your* benefits by making sure that *your* care is handled as efficiently as possible.

The case management staff at UM consists of licensed, professional nurses. The nurses have years of experience in health care. They know the importance of not intruding in the doctor/patient relationship. By promoting health care alternatives that are acceptable to *you*, *your* doctors and *your employer*, case management helps to control health care costs and use *your* benefits wisely.

DISEASE MANAGEMENT

Disease Management is a proactive approach to better health. The need for services is identified through a screening process conducted by UM. Participation in the program is voluntary. After an initial contact, the patient must agree to continue in the program. The program will then provide ongoing support, education, and coordination of professional and self-care needs for the patient.

All services received through this program are confidential. The program is staffed by experienced, licensed nurses. The nurses are available to address questions you may have regarding your condition. The goal of Disease Management is to assist you in enjoying good health and to prevent future medical complications.

MEDICAL BILL REVIEW

You should carefully review *your* bill for any service. If *you* find any errors such as:

1. Treatment that is billed, but was not received;

2. Incorrect arithmetic;

3. Drugs or supplies that were not received;

You should report them to the provider of service and request a corrected itemized billing. *You* should then submit copies of the original bill, with the errors circled, and the corrected bill to the *claim administrator*. This serves as proof that the provider of service agreed to the corrections. **If** *you* **are correct,** *you* **will receive 50% of the errors in the bill, but not more than $1,000 per bill**.

MEDICAL COVERED EXPENSES

INPATIENT HOSPITAL BENEFITS

Charges made for these services furnished during *your hospital confinement* are payable as shown on the Schedule of Benefits:

1. Room and board charges for: average daily semi-private; ward; intensive care; isolation or coronary care. General nursing services for each day of *confinement*. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the *hospital*, unless necessary due to *your sickness* or *injury* or in the case that the *hospital* has private or single-bed rooms only.

2. Services and supplies provided for the treatment of *your sickness* or *injury*. Benefits include services of a radiologist, pathologist and anesthesiologist, when billed directly by the *hospital* or separately.

QUALIFIED PRACTITIONER BENEFITS

Charges for these services of a *qualified practitioner* are payable as shown on the Schedule of Benefits:

1. Home and office visits;

2. Inpatient and outpatient *hospital* visits;

3. Administration of anesthesia;

4. Surgical procedures, including post-operative care.

Benefits are not payable for incidental procedures done during a covered surgery (e.g. the removal of a healthy appendix during abdominal surgery).

Oral Surgery

Charges made for these oral surgeries are payable as shown on the Schedule of Benefits. Benefits include directly related charges for lab tests and x-rays. *Hospital* or *ambulatory surgical center* services are also covered.

1. Excision of unerupted, impacted teeth;

2. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;

3. Incision and drainage of an abscess or cyst;

4. Charges for *hospital confinement* or treatment in a free-standing surgical center for dental treatment, which must be documented by a letter of necessity from the attending *qualified practitioner* or dentist for the claim to be considered;

5. Charges for the extraction of seven or more teeth at the same time;

6. Repair of or initial replacement of natural teeth damaged due to *injury*. To be a *covered expense* under the *plan*, the replacement expense must be incurred within one year of the *injury*. Damage resulting from biting or chewing will not be considered an *injury*.

PREVENTIVE WELLNESS BENEFIT

Charges for preventive medical services are payable as shown on the Schedule of Benefits. Immunizations are payable as a separate benefit (please refer to Schedule of Benefits for information). *Covered expenses* include but are not limited to the following:

All Covered Persons

1. Preventive medicine visits (wellness exams).

Screening/Services For All Covered Persons at Appropriate Ages

1. Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, colonoscopy);
2. Elevated cholesterol and lipids;
3. Certain sexually transmitted diseases and HIV (includes counseling);
4. Alcohol and substance abuse, tobacco use, obesity, diet and nutrition counseling;
5. High blood pressure;
6. Diabetes;
7. Depression;
8. Screening for developmental delay/autism.

For Women

1. Screening mammography;
2. Counseling for genetic testing for BRCA breast cancer gene;
3. Screening for cervical cancer including pap smears;
4. Screening for gonorrhea, chlamydia, syphilis;
5. Screening for pregnant women for anemia and iron deficiency, bacteriuria, hepatitis B virus, Rh incompatibility;
6. Instructions to promote and help with breast feeding;
7. Screening for osteoporosis;
8. Counseling for those at high risk for breast cancer for chemoprevention.

For Men

1. Screening for prostate cancer;
2. Screening for abdominal aortic aneurysm for those ages 65 and older.

For Children

1. Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia;
2. Standard metabolic screening panel for inherited enzyme deficiency diseases;
3. Screening for major depressive disorders;
4. Screening for lead and tuberculosis;
5. Fluoride for prevention of dental cavities;
6. Counseling for obesity.

CONTRACEPTIVES

Charges for all FDA approved contraceptive methods, in accordance with Health Resources and Services Administration (HRSA) guidelines. Coverage for oral, patch, ring, diaphragm/cervical cap, emergency, and injectables is available under the prescription drug plan.

OUTPATIENT HOSPITAL BENEFIT

Charges for these outpatient *hospital* services are payable as shown on the Schedule of Benefits:

1. Services and supplies provided for the treatment of *your sickness* or *injury*;

2. Regularly scheduled medical treatments (e.g. kidney dialysis, chemotherapy, inhalation therapy, physical therapy and radiation therapy) when ordered by *your* attending *qualified practitioner*; and

3. *Emergency* room charges.

URGENT CARE CENTER BENEFIT

Charges for *covered expenses* provided by an *Urgent Care Center* are payable as shown on the Schedule of Benefits.

AMBULATORY SURGICAL CENTER/FREE STANDING SURGICAL FACILITY

Charges made by an *ambulatory surgical center* for use of the facility in performing a covered surgery are payable as shown on the Schedule of Benefits. *Hospital* miscellaneous services provided in the facility are also covered.

X-RAY AND LABORATORY TESTS

Charges for diagnostic x-ray and lab tests are payable as shown on the Schedule of Benefits. A *qualified practitioner* must perform the tests. Tests covered under the Inpatient Hospital Benefit are not covered under this benefit. Dental x-rays are not covered, unless related to a covered *injury* or oral surgery.

AMBULANCE SERVICE BENEFIT

Charges for ground ambulance service to a local *hospital* or skilled nursing facility are payable as shown on the Schedule of Benefits. If *you* need care that is not available in a local *hospital*, transport to the nearest *hospital* that can provide the care is covered. If *you* require care that is not available by ground ambulance, air ambulance service to the nearest *hospital* that can provide the care is covered.

PREGNANCY BENEFIT

Charges for pregnancy are payable as shown on the Schedule of Benefits for any covered female *employee* or *dependent* spouse. *Complications of pregnancy* are payable as a *sickness* at the point the complication sets in.

Charges for selective reduction/multifetal pregnancy reduction are payable if the life of the mother is at risk.

In general, Federal law prohibits group health plans and health insurance issuers from limiting benefits for any *hospital* stay in connection with childbirth to less than 48 hours after a normal vaginal delivery or less than 96 hours after a cesarean section. This law applies equally to the stay of the mother and the stay of the newborn. This law does not generally prohibit the attending provider of the mother or newborn from discharging them, after consulting the mother, at an earlier time than the 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length stay that is not in excess of 48 hours (or 96 hours).

NEWBORN BENEFITS

This benefit does **not** apply unless *you* enroll *your* newborn *dependent* within 31 days of the date of birth. See the "Eligibility" section of this booklet for more information.

Well-Newborn

Charges for these services for a well-newborn are payable as shown on the Schedule of Benefits: hospital nursery services; circumcision of a male *child*; routine examination of the newborn *child* before release from the *hospital*.

Sick-Newborn

Charges for these services for a sick-newborn are payable as shown on the Schedule of Benefits: treatment of *injury* or *sickness*; care and treatment for premature birth; treatment of medically diagnosed birth defects and abnormalities; and surgery to repair or restore normal body functioning. *Covered expenses* do **not** include plastic or cosmetic surgery, **except** surgery for:

1. Reconstruction due to *injury*, infection or other disease of the involved part; or

2. Congenital disease or anomaly that resulted in a functional defect.

BIRTHING CENTER BENEFIT

Charges made by a *birthing center* for services and supplies provided for: prenatal care; delivery of children; and immediate postpartum care are payable as shown on the Schedule of Benefits.

CONVALESCENT NURSING HOME BENEFIT

Charges for room and board and nursing care are payable as shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the charge for a semi-private room in the facility. Custodial care is not a *covered expense*.

Limitations

Benefits are only payable for a *confinement* that:

1. Begins within 15 days of discharge from a *hospital* or prior *convalescent nursing home confinement* of at least three consecutive days;

2. Is necessary for care of the same *injury* or *sickness* which caused the prior *confinement*; and

3. Occurs while *you* are under the care of the *qualified practitioner* who ordered the *confinement*.

HOME HEALTH CARE BENEFIT

Charges for Home Health Care, as described below, are payable as shown on the Schedule of Benefits. Benefits will not exceed the *usual and customary and reasonable* fee for care in a *convalescent nursing home*. Custodial care is not a *covered expense*.

Each visit to evaluate the need for home health care will be considered one home health care visit. Each visit to develop a plan of home health care will be considered one home health care visit. Each four hour period of home health aide service will be considered one home health care visit. A home health aide visit of four hours or more is considered one visit for every four hours or part thereof.

Home Health Care will **not** be covered unless a *qualified practitioner* certifies that:

1. *Confinement* in a *hospital* or *convalescent nursing home* would be required without the home care;

2. Necessary care is not available from *your family members* or other persons residing with *you*, without causing undue hardship;

3. The home health care services will be provided or coordinated by a state-licensed or *Medicare*-certified *home health care agency* or certified rehabilitation agency.

If *you* were in a *hospital* prior to starting home health care, the home health care plan must also be approved by the primary provider of services during *your hospital* stay.

A home health care plan may consist of:

1. Part-time home nursing care by or under the supervision of a registered nurse (R.N.);

2. Part-time home health aide services provided under the supervision of a registered nurse (R.N.) or medical social worker. Services must consist solely of caring for the patient;

3. Physical, respiratory, occupational or speech therapy;

4. Medical supplies and drugs prescribed by a *qualified practitioner*. Lab tests by or on behalf of a *hospital*, when necessary under the home care plan;

5. Nutritional counseling provided under the supervision of a registered or State certified dietician, when such services are necessary as part of the home care plan; and

6. An evaluation of home health care needs. The development of a home health care plan. This service may be done by an R.N., physician assistant or medical social worker.

HOSPICE CARE BENEFIT

Charges for these *hospice care* services are payable as shown on the Schedule of Benefits. H*ospice care* must be in lieu of a covered *hospital* or *convalescent nursing home confinement*.

1. Room and board;

2. Part-time nursing care by or supervised by a registered nurse (R.N.);

3. Counseling by a licensed clinical social worker. Counseling by a pastoral counselor. Benefits are provided for the hospice patient and immediate family;

4. Bereavement counseling by a licensed clinical social worker or a pastoral counselor for the immediate family;

5. Medical social services provided to *you* or *your* immediate family. Services include:

    a. assessment of social, emotional and medical needs, and the home and family situation, and
    b. identification of the community resources available and assisting in obtaining those resources;

6. Dietary counseling;

7. Consultation and case management services;

8. Physical, speech or occupational therapy;

9. Part-time home health aide service; and

10. Medical supplies, equipment, drugs and medicines prescribed by a *qualified practitioner*.

Limitations

Hospice care must be furnished in a *hospice facility* or by a *hospice care agency* in *your* home. A *qualified practitioner* must certify that *you* are terminally ill with a life expectancy of six months or less. For *hospice care* only, *your* immediate family is *your* parent, spouse and *dependent* children.
Hospice care benefits do **not** include: private or special nursing services; a *confinement* not required for pain control or other acute chronic symptom management; funeral arrangements; or financial or legal counseling including estate planning or drafting of a will.

Hospice care benefits do **not** include homemaker or caretaker services; sitter or companion services; house cleaning or household maintenance; services by volunteers or persons who do not regularly charge for their services; or services by a licensed pastoral counselor to a member of his congregation.

PSYCHOLOGICAL DISORDERS, CHEMICAL DEPENDENCE AND ALCOHOLISM BENEFIT

Inpatient and Transitional Treatment Benefits

Charges for inpatient treatment are payable as shown on the Schedule of Benefits. Charges for a transitional treatment program are payable as shown on the Schedule of Benefits.

Transitional treatment means treatment that is provided in a less restrictive manner than inpatient treatment, but in a more intensive manner than outpatient treatment.

Transitional treatment includes the following services or programs when approved by the Department of Health and Social Services: adult day treatment programs; *child* and adolescent day treatment programs; services for the chronically psychologically ill provided by a community support program; services for alcohol and chemical dependence provided by a residential treatment program; and services for alcoholism and other chemical dependence provided in a day treatment program. Transitional treatment also includes services in intensive outpatient programs provided in accordance with the Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders of the American Society of Addiction Medicine.

Outpatient Benefits

Charges for outpatient treatment are payable as shown on the Schedule of Benefits. Outpatient Benefits include related expenses for diagnostic lab tests and psychological testing. Prescription drugs are payable under the Prescription Drug Benefit.

Limitations

Benefits do **not** include:

1. Treatment of nicotine habit or addiction;
2. Treatment of being overweight or obese;
3. Marriage counseling; or
4. Court ordered examinations or counseling.

Covered expenses are applied to the out-of-pocket limit shown on the Schedule of Benefits.

OTHER COVERED EXPENSES

These other *covered expenses* are payable as shown on the Schedule of Benefits:

1. Private duty services of a registered nurse (R.N.) for outpatient nursing care. Private duty services of a licensed practical nurse (L.P.N.) for outpatient nursing care. Care must be ordered by *your* attending *qualified practitioner*.

2. Blood and blood plasma that is **not** replaced by donation. Blood and blood products including blood extracts or derivatives.

3. Prosthetic devices to replace lost natural limbs and eyes. Replacement devices and repair expenses will be covered if due to normal wear and tear. Maintenance expenses are not covered.

4. Special supplies when prescribed by *your* attending *qualified practitioner* and necessary for the continuing treatment of a *sickness* or *injury*:

    a. catheters;
    b. colostomy bags, belts and rings;
    c. flotation pads;
    d. needles and syringes;
    e. casts, splints, surgical dressings, trusses, braces and crutches;
    f. oxygen and other gases.

5. Rental of durable medical equipment or purchase of such equipment when approved by the *plan* (e.g. wheelchair, *hospital* bed). The equipment must be needed for therapeutic treatment and not be mainly hygienic, custodial or educational in nature. It must be able to withstand repeated use. It must be primarily and normally used to serve a medical purpose. It must not be generally useful to a person except for the treatment of an *injury* or *sickness*. Repair and maintenance expenses are not covered. Replacement of external breast prosthesis and bra are limited to two per *calendar year* period. Convenience items, as determined by the *plan*, are not covered. Unless approved by the *plan* benefits for the rental of durable medical equipment will not exceed the cost to purchase the item.

6. Mechanical medical devices placed in the body to aid the function of a body organ (e.g. pacemaker, artificial larynx, artificial hip).

7. Chiropractic care for the treatment of an *injury* or *sickness*. Routine or maintenance chiropractic care is a *covered expense*.

8. Installation and use of an insulin infusion pump. Other equipment and supplies used in the treatment of diabetes, when not covered by the Prescription Drug Benefit. Diabetic self-management education programs.

9. Elective sterilization, vasectomy and tubal ligation. Covered for *employees* and *dependent* spouses only. Benefits will be payable based on services received.

10. Treatment by a licensed: physical therapist; speech therapist; respiratory therapist; or occupational therapist. All treatment must be to restore loss or correct impairment due to an *injury* or *sickness*.

11. Radiation therapy and chemotherapy. Oral and injectable medications may be covered through the Prescription Drug benefit.

12. Pre-admission testing, when the tests are performed in a *qualified practitioner's* office or the *outpatient* department of a *hospital*, within ten days of a covered inpatient *confinement* and accepted by the inpatient facility in lieu of like tests performed after *your* admission. Benefits will be payable based on services received.

13. Surgical and non-surgical treatment of any jaw joint problem, including but not limited to appliances and therapy. TMJ is eligible when the plan determines on the basis of x-rays, study models or other supporting evidence submitted that:

    a. Internal derangement and degeneration exists;
    b. Treatment is appropriate for the existing condition;
    c. A suitable long-term prognosis can be achieved by this treatment; and
    d. There is no alternative treatment that is less irreversible and/or less invasive.

    Biteguards/mouthguards will be covered if used to treat the *medical condition* and not to break a habit. *Covered expenses* do not include orthodontic services or treatment.

14. All standard immunizations recommended by the American Committee on Immunization Practices.

15. *Hospital* admission kits.

16. Allergy testing and treatment, payable as shown on the Schedule of Benefits.

17. Routine patient costs of items and services furnished in connection with participation in an *approved clinical trial* are covered for qualified individuals.

18. Treatment of *autism*, including therapeutic, respite and rehabilitative care. Benefits are subject to the autism maximum stated on the Schedule of Benefits. *Covered expenses* for *autism* are not considered to be treatment of a psychological disorder.

19. Treatment of ADD/ADHD.

20. Hearing aids if necessary by impairment of hearing following ear surgery or due to traumatic *injury*. Replacement of a hearing aid is not a *covered expense*. This benefit is limited to one per ear per lifetime.

21. Contacts or glasses following eye surgery due to cataracts or eye *injury*. No benefits will b*e paya*ble for replacement of contact lenses or *eyeglasses due* to loss, breakage or prescription change.

22. Second surgical opinion. The qualified practitioner giving the second opinion must not be associated with the qualified practitioner who gave the first opinion and must not perform the surgery. The second opinion will be paid as any other sickness or injury. Benefits will include any related x-ray or laboratory tests. Benefits will be paid whether or not the surgical procedure is actually performed.

23. Total parenteral nutrition.

24. When reconstructive surgery is elected after a mastectomy, the following services will also be covered:

    a. reconstruction of the breast that was removed;
    b. surgery and reconstruction of the other breast to produce a symmetrical appearance;
    c. prostheses to replace the breast that was removed; and
    d. any physical complications resulting from all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

    Benefits must have been payable for the mastectomy and these services must be part of the ongoing treatment of that mastectomy to be covered under the *plan*.

25. Wigs/Toupees, when hair loss is the result of radiation or chemotherapy. Limited to one wig per *calendar year*, subject to the maximum stated on the Schedule of Benefits.

26. Sleep Studies are covered in the patient's home, if the patient in enrolled in the *plan.* Sleep therapy studies payable as shown on the Schedule of Benefits.

27. All four Phases for Cardiac Rehabilitation Therapy are covered for inpatient and outpatient therapy.

LIMITATIONS AND EXCLUSIONS

This *plan* does **not** provide benefits for:

ALTERNATIVE TREATMENTS

1. Any charge for **alternative medical treatments**. Treatments include but are not limited to: holistic medicine, ayurveda and ayurvedic nutrition, craniosacral therapy, yoga, homeopathy, movement therapy, naturopathy, tai chi chuan, visualization sessions and other programs with an objective to provide complete personal fulfillment or harmony, rolfing, reiki, reflexology, therapeutic touch, colon therapy, massage therapy not a part of a treatment plan, herbal therapy, vitamin therapy, hypnotherapy and chelation (metallic ion therapy) except in the treatment of heavy metal poisoning;

2. **Acupuncture**;

3. **Mechanotherapy** or other forms of passive motion therapy, unless specifically approved by the *plan*;

4. **Athletic training** or rehabilitation services; or

5. **Vertebral Axial Decompression (VAX-D)**.

DENTAL

1. **Dental care** or treatment to the teeth, nerves and roots of the teeth, gums or other gingival tissues, or the supporting structures of the teeth (alveolar processes), except as stated;

2. **Dental implantology** techniques, including prosthetic devices related to such techniques; or

3. Any **orthodontic** service, treatment or supply.

DRUGS

1. Drugs, food or nutritional supplements, or medical or other supplies that are **available without the written prescription of a** *qualified practitioner* **(OTC - over the counter)**. OTC items specifically stated in this plan as a *covered expense* will be covered. When OTC items are provided as a necessary part of a covered expense incurred in a *qualified practitioner's* office, *hospital* or other facility it will be covered; or

2. Charges for **prescription drugs**, except when not covered by the *employer's* Prescription Drug Benefit and not excluded under any other provision of this *plan*.

EXPERIMENTAL OR UNPROVEN SERVICES

1. Experimental, investigational or unproven services, which means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

    a. items within the research, investigational or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
    b. items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

c. items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
d. items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a service, supply, drug, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered experimental, investigational or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the *plan* and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

PHYSICAL APPEARANCE

1. **Plastic or cosmetic surgery**, including any services or supplies related to, resulting from complications of or for reversal of cosmetic surgery. Reconstructive surgery due to *injury*, infection or other disease of the involved part is a *covered expense* when the need for such surgery is not the result of or a complication of a prior cosmetic procedure;

2. Any charges for, relating to or resulting from **sex change operations**;

3. Treatment of a **congenital disease or anomaly**, except to correct a functional defect;

4. Any treatment or services for **weight control or reduction**. Treatment includes, but is not limited to: nutritional supplements; individual or behavior modification therapy; body composition or underwater weighing procedures; exercise therapy; weight control or reduction programs; except as specifically stated for preventive counseling;

5. Any treatment of **obesity or morbid obesity**, including, but not limited to surgery (e.g. stomach stapling, gastric bubble, intestinal or stomach bypass or suction lipectomy). Treatment of morbid obesity will be covered if organic in nature;

6. **Wigs** or artificial hairpieces, except as specifically stated otherwise;

7. Any treatment of **gynecomastia** (enlargement of the breast tissue in males); or

8. Any treatment of **hyperhidrosis** (excessive sweating).

PROVIDERS

1. Any service or supply:

    a. provided while *you* are **not under the regular care of a** *qualified practitioner*;
    b. **not authorized or prescribed by a** *qualified practitioner*;
    c. authorized or prescribed by a *qualified practitioner*, but **excluded under this** *plan*;

2. Services provided by a **person who ordinarily resides in** *your* **home** or who is a *family member*;

3. **Telephone, computer or Internet consultations** between *you* and any provider (unless listed as a covered expense herein). Completion of claim forms or forms necessary for *your* return to work or school. Any appointment *you* did not attend;

4. **Private duty nursing** while in a *hospital* or other *qualified treatment facility*;

5. Charges for a **standby surgical team**, unless surgery is actually performed;

6. **Professional component charges in relation to an automated test** or procedure; or

7. **After hour charges in relation to a service performed during normal operating hours** for the provider.

REPRODUCTION

1. **Elective abortions** performed by any means including surgical and pharmaceutical methods unless *medically necessary* to save the mother's life. However, complications of an elective abortion are a *covered expense*;

2. Any **artificial means to achieve pregnancy** including, but not limited to, in vitro fertilization, GIFT, ZIFT, artificial insemination and all related fertility testing, treatment and drugs;

3. Treatment, services or supplies for a **surrogate mother** or any pregnancy resulting from *your* service as a surrogate mother;

4. Treatment of a **sexual dysfunction**, including, but not limited to sexual counseling or therapy, implants and hormonal therapy;

5. Services for **Genetic testing or counseling** without established Medical Necessity;

6. The **reversal of voluntary sterilization** procedures; or

7. *Dependent* **daughter maternity**.

ROUTINE AND GENERAL HEALTH

1. **Eye refractive disorders, vision therapy** (orthoptics), corneal refractive therapy, radial keratotomy or keratoplasty to correct refractive disorders, eyeglasses, or the fitting or repair of eyeglasses. The initial purchase of eyeglass frames, eyeglass lenses or contact lenses after a cataract surgery or eye surgery due to an *injury* is a *covered expense*;

2. Charges for **hearing exams**, if not in connection with a traumatic *injury* or following surgery;

3. **Health check-ups or routine exams and immunizations**; prophylactic surgery to prevent a *sickness* that has not occurred yet; or third party exams, including, but not limited to premarital tests or examinations; exams directed or requested by a court of law; routine physical exams for occupation, employment, school, travel or the purchase of insurance; unless specifically stated as a *covered expense*; or

4. Treatment programs, services or supplies having to do with the **cessation of tobacco usage** or nicotine addiction, (unless listed as a covered expense herein). When Part Of PPACA Services Refer To Preventative Care Benefits.

SERVICES UNDER ANOTHER PLAN

1. Any *injury* or *sickness* arising from or sustained in the course of any occupation or employment for pay, profit or gain. This will only apply when benefits are available or payable under any **Workers'**

Compensation or Occupational Disease Act or Law, regardless of whether a claim was filed for such benefits;

2. Any service or supply for which **no charge is made**, or for which *you* would not be required to pay if *you* did not have this coverage;

3. Any charges that **would have been paid by** *your* **primary plan** had *you* complied with all of the pre-certification requirements of that plan;

4. Any service or supply provided by or **payable under any plan or law of any government** or any political subdivision (this does not include *Medicare* or Medicaid); or

5. Any service or supply provided in the care of any service related *injury* or *sickness* (past or present) **if** *you* **are in a** *hospital* **or facility owned or operated by the United States Government** or any of its agencies.

OTHER

1. Charges 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 customary* amount, or are for services not deemed to be *reasonable* or *medically necessary*, based upon the *plan administrator's* determination as set forth by and within the terms of this document;

2. Services **not** *medically necessary* for diagnosis and treatment of an *injury* or *sickness*;

3. *Custodial care*;

4. Any medical expense incurred **after the date** *your* **coverage under the** *plan* **terminates**, except as specifically described;

5. Charges incurred **outside the United States** if *you* traveled to such location to obtain the service, drug or supply;

6. Any medical expense due to commission or attempt to commit a **civil or criminal battery or felony**;

7. Any loss caused or contributed to by:

    a. **war or any act of war**, whether declared or not, or
    b. any act of international armed conflict, or any conflict involving armed forces of any international authority;

8. **Educational testing or training or recreational therapy**;

9. Services or treatment for **behavioral problems, learning disabilities,** or other *medical condition*s that do not constitute a distinct medical diagnosis. Speech therapy to treat a developmental delay. ADD, ADHD and autism are covered as described herein;

10. Any **non-human organ transplant**. Any artificial organ transplant;

11. Any treatment that is provided to **enhance the life style of a person without treating** a *sickness* or *injury*;

12. Any service or supply that is provided in connection with or to comply with: **a court order; an involuntary commitment; a police detention**; or other similar arrangement;

13. Any service or supply provided in connection with or **as a result of any service or supply that is not a** *covered expense;*

14. Charges for ear plugs;

15. Treatment of:

    a. weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations,
    b. corns, calluses or toenails, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral-vascular disease; and

16. Custom molded orthotic devices. Diabetic shoes, Orthopedic shoes, or shoe inserts are not covered.

With respect to any injury which is otherwise covered by the plan, the plan will not deny benefits otherwise provided for treatment of the injury if the injury results from being the victim of an act of domestic violence or a documented medical condition.

PRESCRIPTION DRUG BENEFIT

You can access participating pharmacy information on the pharmacy benefit manager's website that is listed on the back of *your* ID card at no charge.

Covered Drugs

Your prescription drug benefit provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a prescription." *Your* pharmacist or the prescribing physician can verify coverage for a drug by contacting the pharmacy benefit manager at the number on *your* ID card. More information about covered drugs is available at www.navitus.com.

The following types of contraceptives are covered under this *plan*: oral, patch, ring, diaphragm/cervical cap, emergency, and injectables. IUDs are covered under the medical plan.

How To Use The Prescription Drug Benefit

Present the ID Card and the prescription to a participating pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the copay (if applicable) shown on the Schedule of Benefits.

There is no benefit for a non-participating pharmacy unless it is an emergent or urgent situation. If *you* are without *your* ID Card or at a non-participating pharmacy, *you* may be required to pay for the prescription and submit a claim to the pharmacy benefit manager.

Claim forms are available from *your employer*, from the NaviGate For Members web portal, or by calling Navitus Customer Care.

Mail Order Drug Service (not available to Retirees Over 65)

If *you* are using an on going prescription drug, *you* may purchase that drug on a mail order basis. Most drugs covered by the prescription drug benefit may also be purchased by mail order. The mail order drug service is most often used to purchase drugs that treat an on going medical condition and are taken on a regular basis.

The copay for mail order prescriptions (if applicable) is shown on the Schedule of Benefits.

Mail order prescriptions should be sent to the mail order service provider. Order forms are available at the mail order service provider's web site or from *your employer*. All prescriptions will be mailed directly to *your* home.

Formulary Program

This *plan* uses a formulary program to help reduce drug costs and ensure quality. The formulary is a list of covered drugs, both brand and generic. Drugs not listed on the formulary are not covered.

Medicare Eligible Retirees, Disabled and Survivors Over Age 65

You must be enrolled in Medicare Parts A and B to be eligible for Medicare D through the *employer*. *You* must enroll in the KREC Medicare D plan to be eligible for drug coverage under this *plan*.

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SECTION 2 DEFINITIONS

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DEFINITIONS

Certain words and phrases used in this Summary Plan Description are defined below as an explanation of how the terms are used in the *plan*. Defined words appear in *italic* throughout the *plan*.

Accident
A happening by chance and without intention or design. A happening, which is unforeseen, unexpected and unusual at the time it occurs.

Actively at Work
Performing on a regular, full-time basis all normal employment duties for at least 30 hours per week. Duties may be at the *employer's* business or another location if *you* are required to travel on the job. *You* will be *actively at work* on each day of paid vacation if *you* were *actively at work* on *your* last regular working day. *You* will be *actively at work* on each non-working holiday if *you* were *actively at work* on *your* last regular working day.

Adverse Benefit Determination
Any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the *plan*.

Allowable Expense
The *usual and customary* charge for any *medically necessary*, *reasonable*, and eligible items of expense, at least a portion of which is covered under a plan. When some other Plan pays first in accordance with the Application to Benefit Determinations section herein. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *plan*, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore.

Alternate Recipient
Any *child* of a *covered person* who is recognized under a medical *child* support order as having a right to enrollment under this plan as the *covered person*'s eligible *dependent*. For purposes of the benefits provided under this plan, an *alternate recipient* shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under ERISA, an *alternate recipient* shall have the same status as a *covered person*.

Ambulatory Surgical Center
A distinct facility whose business purpose is to provide surgical services on an outpatient basis. The facility must be duly licensed by the state in which it is located. It may not provide accommodations for patients to stay over-night.

Amendment
A written document that changes the provisions of the *plan*. It must be duly authorized and signed by the *plan administrator*.

Approved Clinical Trial
A phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "*approved clinical trial*," the *Plan* cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an *approved clinical trial* and either the individual's doctor has concluded that participation is appropriate or the *covered person* provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the *Plan* that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the *Plan's* network area unless out-of network benefits are otherwise provided under the *Plan*.

Birthing Center
A licensed facility which: 1. Provides prenatal care, delivery and immediate postpartum care, and care of a *child* born at the *birthing center*; 2. Is directed by a *qualified practitioner* specializing in obstetrics and gynecology; 3. Has a *qualified practitioner* or certified nurse midwife present at all births and during the immediate postpartum period; 4. Extends staff privileges to *qualified practitioners* who practice obstetrics and gynecology in the area; 5. Has at least two beds or birthing rooms for use by patients during labor and delivery; 6. Provides full-time skilled nursing services (directed by a R.N. or certified nurse midwife) in the delivery and recovery rooms; 7. Provides diagnostic x-ray and laboratory services for the mother and newborn; 8. Has the capacity to administer a local anesthetic and perform minor surgery (including episiotomy and repair of perineal tear); 9. Is equipped and staffed to handle medical emergencies and provide immediate life support measures; 10. Accepts only patients with low risk pregnancies; 11. Has a written agreement with an area *hospital* for *emergency* transfer of patients and ensures its staff is aware of the procedure; 12. Provides an ongoing quality assurance program; and 13. Keeps a medical record for each patient.

Calendar Year
A 12 month period of time that starts on January 1 and ends on December 31.

Child
In addition to the employee's own blood descendant of the first degree or lawfully adopted *child*, a *child* placed with a covered employee in anticipation of adoption, a covered employee's *child* who is an *alternate recipient* under a qualified medical *child* support order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster *child*," which is defined as an individual placed with the employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other *child* for whom the employee has obtained legal guardianship.

CHIP
The Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA
The Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Claims Administrator
The person or firm employed by the *plan administrator* to provide clerical services to the *plan*. Clerical services include the processing of claims. If a *claims administrator* is not employed by the *plan administrator*, *claims administrator* will mean the *employer*.

Clean Claim
A claim that can be processed in accordance with the terms of this document without obtaining additional information from the service provider, the member, or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A *clean claim* does not include claims under investigation for fraud and abuse or claims under review for medical necessity and reasonableness, or fees under review for usual and customariness, or any other matter that may prevent the charge(s) from being *covered expenses* in accordance with the terms of this document.

Filing a clean claim. A provider submits a *clean claim* by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The *plan administrator* may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute *covered expenses* as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a *clean claim* if the *covered person* has failed to submit required forms or additional information to the *plan* as well.

Complications of Pregnancy
1. *Medical condition*s that are distinct from pregnancy, but adversely affected by pregnancy or caused by pregnancy. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
2. A non-elective cesarean section surgical procedure;
3. A terminated ectopic pregnancy; or
4. A spontaneous termination of pregnancy that occurs during a gestation in which a viable birth is not possible.

Complications of pregnancy does not mean: false labor; occasional spotting; prescribed rest during the pregnancy; or similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct medical diagnosis.

Confinement
Being a resident patient in a *hospital* for at least 15 consecutive hours per day. Being a resident bed patient in a *convalescent nursing home* or other *qualified treatment facility* 24 hours a day. Successive *confinements* are considered one if:
1. Due to the same *injury* or *sickness*; and
2. Separated by fewer than 30 consecutive days when *you* are not confined.

Convalescent Nursing Home **(Skilled Nursing Facility or Extended Care Facility)**
1. A facility, or distinct part thereof, that is duly licensed where it is located. It must maintain and provide:
2. Full-time bed care facilities for resident patients;
3. A *qualified practitioner's* services available at all times;
4. A registered nurse (R.N.) or *qualified practitioner* in charge and on full-time duty. With one or more registered nurses (R.N.'s) or licensed vocational or practical nurses on full-time duty;
5. A daily record for each patient; and
6. Continuous skilled nursing care during convalescence from *sickness* or *injury*.

A *convalescent nursing home* is not, except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of drug addicts or alcoholics.

Covered Expense
Expense not excluded by the *plan* that is incurred by *you* or *your* covered *dependents* due to an *injury* or *sickness*. Expenses must be incurred while *you* are covered for that benefit under this *plan*.

Covered Person
The *employee* or any *dependent*, when *you* are properly enrolled in the *plan*.

Custodial Care
Care to assist in the activities of daily living. Care that is not likely to improve *your sickness* or *injury*.

Dependent
1. A covered *employee's* lawful spouse, as defined in the State where *you* reside, provided that:
    a. the spouse is not legally separated from the *employee*, and
    b. the *employee* is eligible to claim a marital status of married on their current Federal Income Tax Return as a result;
2. A covered *employee's* married or unmarried: natural born, blood related *child*; step-child; legally adopted *child*; *child* placed in the *employee's* legal guardianship by court order; or a *child* placed with the *employee* for the purpose of adoption and for which the *employee* has a legal obligation to provide full or partial support; whose age is less than the limiting age.
3. The limiting age for each *dependent child* is 26 years of age.
4. A foster *child* meeting the same eligibility requirements as stated in item 2 may be covered under the *plan.*

    A foster *child* is:
    a. a *child* that *you* are raising as *your* own,
    b. a *child* who lives in *your* home,
    c. a *child* who is chiefly *dependent* on *you* for support, and
    d. a *child* for whom *you* have taken full parental responsibility and control.

    A foster *child* is not:
    a. a *child* temporarily living in *your* home,
    b. a *child* placed with *you* by a social service agency which retains control of the *child*,
    c. a *child* whose natural parent is in a position to exercise or share parental responsibility and control, and
    d. a *child* or grand*child* who is eligible for other coverage.

If, from the date a *dependent child* reaches a limiting age, all of the following conditions exist at the same time:
1. The *child* is mentally retarded or physically handicapped;
2. The *child* is incapable of self-sustaining employment;
3. The *child* is *dependent* on the covered *employee* for at least 50% support and maintenance; and
4. The *child* is unmarried,

that *child* will remain an eligible *dependent* of a covered *employee* or may be enrolled as the *dependent* of a new *employee*. If the *child* has not continuously satisfied all of the conditions above since reaching a limiting age, the *child* will not be eligible for coverage under the *plan*.

You must provide satisfactory proof that the above conditions exist on and after the date the limiting age is reached. Such proof may not be requested more often than annually after two years from the date the first proof was provided. If satisfactory proof is not submitted, the *child*'s coverage will cease on the date such proof is due.

In any event, no person may be covered as both an *employee* and a *dependent* at the same time. If both parents are eligible for coverage under this *plan*, only one may enroll for *dependent* coverage.

Director
An elected member of the Board of Directors of an *employer* Cooperative.

Emergency
Any *injury* or *sickness* that would jeopardize or impair the health of the *covered person* if not treated immediately. An *emergency* may or may not be life threatening. A condition is considered to be an *emergency*

care situation when a sudden and serious condition such that a *prudent layperson* could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of bodily functions would result unless immediate medical care is rendered. Examples of an *emergency* care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

Employee
You when *you* are: regularly employed by the *employer*; paid a salary or earnings by the *employer*; and actively *at work*. For purposes of this *plan*, *employee* does not include independent contractors, leased *employees*, or any *employee* who is temporary or seasonal.

Employer
The participating cooperative, an *employer* in the Kentucky Rural Electric Cooperative Employers Benefit Plan, who employs the covered *employee*.

Enrollment Date
The first day of *your* eligibility period or if earlier, *your* effective date of coverage under this *plan*. If *you* are a *late applicant*, *your enrollment date* is the effective date of *your* coverage under this *plan*.

Essential Health Benefits
Essential health benefits shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse 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 limited oral and vision care.

Expense Incurred
For medical expenses, the *usual and customary and reasonable* fee charged for services and supplies needed to treat the *injury* or *sickness*. The date a supply or service is provided is the *expense incurred* date.

Family Member
Your lawful spouse. *Your child*. *Your* parent. *Your* grandparent. *Your* brother or sister. Any person related in the same way to *your* covered *dependent*.

Final Internal Adverse Benefit Determination
An *adverse benefit determination* that has been upheld by the *plan* at the conclusion of the internal claims and appeals process, or an *adverse benefit determination* with respect to which the internal claims and appeals process has been deemed exhausted.

FMLA
The Family and Medical Leave Act of 1993.

FMLA Leave
A leave of absence, which the company is required to extend to an employee under the provisions of FMLA.

HIPAA
The Health Insurance Portability and Accountability Act of 1996.

Home Health Care Agency
An agency or organization that specializes in providing medical care in the home. Such a provider must meet all of the following conditions:

1. Its primary purpose is to provide skilled nursing and other medical services. Is duly licensed in the location where services are provided;

2. Has policies set by a professional group. This professional group must have at least one registered nurse (R.N.) to govern the services provided. It must provide for full-time supervision of such services by a *qualified practitioner* or registered nurse;
3. Maintains a complete medical record on each patient;
4. Has a full-time administrator; and
5. Is approved by *Medicare*.

Hospice Care Agency
An agency whose primary purpose is providing hospice services. It must be licensed and operated according to the laws of the state in which it is located. It must meet all of the following requirements: has obtained any required certificate of need; provides 24 hour a day, seven day a week service; is supervised by a *qualified practitioner*; has a full-time coordinator; keeps written records of services provided to each patient; has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and has a licensed social service coordinator.

A *hospice care agency* will establish policies for the provision of *hospice care*. It will assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program. It will permit area medical personnel to use its services for their patients. It will use volunteers trained in care of and services for non-medical needs.

Hospice Care
Palliative and supportive care to hospice patients. It offers supportive care to the families of the hospice patients. It offers an assessment of the hospice patient's medical and social needs and a description of the care necessary to meet those needs. *Hospice care* must be provided under a written plan of *hospice care*. The plan must be established and reviewed by the *qualified practitioner* attending the person and the *hospice care agency*.

Hospice Facility
A licensed facility or part thereof that principally provides *hospice care*. It has 24 hour a day nursing services provided under the direction of a registered nurse (R.N.). It has a full-time administrator. It keeps medical records of each patient. It has an ongoing quality assurance program and has a *qualified practitioner* on call at all times.

Hospital
A facility that:
1. Maintains full-time facilities for bed care of resident patients;
2. Has a *qualified practitioner* and surgeon in regular attendance;
3. Provides continuous 24 hour a day nursing services;
4. Primarily provides diagnostic and treatment facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical services with a facility having a valid license to provide such surgical services.

Hospital does **not** include an institution, which is principally a rest home, nursing home, convalescent home or a home for the aged. *Hospital* does **not** include a place principally for alcoholics, drug addicts or persons with psychological disorders.

Injury
Physical damage to *your* body caused by an external force. Damage must be due directly and independently of all other causes to an *accident*. Muscle tiredness or soreness is a *sickness* under the *plan*. Overexertion in an athletic or physical activity is a *sickness* under the *plan*.

Late Applicant
An *employee* who enrolls for coverage more than 31 days after they are eligible to be covered. A *dependent* who is enrolled for coverage more than 31 days after they are eligible to be covered.

Lifetime
When used in reference to benefit maximums and limitations, the time *you* are covered under this *plan*. In no circumstances does *lifetime* mean *your* life span.

Medical Condition
A syndrome or group of symptoms that are not attributable to a specific disease or a distinct medical diagnosis.

Medical Child Support Order
Any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for *child* support with respect to a *covered person*'s *child* or directs the *covered person* to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical *child* support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Medical Necessity or Medically Necessary
Means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a *sickness, injury*, psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms, that are all of the following, as determined by the *plan* or *our* designee, within our sole discretion:

1. In accordance with Generally Accepted Standards of Medical Practice; and
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for *your sickness, injury,* psychological disorder, chemical dependence disorder, alcoholism disorder or its symptoms; and
3. Not mainly for *your* convenience or that of *your qualified practitioner*; and
4. Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of *your sickness, injury* or symptoms.

The fact that a physician or *qualified practitioner* has performed, prescribed, recommended, ordered or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility *medically necessary*.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The Plan reserves the right to consult expert opinion in determining whether health care services are *medically necessary*. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

Medicare
Title XVIII, Parts A and B, of the Social Security Act as enacted and amended.

Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA
In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and

surgical benefits covered by the plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Mental or Nervous Disorder
Any disease or condition, regardless of whether the cause is organic, that is classified as a mental or nervous disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

Named Fiduciary
Kentucky Rural Electric Cooperative Employers Benefit Plan (KREC), which has the authority to control and manage the operation of the *plan*.

National Medical Support Notice (NMSN)
A notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an employee who is a *covered person* under the plan;
3. Name and mailing address of one or more *alternate recipients* (i.e., the *child* or children of the *covered person* or the name and address of a substituted official or agency that has been substituted for the mailing address of the *alternate recipients*(s)); and
4. Identity of an underlying *child* support order.

Non-Essential Health Benefits
Any *covered expense* that is not an *essential benefit*. Please refer to the *essential health benefits* definition.

Other Plan
Including, but is not limited to:

1. Any primary payer besides the plan;
2. Any other group health plan;
3. Any other coverage or policy covering the *covered person*;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Outpatient
A period of time during which *you* are not confined as a resident bed patient in a: *hospital*; *convalescent nursing home*; or other *qualified treatment facility*.

PPO
Preferred Provider Organization. If a provider has contracted with the *PPO* Network, they are a *PPO* Provider. *PPO* providers furnish services at a discounted rate to the *plan*. If a provider has not contracted with the *PPO* Network, they are a Non-*PPO* provider.

Plan
This *plan* of benefits as established by the *employer*. The term *plan* includes any schedules, attachments and *amendments* to the *plan*. Prior, current and successive *plans* will be considered one *plan* and not separate and distinct *plans*. This Summary Plan Description provides a description of the *plan*.

Plan Administrator
The *employer*, who is responsible for the day to day functions and engagement of the *plan*. The *plan administrator* may employ other persons or firms to process claims and perform other services.

Post-Service Claim
Any claim that is not a pre-service claim.

Pre-Service Claim
Any claim for a benefit that is conditioned, in whole or in part, on obtaining prior approval from the *plan* for the medical care.

Preventive Care
Preventive care shall mean certain preventive care services.

This plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the plan will provide in-network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here:
http://www.uspreventiveservicestaskforce.org or at
https://www.healthcare.gov/preventive-care-benefits/.
For more information, you may contact the *plan administrator* or *employer*.

Prior Authorization
The process of determining benefit coverage prior to service being rendered to a *covered person*. A determination is made based on medical necessity (*medically necessary*) criteria for services, tests or procedures that are appropriate and cost-effective for the *covered person*. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Privacy Standards
The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Prudent Layperson
A person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Qualified Medical Child Support Order (QMCSO)
A medical *child* support order that creates or recognizes the existence of an *alternate recipient*'s right to, or assigns to an *alternate recipient* the right to, received benefits for which a *covered person* or eligible *dependent* is entitled under this plan.

Qualified Practitioner
A licensed practitioner providing services within the scope of that license. A *qualified practitioner's* services are not covered if the practitioner resides in *your* home or is a *family member*.

Qualified Treatment Facility
A facility that is duly licensed and operating within the scope of its license.

Reasonable
Reasonable and/or *reasonableness* shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or *injury* not caused by the treating provider. Determination that fee(s) or services are *reasonable* will be made by the *plan administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or *illness* necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be *reasonable*, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not *reasonable*. The *plan administrator* retains discretionary authority to determine whether service(s) and/or fee(s) are *reasonable* based upon information presented to the *plan administrator*. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not *reasonable*.

Charge(s) and/or services are not considered to be *reasonable*, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *plan*, to identify charge(s) and/or service(s) that are not *reasonable* and therefore not eligible for payment by the *plan*.

Security Standards
The final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Sickness
A disease or disturbance in function or structure of *your* body. It must cause physical signs and/or symptoms and if left untreated, will result in a deterioration of the health state of the structure or systems of *your* body.

Substance Abuse
Any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "substance use disorder" is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:
    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);

b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
c. Craving or a strong desire or urge to use a substance; or
d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

2. The symptoms have never met the criteria for substance dependence for this class of substance.

Total Disability or Totally Disabled
The inability at all times, due to *injury* or *sickness*, to perform each and every material duty of *your* job or occupation.

Uniformed Services
The Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or *emergency*.

Urgent Care
Any care that in the opinion of *your qualified practitioner* is an urgent care situation. Any care that the use of non-urgent care time frames would put *your* life, health or ability to regain maximum function at risk.

Urgent Care Center (Walk-In Clinic)
A facility that provides outpatient medical care on a walk-in or unscheduled basis. Such care may be offered during extended hours that include evenings, weekends and holidays. *Urgent Care Center* does not include a *hospital* or emergency room.

USERRA
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Usual and Customary
Usual and customary shall mean *covered expenses* which are identified by the *plan administrator*, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be *usual and customary,* fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term *"usual"* refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

The term *"customary"* refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term *"usual and customary"* does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a *covered person* by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The *plan administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and customary charges may, at the *plan administrator's* discretion, alternatively be determined and established by the *plan* using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

You and Your
You as the covered *employee*. Any of *your dependents*, unless otherwise indicated.

SECTION 3 ELIGIBILITY

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ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

The Employee Coverage section applies to *employees* hired on or after the effective date of this *plan*. The Dependent Coverage section applies to *dependents* that are added on or after the effective date of this *plan*.

Employees who were covered under any plan that this *plan* replaces will be covered on the effective date of this *plan*. Coverage will include *dependents* of such an *employee*. *You* must have met the eligibility requirements of the *plan*.

EMPLOYEE COVERAGE

Employee Eligibility

You are eligible for coverage under the *plan* if the following conditions are met:

1. *You* are an *employee* who meets the eligibility requirements of the *employer*; and
2. *You* satisfy *your* co-op's eligibility period; or
3. If applicable, *you* are a *director* or attorney for the *employer*.

You are eligible to be covered on the date following *your* completion of the eligibility period. This is *your* eligibility date.

Transfer Between Employers

Employees that transfer employment from one KREC member cooperative to another will be eligible to have their accumulators (amounts paid toward deductible and out-of-pocket limits, *calendar year* and any *lifetime* benefit maximums on *non-essential health benefits*) treated as continuous coverage under the new *plan*. If the *employee* (or *dependent*) was enrolled in the KREC plan at the time of transfer and does not have a break in coverage, they will enter the subsequent plan with a carry-forward of all deductible payments, out-of-pocket payment and other accumulated *plan* benefits and limitations as applicable to the current *calendar year* and any *lifetime* benefits and limitations under the *plan*. Prior benefits and limitations shall be applied as if no break in coverage occurred. This includes but is not limited to:

1. The amount of *calendar year* deductible that was satisfied under the former KREC *employer's* plan will carry forward under the new KREC *employer's* plan;
2. Any amounts accrued toward *calendar year* and *lifetime* maximum benefits on *non-essential health benefits* will carry forward to the new KREC *employer's* plan.

To be eligible for this benefit, the *employee* must start work at the new KREC *employer* within 60 calendar days of leaving the former KREC *employer*.

If the *employee* takes any time off between leaving the former KREC *employer* and starting work at the new KREC *employer*, the *employee* may need to elect COBRA in order to continue coverage during the break.

If an *employee* did not have coverage under the KREC plan with their former cooperative, this provision will not apply and they will be treated as a new *employee* under the *plan*.

Employee Effective Date

You must enroll on forms accepted by the *plan administrator*. Each *employee's* effective date is determined as follows:

1. *Your* completed forms are received by the *plan administrator* within 31 days of the date *you* are eligible. This is a timely enrollment. *Your* coverage will be effective on *your* eligibility date.

2. *Your* completed forms are received by the *plan administrator* **more than** 31 days after the date *you* are eligible. This is **late enrollment**. *Your* coverage will be effective on the date *your* completed forms were received.

Coverage will begin at 12:01 AM, Standard Time, on *your* effective date. *You* must begin active work with the *employer* before coverage will be effective under the *plan*.

DEPENDENT COVERAGE

Dependent Eligibility

A *dependent* is eligible to be covered on the later of:

1. The date the *employee* is covered;
2. The date of the *employee's* marriage for a *dependent* acquired on that date;
3. The *child*'s date of birth;
4. The date a court order places a *child* in the *employee's* home. The *child* must be under the *employee's* legal guardianship;
5. The date a *child* is legally adopted; or
6. The date a valid court order is issued which, by federal law or *plan* provision, requires the *plan* to provide coverage.

Dependents may only be covered if the *employee* is covered. Check with *your employer* on how to enroll for *dependent* coverage.

When both parents are *employees* only one may enroll for *dependent* coverage.

Dependent Effective Date

Each *dependent* must be enrolled on forms accepted by the *plan administrator*. Each *dependent's* effective date of coverage is determined as follows:

1. The completed forms are received by the *plan administrator* within 31 days of the *dependent's* eligibility date. This is a timely enrollment. That *dependent* is covered on their eligibility date.
2. The completed forms are received by the *plan administrator* **more than** 31 days after the *dependent's* eligibility date. This is a **late enrollment**. That *dependent* will be covered on the date their completed forms were received.

Coverage will begin at 12:01 AM, Standard Time, on the *dependent's* effective date.

A *dependent child* that becomes an *employee* and obtains coverage under this *plan* as an *employee* may not be covered as both an *employee* and a *dependent.*

RETIREE COVERAGE

To elect retiree coverage, *you* must meet *your employer's* eligibility requirements for retiree coverage. Retiree coverage can also be elected for *your dependents*, provided they meet this *plan's* definition of *dependent*. *You* may be required to pay a *plan* contribution for retiree coverage.

Your rights to and cost of postretirement benefits are subject to the policies of *your employer* cooperative and can change at any time. *Your employer* cooperative may cease to provide coverage for retirees or increase the cost to retirees of coverage at any time. This is effective for both *employees* who have already retired and those *employees* who have not yet retired.

NOTE: If *you* are Medicare eligible, claims must be submitted to Medicare first. After Medicare has processed *your* claim, the claim and the Medicare EOB should be submitted to this *plan*.

Eligible Retiree Coverage and Medicare

Retirees and their dependents must enroll for Medicare Parts A & B when they first become eligible. It is the retiree's responsibility to notify the Cooperative when they first become eligible for (or any covered family member becomes eligible for) Medicare.

- Failure to notify the Cooperative will cause any claims paid by this plan after an individual was Medicare eligible to be the sole responsibility of the individual covered by Medicare. This applies to all retirees, their spouses and children when they first become eligible for Medicare.

If *you* are approaching age 65, *you* should apply for Medicare coverage (Parts A and B) at least three months prior to your 65th birthday. Late application for Part B will mean higher Medicare premiums, a delayed Medicare effective date, and a substantial loss of benefits. Once *you* receive *your* Medicare ID Card for Parts A & B, then *you* should apply for Part D coverage through *your employer*.

The KREC Plan provides secondary coverage to Parts A, B and D. *You and/or your dependents* must be enrolled in Medicare Parts A and B to be eligible for Medicare D through the *employer*. *You* must enroll in the KREC Medicare D plan to be eligible for any drug coverage under this *plan*. To enroll in Part D through *your employer*, *you* will need to provide the *employer* with a copy of *your* Medicare ID card for Parts A and B. Medicare will be primary. If *you* do not enroll in Part D through the *employer*, *you* will not be eligible for prescription drug coverage through this *plan*. If *you* choose not to enroll in Part D, and therefore choose to lose *your* prescription coverage through this *plan*, *you* will be charged the same contribution for the medical coverage.

SPECIAL ENROLLMENT RIGHTS

If *you* have a special enrollment event, the *plan* will provide a new enrollment date for *you* to enter the *plan* as shown below. At that time, *you* will be able to enroll in the *plan* without being subject to the *late applicant* provisions of the *plan*. If the *plan* has more than one benefit option, *you* will be able to select from all options for which *you* are eligible.

Loss of Other Coverage

If *you* declined coverage under this *plan* in favor of other group or individual health coverage, or COBRA continuation, and coverage under that other plan ends:

1. Due to *your* exhaustion of the maximum COBRA period;
2. Due to *your* loss of eligibility, for any reason;
3. Employer contributions towards the cost of the other coverage;

Then a special enrollment event has occurred. At that time, an *employee* or *dependent* may be enrolled in this *plan* as follows:

1. When the *employee* has a loss of coverage, the *employee* and any *dependent* may enroll. The *dependent* does not have to have had a loss of coverage at that time to be enrolled;
2. When a *dependent* has a loss of coverage, that *dependent*, the *employee* and any other eligible *dependent* may enroll. The *employee* and other *dependents* do not have to have had a loss of coverage at that time to enroll.

You must enroll in this *plan* within 31 days of the date of a loss of other coverage to be a timely entrant to the *plan*. *You* **must** provide proof that the other coverage was lost due to one of the above shown reasons. Coverage under this *plan* will not be effective until such proof is provided. Coverage under this *plan* will be effective on the day coverage under the other group plan ends.

If *you* apply more than 31 days after the date the other coverage ends, you will be *late applicants* under this *plan*.

Marriage

If *you*, as the *employee*, are now getting married, a special enrollment event will occur on the date of *your* marriage. At that time, *you* may enroll in this *plan*. Any *dependents* acquired on the date of *your* marriage may also be enrolled at this time as well as any other *dependents* that were not previously covered under the *plan*.

You must enroll in this *plan* within 31 days of the date of *marriage* to be a timely entrant to the *plan*. Coverage under the *plan* will be effective on the day of *your* marriage.

If *you* apply more than 31 days after the date of *your* marriage, it will be considered late enrollment under this *plan*.

Birth, Adoption or Placement for Adoption

If *you* experience the birth of a *dependent child*, or the adoption or placement for adoption of a *dependent child*, a special enrollment event will occur on that date. At that time, *you* may enroll in this *plan*. *Your dependent* spouse and the newborn or adopted *child* may also be enrolled at this time as well as any other *dependents* that were not previously covered under the *plan*.

You must enroll in this *plan* within 31 days of the date of birth, adoption or placement to be a timely entrant to the *plan*. Coverage under the *plan* will be effective on the date of such an event.

If *you* apply more than 31 days after the date of such an event, it will be considered late enrollment under this *plan*.

MEDICAID/STATE CHILD HEALTH PLAN

If *you* and/or *your dependents* were covered under a Medicaid plan or State *child* health plan and *your* coverage is now being terminated due to a loss of eligibility, a special enrollment event will occur on the date Medicaid or the State *child* health plan coverage ends.

You must request coverage under this *plan* within 60 days after the date of termination of such coverage. Coverage under this *plan* will be effective on the date the other coverage ends.
If *you* apply for coverage more than 60 days after the date the Medicaid or State *child* health plan coverage ends, *you* will be considered a *late applicant* under this *plan.*

Premium Assistance

Current *employees* and their eligible *dependents* may be eligible for a special enrollment event if the *employee* and/or *dependents* are determined eligible, under a state's Medicaid plan or State *child* health plan, for premium assistance with respect to coverage under this *plan*. *You* must request coverage under this *plan* within 60 days after the date the *employee* and/or *dependent* is determined to be eligible for such assistance. If *you* apply for coverage more than 60 days after this date, *you* will be considered a *late applicant* under the *plan*.

SPOUSAL TRANSFER PROVISION

If both spouses are *employees* and each has taken single coverage under this *plan*, this *plan* permits *your* spouse to take coverage as *your dependent* at any time.

In addition, if both spouses are *employees* and eligible for coverage under this *plan* and *your* spouse previously waived coverage as an *employee* in favor of coverage as *your dependent*, this *plan* permits *your* spouse to take coverage as an *employee* under the *plan* and to enroll *you* and any other eligible *dependents* as *dependents* of *your* spouse when:

1. *You* and *your* spouse decide to transfer coverage under the *plan* from one spouse to the other;
2. *Your* spouse decides to take coverage as an *employee* for any reason; or
3. *You* terminate *your* coverage under the *plan* for any reason.

Your spouse must elect coverage under this *plan* within 31 days of the date *your* coverage ends to be a timely enrollment. *Your* spouse's coverage under this *plan* will be effective on the day *your* coverage ends.

If *your* spouse applies more than 31 days after the date *your* coverage ends, *you* will be *late applicants* under the *plan*.

BENEFIT CHANGES

Any change in benefits will be effective on the date of change for all *employees* and *dependents*. Any change in coverage will be effective on the date of change for all *employees* and *dependents*.

SPECIAL PROVISIONS FOR NOT BEING ACTIVELY AT WORK

If *you* continue to pay the required *plan* contributions, *your* coverage will remain in force during an approved, non-military leave of absence; layoff; or period of *total disability* in accordance with *your* cooperative's policy. Coverage that is required by the Family and Medical Leave Act will reduce any period shown above. The *plan* must remain in effect for this provision to apply.

At the end of this period, COBRA continuation will be offered.

REHIRE/REINSTATEMENT

If *you* are terminated or laid off and return to work within 13 consecutive weeks *your* coverage will be reinstated effective immediately, so long as all other eligibility criteria are satisfied.

TOTAL DISABILITY EXTENSION OF BENEFITS

If *you* are totally disabled on the date *your* coverage terminates, *your* benefits may be extended only during the subsequent period of continuous total disability until the earliest of:
1. The date the *plan* terminates;
2. The date *you* cease to be totally disabled on a continuous basis. Total disability for this provision is determined by *your* cooperative's disability insurance plan. If *you* are receiving disability benefits, *you* will be considered to be totally disabled;
3. The last day of the period for which any required contributions for coverage have been made.

The benefits so extended will be the same benefits that were in force at the time *your* coverage terminated, provided the required contributions have been made. Benefits may be extended for *your* eligible *dependents* provided any required contributions are made. *Your dependents* must remain eligible as defined under *dependent* eligibility.

Disabled employees *and/or their dependents* must enroll in Medicare parts A & B when they become eligible for Medicare. If *you* are approaching age 65, *you* should apply for Medicare coverage (Parts A and B) at least three months prior to your 65th birthday. Late application for Part B will mean higher Medicare premiums, a delayed Medicare effective date, and a substantial loss of benefits. Once *you* receive *your* Medicare ID Card for Parts A & B, then *you* should apply for Part D coverage through *your employer*.

When You or Your Family Member Becomes Eligible for Medicare
Disableds and their dependents <u>must enroll for Medicare Parts A & B when they first become eligible</u>. It is the disabled's responsibility to notify the Cooperative when they first become eligible for (or any covered family member becomes eligible for) Medicare.

- Failure to notify the Cooperative will cause any claims paid by this plan after an individual was Medicare eligible to be the sole responsibility of the individual covered by Medicare. This applies to all disableds, their spouses and children when they first become eligible for Medicare.

The KREC Plan provides secondary coverage to Parts A, B and D. *You* must be enrolled in Medicare Parts A and B to be eligible for Medicare D through the *employer*. *You* must enroll in the KREC Medicare D plan to be eligible for any drug coverage under this *plan*. To enroll in Part D through *your employer*, *you* will need to provide the *employer* with a copy of *your* Medicare ID card for Parts A and B. Medicare will be primary. If *you* do not enroll in Part D through the *employer*, *you* will not be eligible for prescription drug coverage

through this *plan*. If *you* choose not to enroll in Part D, and therefore choose to lose *your* prescription coverage through this *plan*, *you* will be charged the same contribution for the medical coverage.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the *plan* terminates;
2. For any benefit, the date the benefit is removed from the *plan*;
3. The end of the period for which any required *employee* or *employer* contribution was due and not paid;
4. The date *you* enter the full-time military, naval or air service of any country;
5. The date *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;
6. For all *employees*, the date of termination of employment with the *employer* or, if earlier, the date *you* are no longer *actively at work* as defined in this *plan*;
7. For all *employees*, the date of *your* retirement, unless you are eligible for and elect Retiree Coverage;
8. For *your dependents*, the date *your* coverage terminates;
9. For a *dependent*, the date the *dependent* enters the full-time military, naval or air service of any country;
10. For a *dependent* who attains age 26, the last day of the month in which the *dependent* attains age 26;
11. For a *dependent*, the date that *dependent* no longer meets this *plan's* definition of *dependent*, except in the case of a *dependent* who attains age 26 (see above)*;*
12. The date *you* request termination of coverage to be effective for yourself and/or *your dependents*; or
13. The date *you* die.

Rescission of Coverage
As permitted by the Patient Protection and Affordable Care Act, the *plan* reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is not a rescission if:

1. It has only a prospective effect; or
2. It is attributable to non-payment of premiums or contributions.

SURVIVORSHIP CONTINUATION

If *you* have *dependent* coverage in force on the date that *you* die, coverage under this *plan* will continue for *your* covered *dependents*. Survivorship Continuation will end on the earliest of:
1. The date the *dependent* becomes eligible for benefits under any other employer-sponsored plan;
2. The date the *dependent* no longer qualifies as an eligible *dependent* for any reason other than lack of primary support by the *employee*;
3. The date the surviving spouse remarries;
4. The date required contributions are not made;
5. The date this *plan* terminates.

When You or Your Family Member Becomes Eligible for Medicare
Surviving dependents must enroll for Medicare Parts A & B when they first become eligible.

- It is the survivor's responsibility to notify the Cooperative when they first become eligible for (or any covered family member becomes eligible for) Medicare.
- Failure to notify the Cooperative will cause any claims paid by this plan after an individual was Medicare eligible to be the sole responsibility of the individual covered by Medicare. This applies to all surviving spouses and children when they first become eligible for Medicare.

The KREC Plan provides secondary coverage to Parts A, B and D. *You* must be enrolled in Medicare Parts A and B to be eligible for Medicare D through the *employer*. *You* must enroll in the KREC Medicare D plan to be eligible for any drug coverage under this *plan*. To enroll in Part D through *your employer*, *you* will need to provide the *employer* with a copy of *your* Medicare ID card for Parts A and B. Medicare will be primary. If *you* do not enroll in Part D through the *employer*, *you* will not be eligible for prescription drug coverage through this *plan*. If *you* choose not to enroll in Part D, and therefore choose to lose *your* prescription coverage through this *plan*, *you* will be charged the same contribution for the medical coverage.

IMPORTANT NOTICE FOR ACTIVE EMPLOYEES AND SPOUSES AGE 65 AND OVER

The *plan* cannot terminate *your* coverage due to age or *Medicare* status. An active *employee* that is eligible for *Medicare* due to age (age 65 or over) has the choice to:

1. Maintain coverage under this *plan*, in which case *Medicare* benefits would be secondary to this *plan*; or
2. End coverage under this *plan*, in which case *Medicare* would be the only coverage available to *you*.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) applies to *employers* with fifty (50) or more *employees* for at least twenty (20) workweeks in the current or preceding *calendar year*. The following are some definitions identified by the FMLA:

Covered Service Member
Covered Service Member shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible *employee* takes FMLA Leave to care for the covered veteran.

Eligible Employee
Eligible Employee shall mean an individual who has been employed by the Employer for at least twelve (12) months, has performed at least one thousand two hundred and fifty (1,250) hours of service during the previous twelve (12) month period, and has worked at a location where at least fifty (50) *employees* are employed by the *employer* within seventy-five (75) miles.

Family Member
Family Member shall mean the (a) *employee's* biological, step, or foster parent or (b) a natural, adopted, foster, or stepchild, or a legal ward under eighteen (18) years of age, or eighteen (18) years and older and incapable of self-care because of a mental or physical disability or (c) spouse.

Serious Illness or Injury (of a service member or covered veteran)
Serious Illness or Injury shall mean an illness or *injury* incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious *injury* or illness for a current service member includes an *injury* or illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious *injury* or illness for a covered veteran means an *injury* or illness that was incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

Basic Leave Entitlement
FMLA requires covered Employers to provide up to twelve (12) weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. for incapacity due to pregnancy, prenatal medical care or *child* birth;
2. to care for the *employee's child* after birth, or placement for adoption or foster care;
3. to care for the *employee's* spouse, son, daughter or parent, who has a serious health condition; or
4. for a serious health condition that makes the *employee* unable to perform the *employee's* job.

Military Family Leave Entitlements
Eligible *employees* whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their twelve (12) week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible *employees* to take up to twenty-six (26) weeks of leave to care for a covered service member during a single twelve (12) month period. A covered service member is:

(1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible *employe*e takes FMLA Leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness.*

***The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections
During FMLA Leave, the *employer* must maintain the *employee's* health coverage under any "group health plan" on the same terms as if the *employee* had continued to work. Upon return from FMLA Leave, most *employees* must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA Leave cannot result in the loss of any employment benefit that accrued prior to the start of an *employee's* leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered *employer* for at least twelve (12) months, have one thousand two hundred and fifty (1,250) hours of service in the previous twelve (12) months*, and if at least fifty (50) *employees* are employed by the *employer* within seventy-five (75) miles.

***Special hours of service eligibility requirements apply to airline flight crew *employees*.**

Definition of Serious Health Condition
A serious health condition is an illness, *injury*, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the *employee* from performing the functions of the *employee's* job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care provider or one (1) visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An *employee* does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when *medically necessary*. *Employees* must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the *employer's* operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or *employers* may require use of accrued paid leave while taking FMLA Leave. In order to use paid leave for FMLA Leave, *employees* must comply with the *employer's* normal paid leave policies.

***Employee* Responsibilities**
Employees must provide thirty (30) days advance notice of the need to take FMLA Leave when the need is foreseeable. When thirty (30) days notice is not possible, the *employee* must provide notice as soon as practicable and generally must comply with an *employer's* normal call-in procedures.

Employees must provide sufficient information for the *employer* to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the *employee* is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. *Employees* also must inform the *employer* if the requested leave is for a reason for which FMLA Leave was previously taken or certified. *Employees* also may be required to provide a certification and periodic recertification supporting the need for leave.

***Employer* Responsibilities**
Covered *employers* must inform *employees* requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the *employees'* rights and responsibilities. If they are not eligible, the *employer* must provide a reason for the ineligibility.

Covered *employers* must inform *employees* if leave will be designated as FMLA-protected and the amount of leave counted against the *employee's* leave entitlement. If the *employer* determines that the leave is not FMLA-protected, the *employer* must notify the *employee*.

Unlawful Acts by *Employers*
FMLA makes it unlawful for any *employer* to:

1. Interfere with, restrain, or deny the exercise of any right provided under FMLA; and
2. Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An *employe*e may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an *employer*.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered *employers* to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:

1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV
U.S. Department of Labor Wage and Hour Division
WHD Publication 1420 · Revised February 2013

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a federal law.

CONTINUATION OF COVERAGE DURING MILITARY LEAVE

The law requires that coverage under this *plan* be continued during a leave that is covered by the Act. Coverage must be the same as is provided under the *plan* to similar active *employees*. This means that when coverage is changed for similar active *employees* it will also change for the person on leave. The cost of such coverage will be:

1. For leaves of 30 days or less, the same as the *employee* contribution required for active *employees*;
2. For leaves of 31 days or more, up to 102% of the full contribution.

This Act only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the Act.

Coverage provided due to this Act will reduce any coverage required by COBRA.

Maximum Period of Coverage during Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date *you* fail to return to employment with the *employer* after completion of *your* leave. *Employees* must return to employment within:
    a. the first full business day of completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
    b. 14 days of completing military service, for leaves of 31 to 180 days,
    c. 90 days of completing military service, for leaves of more than 180 days; or
2. 24 months from the date your leave began.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

The law requires that coverage be reinstated upon *your* return to work. Reinstatement will apply whether coverage under the *plan* was maintained during the leave or not. To be eligible for reinstatement *you* must be honorably discharged from the military service and return to work within:

1. The first, full business day after *your* military service ends, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days after *your* military service ends, for leaves of 31 to 180 days;
3. 90 days after *your* military service ends, for leaves of more than 180 days.

You may be allowed more time to return to work if *your* military service: causes a *sickness* or *injury*; or worsens a *sickness* or *injury*. Your failure to return within the times stated must be due to such a *sickness* or *injury*. In that case, *you* may take up to a period of two years to return to work. If for reasons beyond *your* control *you* cannot return to work within two years, *you* must return as soon as is reasonably possible.

On reinstatement, all provisions and limits of the *plan* will apply to the extent that they would have had *you* not taken leave.

This does not waive the *plan's* limits on *sickness* or *injury*: caused by *your* military service; or worsened by *your* military service. The Secretary of Veterans Affairs will determine if *your* military service caused or worsened a *sickness* or *injury*.

NOTE: For complete information regarding *your* rights under the Uniformed Services Employment and Reemployment Rights Act, contact *your employer*.

CONTINUATION OF BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA is a federal law. It applies to *employers* that have 20 or more employees. The law requires these *employers* to offer covered individuals continuation coverage (COBRA) under the *plan* if coverage is lost or cost increases due to specific events. COBRA must be offered at group rates. The *employer* cannot require evidence of good health as a condition of COBRA. COBRA must be the same as coverage for similar active *employees* under the *plan*. This means that when coverage is changed for similar active *employees* it will also change for the person on COBRA.

COBRA only applies to health coverage (i.e. medical, dental, drug, vision). Short and long term disability and life benefits are not subject to the COBRA.

Employee Rights to COBRA

An *employee* that is covered by this *plan* has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the *employee's* hours of work; or
2. The termination of the *employee's* employment. This will not apply if termination is due to gross misconduct on the *employee's* part.

Spouse Rights to COBRA

The spouse of an *employee* that is covered by this *plan* has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the *employee's* hours of work;
2. The termination of the *employee's* employment. This will not apply if termination is due to gross misconduct on the *employee's* part;
3. The death of the *employee*;
4. The end of the spouse's marriage to the *employee*. The marriage must end due to dissolution, annulment, divorce, or legal separation; or
5. The *employee* becoming entitled to *Medicare*.

Dependent Child Rights to COBRA

The *dependent child* of an *employee* that is covered by this *plan* has a right to elect COBRA if coverage is lost or cost increases due to:

1. A reduction in the employee's hours of work;
2. The termination of the employee's employment. This will not apply if termination is due to gross misconduct on the employee's part;
3. The death of the employee;
4. The end of the employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;
5. The employee becoming entitled to Medicare; or
6. The *child* ceasing to be considered a dependent *child* as defined in this plan.

Electing COBRA

Each person covered by this *plan* has an independent right to elect COBRA for himself or herself. A covered *employee* or spouse may elect COBRA for all family members. A parent or legal guardian may elect coverage for a minor *child*.

If coverage has been terminated in anticipation of a qualifying event, the right to COBRA will still apply at the time of the event. In this case, COBRA will be effective on the date of the event even though it is after the date coverage was lost or cost increased.

If the *employee's dependent child* is born during the COBRA coverage period, that *child* may be added to the coverage. The *child* will have all of the rights that any other *child* would have under COBRA. If a *child* is adopted by or placed for adoption with the *employee* during the COBRA coverage period, that *child* may be added to the coverage. The *child* will have all of the rights that any other *child* would have under COBRA.

Notices and Election of Coverage

Under the law, *you* must inform the *plan administrator* within 60 days of: a divorce; legal separation; annulment; or dissolution of marriage. *You* must also inform the *plan administrator* within 60 days of a *child* no longer meeting the *plan's* definition of *dependent*. The *employer* must notify the *plan administrator* of: the *employee's* death; termination of employment; reduction in hours of work; or *Medicare* entitlement. The *employer* must also notify the *plan administrator* of a termination or substantial elimination of retiree coverage due to Chapter 11 bankruptcy. See Procedures for Providing Notice to the Plan for further information.

Within 14 days of receiving notice that one of the above events has happened, the *plan administrator* will notify *you* that *you* have the right to elect COBRA. If the employer and plan administrator are the same entity, notice of the right to elect will be provided within 44 days. Under the law *you* must elect COBRA within 60 days from the later of: the date *you* would lose coverage or cost would increase due to the qualifying event; or the date notice of *your* right to COBRA and the election form are sent.

The *plan administrator* must provide *you* with a quote of the total monthly cost of COBRA. The initial payment is due by the 45th day after coverage is elected. All other payments are due on a monthly basis, subject to a 30 day grace period.

If *you* elect COBRA within the 60 day period, COBRA will be effective on the date that *you* would lose coverage. If *you* do not elect COBRA within this 60 day period, COBRA will not be available. *Your* coverage under the *plan* will terminate.

If *you* elect COBRA, it is *your* duty to pay all of the monthly payments directly to the *plan administrator*. The cost of COBRA must be a reasonable estimate of the cost of coverage had it not ended. The *plan* may add a 2% administration charge to that cost. The *plan* may charge an additional 50% during the 11 month extension for total disability if the disabled individual is covered. If the disabled individual is not covered, only the 2% administration charge will apply during the extension.

Payments for COBRA may only be increased once during any one 12 month period. The timing of the 12 month period is set by the *plan administrator*.

Maximum Period of Continuation of Coverage

When coverage is lost or cost increases the law requires that the *employer* maintain COBRA for up to:

1. 18 months, if due to the employee's termination of employment. Termination must be for reasons other than gross misconduct on the employee's part;
2. 18 months, if due to the employee's reduction in work hours;
3. 36 months, if due to the death of the employee;
4. 36 months, if due to the end of the employee's marriage. The marriage must end due to dissolution, annulment, divorce or legal separation;
5. 36 months, if due to the employee becoming entitled to Medicare. If coverage is not lost or cost does not increase until a later date, COBRA will end at the later of: 36 months from the date of the employee's Medicare entitlement; or the maximum period of COBRA allowed due to the event that caused the loss of coverage or increase in cost;
6. 36 months, if due to your ceasing to be a dependent *child* as defined in the plan; or
7. The lifetime of the retiree, if due to the termination of retiree benefits. The same period will apply if due to the substantial elimination of retiree benefits. Termination or substantial elimination must occur within one year before or after the employer files Chapter 11 bankruptcy. Upon the retiree's death, any covered dependent may elect COBRA for an additional 36 months from that date.

If *you* or a *dependent* are disabled at the time of a qualifying event, an 18 month COBRA period may be extended by 11 months. The 18 month period may also be extended if *you* or a *dependent* become disabled during the first 60 days of COBRA. *You* must be disabled under the terms of Title II or Title XVI of the Social Security Act. The maximum period may extend to 29 months from the original event. *You* must provide notice to the *plan administrator* within 60 days after such determination of disability is made. This notice must also be prior to the end of the 18 month COBRA period. If notice is not given within these times, *you* will not be eligible for the extended period. If it is determined that *you* are no longer disabled, *you* must notify the *plan administrator* within 30 days of that final determination. The right to this extended period applies to each individual. It will apply even if the disabled individual does not remain covered. See Procedures for Providing Notice to the Plan for further information.

If a second event occurs during the initial 18 or 29 month period, COBRA may be extended to 36 months. Second events include: the *employee's* death; the *employee's* divorce; a *child* no longer meeting the definition of *dependent*. A second event will not result in an extension of COBRA, if the event would not result in a loss of coverage for an active employee or dependent. Except in the case of bankruptcy the period will not exceed 36 months from the date of the original event.

The maximum coverage period is measured from the date of the qualifying event. This is true even if the qualifying event does not result in a loss of coverage or increase in cost until a later date.

If COBRA is rejected in favor of an alternate coverage under the *plan*, COBRA will not be offered at the end of that period. If an alternate coverage is offered, COBRA will be reduced to the extent such coverage satisfies the requirements of COBRA. Alternate coverage includes continuation by: state law; USERRA; or any other plan provision.

Termination Before the End of the Maximum Coverage Period
The law allows COBRA to be terminated prior to the end of the maximum period. Such termination can only be for one of the following reasons:

1. The employer no longer provides a group benefit plan to any of its employees;
2. The payment for COBRA is not paid on time. Monthly payments are subject to a 30 day grace period. If a payment is on time and not significantly less than the amount due, it will be considered full payment unless notice of the amount due is provided to you. You will have 30 days from the date of notice to make the additional payment;
3. You obtain another group plan after the date you elect COBRA;
4. You become entitled to Medicare after the date you elect COBRA;
5. There has been a final determination that you are no longer disabled. Such determination must be made under Title II or XVI of the Social Security Act. This will only apply during the 11 month extension of COBRA due to disability. In this case, COBRA will not end until the first day of the month that is more than 30 days after the determination.

Procedures for Providing Notice to the Plan
In order to maintain *your* rights under COBRA, *you* are required to provide the *plan* with notice of certain events, as described above. The *plan* will consider *your* obligation to provide notice satisfied if *you* provide written notice to the *plan administrator* that includes:

1. The employee's name and social security number;
2. The name of the individual(s) to whom the notice applies;
3. The reason for which notice is being provided; and
4. The address and phone number where you can be contacted.

Notice should be addressed to the Human Resources Department, Attn: COBRA Administration. Notice should be mailed to the *plan administrator's* address shown in this *plan*. *Your* notice will not satisfy *your* obligation if it is not provided within the time frame stated above for that notice.

Other Information

The *plan administrator* will answer any questions *you* may have on COBRA. *You* can also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) for answers to *your* questions. Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

To protect *your* rights under COBRA, *you* should notify the *plan administrator* of any changes that affect *your* coverage. Such changes include a change for *you* or a family member in marital status; address; or other insurance coverage. When providing any notice to the *plan*, a copy should be maintained for *your* own records.

SECTION 4 GENERAL PLAN INFORMATION

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PLAN DESCRIPTION INFORMATION

The *employer* sets the benefits under the *plan*. The *employer* sets the rights and privileges of *covered persons* to those benefits. The *plan* pays benefits directly from the general assets of the *employer*, as needed.

Each *employee* in the *plan* will receive a Summary Plan Description (SPD). This booklet is the SPD and Plan Document for the *plan*. It contains information on: eligibility; termination; benefits provided; and other general *plan* provisions.

The purpose of this SPD is to set forth the provisions of this *plan*. The *plan* provides for the payment or reimbursement of eligible medical expenses.

PLAN NAME	Kentucky Rural Electric Cooperative Employers Benefit Plan
TYPE OF PLAN	A self-funded welfare plan that provides medical benefits to covered *employees* and *dependents*. This *plan* is not financed or administered by an insurance company. The *plan's* benefits are not guaranteed by a contract of insurance.
PLAN EFFECTIVE DATE	January 1, 2020 Revision
GROUP NUMBER	K007
PLAN STATUS	Non-grandfathered
PLAN YEAR FOR GOVERNMENT REPORTING	January 1 to December 31
PARTICIPATING COOPERATIVE EMPLOYER	Kenergy 6402 Old Henderson-Corydon Road Henderson, KY 42419 Phone: (800) 844-4832
PLAN ADMINISTRATOR/ PLAN SPONSOR	Kentucky Rural Electric Cooperative Employers Benefit Plan East Kentucky Power Cooperative 4775 Lexington Road Winchester, KY 40391 (859) 744-4812
PLAN NUMBER	#501
PLAN SPONSOR IDENTIFICATION NUMBER	61-0461919
CLAIMS ADMINISTRATOR	ARC Administrators PO Box 12290 Lexington, Kentucky 40582 (855) 981-2583

AGENT FOR SERVICE OF LEGAL PROCESS

Kentucky Rural Electric Cooperative Employers Benefit Plan
East Kentucky Power Cooperative
4775 Lexington Road
Winchester, KY 40391
(859) 744-4812

STATEMENT OF ERISA RIGHTS

COVERED PERSONS' RIGHTS

As an *employee* covered by this welfare *plan*, *you* have certain rights through the Employee Retirement Income Security Act of 1974 (ERISA). *You* also have certain protections through ERISA. ERISA provides that all covered *employees* will be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, all documents governing the *plan*. *You* may examine them at the *plan administrator's* office. *You* may also examine them at other specified locations, such as worksites and union halls, if any. This includes insurance contracts and collective bargaining agreements, if any. It also includes the latest annual report (Form 5500 Series) filed by the *plan* with U.S. Department of Labor, if filing is required by law. These filings are available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of documents governing the *plan*. This includes insurance contracts and collective bargaining agreements, if any. It also includes the latest annual report (Form 5500 Series), if the report is required by law, and an updated summary plan description. Written request must be made to the *plan administrator*. The *plan administrator* may make a reasonable charge for the copies.

Receive a summary of the *plan's* annual financial report, if one is required by law. If a summary annual report is required, the *plan administrator* is required by law to furnish each covered *employee* with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or *dependents* if there is a loss of coverage under the *plan* as a result of a qualifying event. *You* or *your dependents* may have to pay for such coverage. Review this summary plan description and the documents governing the *plan* on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

ERISA also imposes duties on the people who are responsible for the *plan*. The people who operate the *plan* are called "fiduciaries" of the *plan*. They have a duty to operate the *plan* prudently and in the interest of *you* and other *covered persons*. No one may fire or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising *your* rights under ERISA. This includes *your employer*, *your* union if any or any other person.

Enforce Your Rights

If *your* claim for a welfare benefit is denied or ignored, in whole or in part, *you* have a right to know why this was done with certain time frames. *You* have a right to obtain copies of documents relating to the decision without charge and within certain time frames. *You* also have the right to appeal any denial, within certain time frames.

Under ERISA, there are steps *you* can take to enforce the above rights. For instance, if materials, such as plan documents or the latest annual report, that *you* asked the *plan* for are not received within 30 days, *you* may request the alternate dispute resolution process provided by the *plan* or file suit in Federal court. In such a case, the *plan administrator* may be ordered to provide *you* with the materials. The *plan administrator* may also be ordered to pay *you* up to $110 a day until the materials are received. If the materials were not sent due to reasons beyond the *plan's* control, penalties will not be imposed.

If *you* have a claim or part of a claim for benefits that is denied or ignored, *you* may request the alternate dispute resolution process provided by the *plan* or file suit in state or Federal court. In addition, if *you* do not agree with the *plan's* decision or lack of decision on the qualified status of a medical *child* support order, *you* may file suit

in Federal court. If the *plan's* fiduciaries misuse the *plan's* money, or if *you* are discriminated against for asserting *your* rights, *you* may seek assistance from the U.S. Department of Labor, or file suit in a Federal court. The court will decide who should pay filing costs and legal fees. If *you* are successful, the person *you* have sued may be ordered to pay these costs and fees. If *you* lose, for example, *your* claim is found frivolous; *you* may be ordered to pay these costs and fees.

Assistance with Your Questions

If *you* have any questions about *your plan*, *you* should contact the *plan administrator*. If *you* have any questions about this statement, *you* should contact the nearest office of the Employee Benefits Security Administration (EBSA). If *you* have any questions about *your* rights under ERISA, *you* should contact the nearest office of the EBSA. If *you* need assistance in obtaining documents from the *plan administrator*, *you* should contact the nearest office of the EBSA. *You* can contact the EBSA at the U.S. Department of Labor number listed in *your* telephone directory. *You* can also contact them at the Division of Technical Assistance and Inquiries; Employee Benefits Security Administration, U.S. Department of Labor; 200 Constitution Avenue N.W.; Washington, D.C. 20210. Certain publications about *your* rights and responsibilities under ERISA can be obtained by calling the publications hotline of the EBSA.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This *plan's* benefits are coordinated with benefits provided by other plans that cover *you*. This is done to prevent over insurance, which would result in an increase in the cost of coverage under this *plan*. This provision will apply whether or not *you* file a claim under any other plan that covers *you*.

Effect on Benefits

In certain cases, this *plan's* benefits will be reduced when *you* are covered by other plans that provide benefits for the same service. Benefits under this *plan* and any other plans, as defined below, will be coordinated. The total benefit will not exceed the amount this *plan* would have paid for the *covered expenses* had it been primary.

Definitions

A plan is any coverage that provides benefits for medical or dental expenses. Benefits may be provided by payment or service. Plan includes any of the following:

1. Group or franchise insurance coverage, whether insured or self-funded;
2. *Hospital* or medical service organizations on a group basis and other group pre-payment plans;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage sponsored or provided by or through an educational institution;
5. Any governmental program or a program mandated by state statute;
6. Any coverage sponsored or provided by or through an *employer*, trustee, union, *employee* benefit, or other association.

This includes group type contracts not available to the general public. Such contracts may be obtained due to the *covered person's* membership in or connection with a particular group. This provision will apply whether or not such coverage is designated as franchise, blanket, or in some other fashion.

This does not include group or individual automobile "no fault" or traditional "fault" type contracts. It does not include school or other similar liability type contracts. Nor does it include other types of contracts claiming to be excess or contingent in all cases.

How Coordination of Benefits Works

This is called the primary plan. The other plans will then process the claim and make payments based on that plan's specific plan of benefits. These plans are called secondary plans. Secondary plans generally do not pay more than they would had they been the primary plan, payment or payment consideration shall not exceed the total *covered expense.*

When a plan provides benefits in the form of services rather than cash payments, the *usual and customary and reasonable* value of each service will be deemed to be the benefit paid. No plan will pay more than it would have paid without this provision.

Order of Benefit Determination

(Note: Also see the COB Guidelines at the end of this section.)

The primary plan will be determined by the following rules. That plan will pay benefits first.

1. The plan that has no coordination provision will be primary.
2. The plan that covers the person as an *employee* will be primary.
3. For a *child* who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* will be primary. If both parents have the same birthday, the plan covering a parent for the longest period of time will be primary.

4. In the case of a *child* that is placed in the joint custody and physical placement of divorced, separated or unmarried parents rule 3 will apply unless one parent has been assigned financial responsibility for the medical expenses of the *child*. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.
5. In the case of a *child* of divorced, separated or unmarried parents that is not in the joint custody and physical placement of both parents:
    a. the plan of a parent who has primary physical placement will be primary,
    b. the plan of a step-parent that has primary physical placement will pay benefits next,
    c. the plan of a parent who does not have primary physical placement will pay benefits next, and
    d. the plan of a step-parent that does not have primary physical placement will pay benefits next.

    Unless one parent has been assigned financial responsibility for the medical expenses of the *child*. In that case, the plan of the parent with financial responsibility, as ordered by the court, will be primary.
6. The plan covering an inactive person: laid off; retired; on COBRA or any other form of continuation; or the dependent of such a person will pay benefits after the plan covering such persons as an active employee or the dependent of an active employee. (Note: Please refer to the KREC Coordination of Benefit Guidelines at the end of this section for additional information.)
7. The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active employee or the dependent of an active employee.

When an individual is covered under a spouse's plan and also under his or her parent's plan, the primary plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the secondary plan.

If the primary plan is not established by the above rules, the plan that has covered the person for the longest period of time will be primary. If all plans have covered the person for the same period of time, the plans will share equally in the *allowable expenses*. In no event, will any plan pay more than it would have paid as primary.

If a plan other than this *plan* does not include provision 3, then that provision will be waived in order to determine benefits with the other plan.

Coordination of Benefits between Medical and Dental Plans

In all cases, the dental plan will be secondary. It will only pay benefits after the medical plan pays its benefits as the primary plan.

Coordination of Benefits with Medicare

In all cases, coordination with *Medicare* will conform to Federal Statutes and Regulations. Each person that is eligible for *Medicare* will be assumed to have full *Medicare* coverage. Full *Medicare* coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full *Medicare* coverage will be assumed whether or not it has been taken. *Your* benefits under this *plan* are subject to the allowable limiting charges set by *Medicare*. Benefits will be coordinated to the extent they would have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

If the primary payer cannot be determined due to coverage under more than one plan and *Medicare*, the plan that is primary to *Medicare* by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.

KREC - Coordination of Benefits (COB) Guidelines

ALTERNATE METHOD

1. **Deductible Credit.** This plan shall provide a $600 deductible credit for any claim(s) to covered participants coming in as secondary.
2. **Copayments.** The deductible credit does not impact required Copayments. Copayments will apply to applicable services as detailed in the schedule of benefits. If the covered service involves a copayment, member would pay the KREC copayment amount. Unless the remainder from the primary plan was less than the KREC copayment amount. In this scenario the member would pay the full balance transferred from the primary plan, as long as it was less than the KREC copayment amount.
3. **Coinsurance.** For claims coming in as secondary, involving benefits that would normally apply to coinsurance after the deductible had been meet, the claims will immediately be payable with the applicable coinsurance amount.

ACTIVE EMPLOYEES

1. **Active *employee*** with a **non-*Medicare* retired spouse**:
    a. The spouse's plan will be primary for the spouse;
    b. This *plan* (KREC plan) will pay secondary for the spouse.

Medicare Secondary Payor Rules (MSPR): The *plan* cannot terminate coverage due to age or *Medicare* status. An active *employee* that is eligible for *Medicare* due to age (65 or over) has the choice to:

1. Maintain coverage under this *plan*, in which case *Medicare* benefits would be secondary to this *plan*; or
2. End coverage under this *plan*, in which case *Medicare* would be the only coverage available to *you*.

An active *employee's* spouse who is eligible for *Medicare* due to age (65 or over) has the same choice.

RETIREES

1. A **non-*Medicare* (early) retiree** with a **non-*Medicare* retired or active spouse**:
    a. The spouse's plan will be primary for the spouse;
    b. This *plan* (KREC plan) will be secondary for the spouse.
2. A ***Medicare* retiree** that covers a **non-*Medicare* spouse**:
    a. The spouse's employer's plan will be primary for the spouse;
    b. This *plan* (KREC plan) will be secondary for the spouse.
3. A **non-*Medicare* (early) retiree** that covers a ***Medicare* retired spouse**:
    a. *Medicare* will be primary for the spouse;
    b. The spouse's retiree coverage pays secondary for the spouse;
    c. This *plan* (KREC plan) pays third for such spouse.
4. A ***Medicare* retiree** with a ***Medicare* retired spouse**:
    a. *Medicare* pays primary for the spouse;
    b. The spouse's retiree coverage pays secondary for the spouse;
    c. This *plan* (KREC plan) pays third for such spouse.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

The *Plan* is designed to only pay *covered expenses* for which payment is not available from anyone else, including any insurance company or another health plan. In order to help *a covered person* in a time of need, however, the *Plan* may pay *covered expenses* that may be or become the responsibility of another person, provided that the *Plan* later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the *Plan,* as well as by applying for payment of *covered expenses,* a *covered person* is subject to, and agrees to, the following terms and conditions with respect to the amount of *covered expenses* paid by the *Plan:*

1. Assignment of Rights (Subrogation). The *covered person* automatically assigns to the *Plan* any rights the *covered person* may have to recover all or part of the same *covered expenses* from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the *Plan.* This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a *covered person* or paid to another for the benefit of the *covered person.* This assignment applies on a first-dollar basis *(i.e.,* has priority over other rights), applies whether the funds paid to (or for the benefit of) the *covered person* constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the *Plan* to pursue any claim that the *covered person* may have, whether or not the *covered person* chooses to pursue that claim. By this assignment, the *Plan's* right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The *Plan* shall have an equitable lien against any rights the *covered person* may have to recover the same *covered expenses* from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the *Plan.* The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the *Plan* has paid *covered expenses* prior to a determination that the *covered expenses* arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the *covered person,* the *covered person's* attorney, and/or a trust) as a result of an exercise of the *covered person's* rights of recovery (sometimes referred to as "proceeds"). The *Plan* shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the *Plan administrator,* the *Plan* may reduce any future *covered expenses* otherwise available to the *covered person* under the *Plan* by an amount up to the total amount of Reimbursable Payments made by the *Plan* that is subject to the equitable lien.

   This and any other provisions of the *Platt* concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement that were enunciated in the United States Supreme Court's decision entitled, Greg: West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the *Plan* concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in *Plan's* Reimbursement Activities. The *covered person* has an obligation to assist the *Plan* to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the *covered person,* and to provide the *Plan* with any information concerning the *covered person's* other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the *covered person.* The *covered person* is required to (a) cooperate fully in the *Plan's* (or any *Plan* fiduciary's) enforcement of the terms of the *Plan,* including the exercise of the *Plan's* right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those

enforcement efforts or rights (such as settling a claim against another party without including the *Plan* as a co-payee for the amount of the Reimbursable Payments and notifying the *Plan),* (c) sign any document deemed by the *Plan administrator* to be relevant to protecting the *Plan's* subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the *Plan administrator* to enforce the *Plan's* rights,

The *Plan administrator* shall retain discretionary authority with regard to asserting the *Plan's* recovery rights.

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the *plan*.

Amendments to or Termination of the Plan

The *plan's* benefits may be amended by the *employer* at any time. The *plan* may be terminated by the *employer* at any time. Any changes to the *plan* will be communicated immediately by the *employer* to the persons covered under the *plan*.

If the *plan* is terminated, the rights of the *covered persons* to benefits are limited. Only claims incurred and payable prior to the date of termination will be payable. *Plan* assets will be allocated to the exclusive benefit of the *covered persons*. Any taxes and expenses of the *plan* may be paid from the *plan* assets.

Assignment

Any assignment will only be applied if the provider will refund any payments made in error. The *plan* does not attest to the legal validity or effect of any assignment.

Conformity with Applicable Law

If any part of this *plan* conflicts with any law that applies to the *plan*, it is hereby amended to comply with that law.

Contributions to the Plan

The *plan* is funded by contributions from the *employer* and may require a contribution from the covered *employees*.

Any funds contributed by the *employees* are applied to the expenses of the *plan* as soon as is reasonably possible. Any excess funds are used to pay claims. The *employer* sets the amount of the *employee* contribution. The *employer* reserves the right to modify such contributions. All *employee* contributions are on a non-discriminatory basis.

Discretionary Authority

Benefits under this *plan* will be paid only if the *plan administrator* decides in its discretion that the *covered person* is entitled to the benefits. The *plan administrator* will have full discretion to interpret *plan* terms; make decisions regarding eligibility; and resolve factual questions. This discretion will apply with respect to all claim payments and benefits under the *plan*.

Failure to Enforce Plan Provisions

The *plan's* failure to enforce any part of the *plan* will not affect the right, thereafter, to enforce that provision. Such failure will not affect the right to enforce any other provision of the *plan*.

Free Choice of Provider

The *covered person* has a free choice of any legally licensed provider. The *plan* will not interfere with the provider/patient relationship.

Interpretation

This *plan* does not constitute a contract between the *employer* and any *covered person*. It will not be considered as an incentive or condition of employment. The *plan* will not modify the provisions of any collective bargaining agreement that may be made by the *employer*. A copy of any such agreement is available from the *plan administrator* upon written request.

Legal Actions

You may request the alternate dispute resolution process provided by the *plan* or bring an action at law or equity against the *plan*. Such action may not be sought until 60 days after the date *you* provide written proof of loss to the *plan*. If an alternative method of dispute resolution has been agreed to, action at law or equity may not be sought until the end of that process. Any such action cannot be sought more than three years after such proof of loss is submitted.

Payment of Claims
All benefits (except for prescription drugs) will be paid directly to the provider of services, unless *you* direct otherwise in writing at the time proof of loss is filed.

Benefits payable on behalf of *you* or *your* covered *dependent*, upon death, will be paid at the *plan's* option to any one or more of the following: y*our* spouse; y*our dependent* children, including legally adopted children; y*our* parents; y*our* brothers and sisters; or y*our* estate.

Any payment made in good faith will fully discharge the *plan* of its obligations to the extent of such payment.

Physical Examination
The *plan* has the right to have *you* examined as often as reasonably necessary while a claim is pending. Such examination will be at the *plan's* expense.

HIPAA PRIVACY

THE PLAN PROVIDES EACH MEMBER WITH A SEPARATE NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW THE PLAN USES AND DISCLOSES YOUR PERSONAL HEALTH INFORMATION. IT ALSO DESCRIBES CERTAIN RIGHTS YOU HAVE REGARDING THIS INFORMATION. ADDITIONAL COPIES OF OUR NOTICE OF PRIVACY PRACTICES ARE AVAILABLE BY CALLING (859) 744-4864.

Definitions

1. **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
2. **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of *covered persons*. Privacy Standards will be implemented and enforced in the offices of the *employer* and *plan sponsor* and any other entity that may assist in the operation of the *plan*.

The *plan* is required by law to take reasonable steps to ensure the privacy of the *covered person's* PHI, and inform him/her about:

1. The *plan's* disclosures and uses of PHI;
2. The *covered person's* privacy rights with respect to his/her PHI;
3. The *plan's* duties with respect to his/her PHI;
4. The *covered person's* right to file a complaint with the *plan* and with the Secretary of HHS; and
5. The person or office to contact for further information about the *plan's* privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation

modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed
In general, the Privacy Rules permit the *plan* to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes
In order that the *plan sponsor* may receive and use PHI for plan administration purposes, the *plan sponsor* agrees to:

1. Not use or further disclose PHI other than as permitted or required by the *plan* documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the *plan sponsor* provides PHI received from the *plan*, agree to the same restrictions and conditions that apply to the *plan sponsor* with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or *plan* operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out *plan* administration functions;
6. Not use or disclose genetic information for underwriting purposes;
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *plan sponsor*, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the *plan* any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the *plan sponsor* becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or e*mployee* of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the *plan* with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
13. Report to the *plan* any inconsistent uses or disclosures of PHI of which the *plan sponsor* becomes aware;
14. Train *employees* in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. If feasible, return or destroy all PHI received from the *plan* that the *plan sponsor* still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
16. Ensure that adequate separation between the Plan and the *plan sponsor*, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following *employees*, or classes of *employees*, or other persons under control of the *plan sponsor*, shall be given access to the PHI to be disclosed:

i. Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the *plan sponsor* performs for the *plan*.

b. In the event any of the individuals described above do not comply with the provisions of the *plan* documents relating to use and disclosure of PHI, the *plan administrator* shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The *plan administrator* will promptly report such violation or non-compliance to the *plan*, and will cooperate with the *plan* to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The *plan* may disclose PHI to the *plan sponsor* of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the *covered person*. The Plan may use or disclose "summary health information" to the *plan sponsor* for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the *plan* may disclose to the *plan sponsor* information on whether an individual is participating in the *plan* or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the *plan* to the *plan sponsor*.

Disclosure of PHI to Obtain Stop Loss or Excess Loss Coverage

The *plan sponsor* may hereby authorize and direct the *plan*, through the *plan administrator* or the c*laims administrator*, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the *plan*. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The *plan* has the right to use and disclose a *covered person's* PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. Business Associates: The p*lan* contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the *plan* and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the *covered person's* information; and
3. Other Covered Entities: The *plan* may disclose PHI to assist health care *providers* in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the *plan* may disclose PHI to a health care *provider* when needed by the *provider* to render treatment to a *covered person*, and the *plan* may disclose PHI to another covered entity to conduct health care operations. The *plan* may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a *covered person* has coverage through another carrier.

Other Possible Uses And Disclosures of PHI

1. Required by Law: The *plan* may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The *plan* may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. A public health authority or other appropriate government authority authorized by law to receive reports of *child* abuse or neglect;
    b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c. Locate and notify persons of recalls of products they may be using; and
    d. A person who may have been exposed to a communicable *disease* or may otherwise be at risk of contracting or spreading a *disease* or condition, if authorized by law;
3. The *plan* may disclose PHI to a government authority, except for reports of *child* abuse or neglect, when required or authorized by law, or with the *covered person*'s agreement, if the *plan* reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the *covered person* that such a disclosure has been or will be made unless the *plan* believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;
4. Health Oversight Activities: The *plan* may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The *plan* may disclose PHI when required for judicial or administrative proceedings. For example, the *covered person's* PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the *plan* is given satisfactory assurances that the requesting party has made a good faith attempt to advise the *covered person* of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. Law Enforcement: The *plan* may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the *covered person's* PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the *sponsor's* or *plan's* premises;
7. Decedents: The *plan* may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. Research: The *plan* may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The *plan* may disclose PHI in accordance with applicable law and standards of ethical conduct, if the *plan*, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. Workers' Compensation: The *plan* may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the *plan* may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to *covered persons*: The *plan* is required to disclose to a *covered person* most of the PHI in a Designated Record Set when the *covered person* requests access to this information. The *plan* will disclose a *covered person's* PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the *plan* must be given written supporting documentation establishing the basis of the personal representation.

   The *plan* may elect not to treat the person as the *covered person's* personal representative if it has a reasonable belief that the *covered person* has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the *covered person's* best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the *covered person*; and

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The *plan* is required to disclose the *covered person's* PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the *plan's* compliance with the HIPAA Privacy Rule.

Instances When Required Authorization is Needed From Covered Persons Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in this section can only be made with authorization from the *covered person*. The *covered person* may revoke this authorization at any time.

Covered Person's Rights

The *covered person* has the following rights regarding PHI about him/her:

1. Request Restrictions: The *covered person* has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The *covered person* may request that the *plan* restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The *plan* is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The *covered person* has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the *covered person* would like to be contacted. The *plan* will accommodate all reasonable requests;
3. Right to Receive Notice of Privacy Practices: The *covered person* is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;
4. Accounting of Disclosures: The *covered person* has the right to request an accounting of disclosures the *plan* has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The *covered person* is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the *covered person* of the basis of the disclosure, and certain other information. If the *covered person* wishes to make a request, please contact the Privacy Compliance Coordinator;
5. Access: The *covered person* has the right to request the opportunity to look at or get copies of PHI maintained by the *plan* about him/her in certain records maintained by the *plan*. If the *covered person* requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other

supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the *covered person* and the recipient must be clearly identified. The *plan* must respond to the *covered person's* request within thirty (30) days (in some cases, the *plan* can request a thirty (30) day extension). In very limited circumstances, the *plan* may deny the *covered person's* request. If the *plan* denies the request, the *covered person's* may be entitled to a review of that denial;

6. Amendment: The *covered person* has the right to request that the *plan* change or amend his/her PHI. The *plan* reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The *plan* may deny the *covered person's* request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and
7. Fundraising contacts: The *covered person* has the right to opt out of fundraising contacts.

Questions or Complaints

If the *covered person* wants more information about the *plan's* privacy practices, has questions or concerns, or believes that the *plan* may have violated his/her privacy rights, please contact the *plan* using the following information. The *covered person* may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The *plan* will provide the *covered person* with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the *covered person* for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Kenergy
6402 Old Henderson-Corydon Road
Henderson, KY 42419
Phone: (800) 844-4832

Pronouns

All personal pronouns used in the *plan* include either gender. This will be true unless its use clearly indicates otherwise.

Protection Against Creditors

Benefit payments under the *plan* are not subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind. Any attempt to accomplish these will be void. If the *plan* finds that such an attempt has been made, it, at its sole discretion, may terminate *your* interest in the payments. The *plan* will then apply the amount of the payment to the benefit of an adult *child*, guardian of a minor *child*, brother or sister, or other relative of the *covered person*. Such payment will fully discharge the *plan* to the extent of the payment.

Qualified Medical Child Support Order

If a *child* is the subject of a Qualified Medical Child Support Order (QMCSO), the *child* must be considered an *alternate recipient* under the *plan*. Upon the *plan's* decision that an order is a QMCSO, coverage must be provided to the *child*. Coverage may not be subject to *plan* requirements such as: custody; claimed on taxes; or 50% support. Enrollment periods and other similar limits on the eligibility of *dependents* are also waived for that *child*. If an *employee* does not enroll the *child* in the *plan*, the *plan* must recognize the *child*'s right to be enrolled as an *alternate recipient*. The custodial parent or legal guardian of the *child* may also exercise this right.

An *alternate recipient* will be as an *employee* under the *plan* for the purpose of reporting and disclosure under ERISA. The custodial parent or legal guardian may have this right on behalf of the *alternate recipient*. They must receive all information needed to be enrolled in and receive benefits under the *plan*. They must be provided with a copy of the *plan's* Summary Plan Description (SPD). Any payments made by the *plan* must be made to the *alternate recipient* or the provider of service. Payment may also be made to the custodial parent or legal guardian.

A QMCSO is any judgment, decree or order relating to the benefits of this *plan* for the *child* of an *employee*. It may be issued pursuant to State domestic relations law, including community property law. It may be issued to enforce a law relating to medical *child* support under the Social Security Act. The order may be from a court of competent jurisdiction. It may also be through administrative process under State law. The order must include the following items to be considered a QMCSO:

1. The name and last known mailing address of the *employee*;
2. The name and address of each *alternate recipient*;
3. A description of the type of coverage to be provided or the manner in which coverage will be determined for each *alternate recipient*; and
4. The period of time for which coverage is to be provided to each *alternate recipient*.

The *plan* will provide *you* with a written notice of its decision regarding the status of an order as a QMCSO. A properly completed National Medical Support Notice will be treated as a QMCSO under this *plan*.

A QMCSO will not require the *plan* to offer any benefits or coverage not already offered by the *plan*.

Right to Necessary Information
The *plan* may require certain information in order to apply the provisions of this *plan*. To get this information the *plan* may release or obtain information from any party it needs to. The exchange of such information will not require *your* consent. Any party may include an insurance company, organization or person. Information will only be exchanged to the extent needed to implement the provisions of the *plan*. *You* agree to furnish any information needed to apply the *plan* provisions.

Right to Recover
The *plan* reserves the right to recover payments made under the *plan*. Recovery is limited to the amount that exceeds the amount the *plan* is obligated to pay. This right of recovery applies against:

1. Any person(s) to, for or with respect to whom such payments were made; and
2. Any insurance company or organization. If under the terms of this *plan*, it owes benefits for the same expense under any other plan.

The *plan* alone shall determine against whom this right of recovery will be exercised.

If benefits have been paid by any other plan that should have been paid by this *plan*, the *plan* reserves the right to directly reimburse such plan. Reimbursement will be to the extent needed to satisfy the obligations of this *plan*. Any such payment made in good faith will fully discharge the *plan* of its obligation to the extent of such payment.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the *plan's* terms, conditions, limitations or exclusions, or should otherwise not have been paid by the *plan*. As such this *plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the *plan* pays benefits exceeding the amount of benefits payable under the terms of the *plan*, the *plan administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *covered person* or dependent on whose behalf such payment was made.

A *covered person*, dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *plan* within thirty (30) days of discovery or demand. The *plan administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *plan administrator* shall have the sole discretion to choose who will repay the *plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *covered person* or other entity does not comply with the provisions of this section, the *plan administrator* shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the *covered person* and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the *plan* by the amount due as reimbursement to the *plan.* The *plan administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the *plan* sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this *plan* and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, current ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the *plan administrator* or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *plan* within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the *plan* must bring an action against a *covered person*, provider or other person or entity to enforce the provisions of this section, then that *covered person*, provider or other person or entity agrees to pay the *plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *covered persons* and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*covered persons*) shall assign or be deemed to have assigned to the *plan* their right to recover said payments made by the *plan*, from any other party and/or recovery for which the *covered person(s)* are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the *plan* has not already been refunded.

The *plan* reserves the right to deduct from any benefits properly payable under this *plan* the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this *plan* within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a *covered person* fails to comply with the *plan's* Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the *plan* to pay benefits under this *plan* in any such instance.

The deduction may be made against any claim for benefits under this *plan* by a *covered person* or by any of his covered dependents if such payment is made with respect to the *covered person* or any person covered or asserting coverage as a dependent of the *covered person.*

If the *plan* seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the *plan*, abstain from billing the *covered person* for any outstanding amount(s).

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

Standards for Security of Individually Identifiable Health Information ("Security Rule")
The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

1. **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
2. **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations
To enable the *plan sponsor* to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the *plan sponsor* agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the *plan*;
2. Ensure that adequate separation between the *plan* and the *plan sponsor*, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the *plan sponsor* provides Electronic PHI created, received, maintained, or transmitted on behalf of the *plan*, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the *plan* any security incident of which it becomes aware; and
4. Report to the *plan* any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI
The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.
When a breach of unsecured PHI is discovered, the *plan* will:

1. Notify the *covered person* whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach Notification must be provided to individual by:
    a. Written notice by first-class mail to *covered person* (or next of kin) at last known address or, if specified by *covered person*, e-mail;
    b. If *plan* has insufficient or out-of-date contact information for the *covered person*, the *covered person* must be notified by a substitute form;
    c. If an urgent notice is required, *plan* may contact the *covered person* by telephone.
        i. The breach notification will have the following content:
            1. Brief description of what happened, including date of breach and date discovered;
            2. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
            3. Steps *covered person* should take to protect from potential harm;
            4. What the *plan* is doing to investigate the breach, mitigate losses and protect against further breaches;
2. Notify the media if the breach affected more than five hundred (500) residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction

without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered;

3. Notify the HHS Secretary if the breach involves five hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each *calendar year*; and
4. When a Business Associate, which provides services for the *plan* and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the *plan* without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected *covered persons* may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

Statements
In the absence of fraud, all statements made by a *covered person* will be deemed representations and not warranties. A statement will not be used to contest coverage under the *plan* unless a signed copy of it has been provided to the *covered person*. If the *covered person* is deceased, the copy will be provided to their beneficiary.

Time of Claim Determination
After receipt of written proof of loss or utilization review request, the *plan* will notify *you* of its decision on *your* claim and issue payment, if any is due, as follows:

Urgent Care
Within 24 hours or as soon as possible if, *your* condition requires a shorter time frame. If more information is needed to make a decision on the claim, the *plan* will notify *you* of the specific information needed within 24 hours. *You* will then have 48 hours from the receipt of the notice to provide the requested information. Within 48 hours of its receipt of the additional information, the *plan* will give its decision on the claim. If *you* fail to provide the information requested by the *plan*, the *plan* will provide *you* with its decision on the claim within 48 hours of the end of the period that *you* were given to provide the information.

If *you* fail to follow the *plan* procedure for a *pre-service claim*, the *plan* will notify *you* within 24 hours of the *plan's* receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Concurrent Care
Prior to the end of any pre-authorized course of treatment, if benefits are being stopped prior to the number of treatments or time period that was authorized. The notice must provide time for *you* to make an appeal and receive a decision on that appeal prior to the benefit being stopped. This will not apply if the benefit is being stopped due to a *plan amendment*. This will not apply if the benefit is being stopped due to the termination of the *plan*.

Requests to extend a pre-authorized treatment that involves *urgent care* must be responded to within 24 hours or as soon as possible if, *your* condition requires a shorter time frame. Such requests must be made at least 24 hours before the authorized course of treatment ends.

Pre-Service Claims
Within 15 days of receipt of a non-*urgent care* claim. The *plan* may extend this period by 15 days if; *you* are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the *plan's* control. If an extension is due to the need for additional information, the *plan* will notify *you* of the specific information needed. *You* will then have 45 days from the receipt of the notice to provide the requested information.

If *you* fail to follow the *plan* procedure for a non-*urgent care pre-service claim*, the *plan* will notify *you* within five days of the *plan's* receipt of the pre-authorization request. The notice will include the reason why the request failed and the proper process for obtaining pre-authorization.

Post-Service Claims
Within 30 days of receipt of the claim. The *plan* may extend this period by 15 days if; *you* are notified of the need for an extension prior to the end of the initial period. The extension must be due to circumstances that are beyond the *plan's* control. If an extension is due to the need for additional information, the *plan* will notify *you* of the specific information needed. *You* will then have 45 days from the receipt of the notice to provide the requested information.

Workers' Compensation Not Affected
This *plan* is not issued in lieu of Workers' Compensation coverage. It does not affect any requirement for coverage by any Workers' Compensation Law. It does not affect any requirement for coverage by any Occupational Disease Act.

CLAIM APPEAL PROCEDURE

You may appeal the denial of a claim, utilization review decision or a rescission of coverage determination by following these procedures:

1. File a written request, with the *claims administrator*, for a full and fair review of the claim by the *plan*;
2. Request to review documents pertinent to the administration of the *plan*; and
3. Submit written comments and issues outlining the basis of *your* appeal.

A request for a review must be filed with the *plan* within 180 days after receipt of the claim denial. If *your* request for review is not received within 180 days, *your* right to appeal the claim denial is forfeited.

If *your* request for review is received within 180 days, a full and fair review of the claim will be held by the *plan*. The review will not give weight to the initial claim decision. If the appeal involves a decision of medical judgment, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. If the appeal involves the experimental status of a service, a medical consultant that has appropriate training and experience in the field of medicine at question will be involved. Any such medical consultant will not have had prior involvement with the claim being appealed. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the *plan* will provide that information to *you* free of charge and sufficiently in advance of the due date of the response to the *adverse benefit determination.*

After the review, the *plan's* decision will be made to *you* in writing. It will include specific reasons for the decision as well as specific references to the *plan* provisions on which the decision is based. *You* will be notified of the *plan's* decision as follows:

1. For *urgent care* claims, within 72 hours or as soon as possible if *your* condition requires a shorter time frame;
2. For *pre-service claims*, within 30 days or as soon as possible if *your* condition requires a shorter time frame; or
3. For *post-service claims*, within 60 days.

An expedited appeal process is available for *urgent care* cases.

If *you* disagree with the result of an appeal, the *plan* provides for an alternative dispute resolution process. Under the process either party may elect to take the appeal to non-binding arbitration or upon agreement of both parties binding arbitration. Arbitration will be under the rules of the American Arbitration Association. The arbitrators will be bound by controlling law. They are not allowed to vary or ignore the provisions of the *plan* as stated in this Summary Plan Description, or to award any punitive or exemplary damages. This provision will apply to *you*, or any person or entity, filing claim through *your* rights under the *plan*. *You* may have representation during the review process.

Federal External Review Program

For purposes of this section, "claimant" shall mean any *covered person* or beneficiary submitting a claim to the *plan* and thereby seeking to receive *plan* benefits.

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible *adverse benefit determination* (including a *final internal adverse benefit determination*) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The *plan* will allow a claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an *adverse benefit determination* or *final internal adverse benefit determination*. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the *plan* will complete a preliminary review of the request to determine whether:
    a. The claimant is or was covered under the *plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *plan* at the time the health care item or service was provided;
    b. The *adverse benefit determination* or the *final adverse benefit determination* does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the *plan* (e.g., worker classification or similar determination);
    c. The claimant has exhausted the *plan*'s internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations;
    d. The claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the *plan* will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the *plan* will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The *plan* will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the *plan* will take action against bias and to ensure independence. Accordingly, the *plan* will contract with (or direct the *claims administrator* to contract with, on its behalf) at least three IROs for assignments under the *plan* and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of *plan*'s decision. Upon receipt of a notice of a final external review decision reversing the *adverse benefit determination* or *final internal adverse benefit determination*, the *plan* will provide coverage or payment for the claim without delay, regardless of whether the *plan* intends to seek

judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The *plan* will allow a claimant to make a request for an expedited external review with the *plan* at the time the claimant receives:
    a. An *adverse benefit determination* if the *adverse benefit determination* involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
    b. A *final internal adverse benefit determination*, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the *final internal adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the *plan* will determine whether the request meets the reviewability requirements set forth above for standard external review. The *plan* will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the *plan* will assign an IRO pursuant to the requirements set forth above for standard review. The *plan* will provide or transmit all necessary documents and information considered in making the *adverse benefit determination* or *final internal adverse benefit determination* to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the *plan*'s internal claims and appeals process.

4. Notice of final external review decision. The *plan*'s (or *claim administrator*'s) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, 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 notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the *plan*.

AMENDMENT #1 TO THE KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS FIRST AMENDMENT TO THE KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY 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 Kentucky Rural Electric Cooperative – Kenergy Employers Benefit Plan, (the "Plan Sponsor"), with its principal place of business located at 6402 Old Henderson-Corydon Road, Henderson, KY 42419.

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 Kentucky Rural Electric Cooperative - Kenergy Employers Benefit Plan is hereby amended as follows:

1. Amendments to existing Plan Document and Summary Plan Description.

   (a) Employee Eligibility in section 3-1 is hereby deleted and replaced with the following.

   Employee Eligibility
   You are eligible for coverage under the *plan* if the following conditions are met:

   1. *You* are an *employee* who meets the eligibility requirements of the *employer*; and
   2. *You* satisfy *your* co-op's eligibility period of first of month following date of full-time hire; or
   3. If applicable, *you* are a *director* or attorney for the *employer*.

   You are eligible to be covered on the first of the month following *your* date of full-time hire. This is *your* eligibility date.

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, KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN – KENERGY PLAN is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY on or as of the day and year first below written.

By Kirk Ellis
KENERGY

Date 3/24/2020

Witness _____

Date _____

AMENDMENT #2 TO THE KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS SECOND AMENDMENT TO THE KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (the "Amendment"), is made and shall take effect as of March 18, 2020. This Amendment is made and entered into by Kentucky Rural Electric Cooperative – Kenergy Employers Benefit Plan, (the "Plan Sponsor"), with its principal place of business located at 6402 Old Henderson-Corydon Road, Henderson, KY 42419.

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 March 18, 2020;

NOW, THEREFORE, the Plan Document and Summary Plan Description for Kentucky Rural Electric Cooperative - Kenergy Employers Benefit Plan is hereby amended as follows:

1. Amendments to existing Plan Document and Summary Plan Description.

   (a) COVID-19 Testing. Testing of COVID-19 shall be covered at 100% with no member cost share. This shall include all related office visits, ER visits, along with any copayment, deductible, coinsurance or any other costs associated with the testing for COVID-19.

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, KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN – KENERGY PLAN is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY on or as of the day and year first below written.

By Kevin Ellis
KENERGY

Date 4-6-2020

Witness _____

Date _____

AMENDMENT #3 TO THE KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS THIRD AMENDMENT TO THE KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (the "Amendment"), is made and shall take effect as of May 1, 2020. This Amendment is made and entered into by Kentucky Rural Electric Cooperative – Kenergy Employers Benefit Plan, (the "Plan Sponsor"), with its principal place of business located at 6402 Old Henderson-Corydon Road, Henderson, KY 42419.

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 May 1, 2020;

NOW, THEREFORE, the Plan Document and Summary Plan Description for Kentucky Rural Electric Cooperative - Kenergy Employers Benefit Plan is hereby amended as follows:

1. Amendments to existing Plan Document and Summary Plan Description.

   (a) ACTIVELY AT WORK. Section 2-1, The following sentence in the definition for Actively at Work "Performing on a regular, full-time basis all normal employment duties for at least 30 hours per week." is hereby deleted and replaced with the following: Performing on a regular, full-time basis all normal employment duties for at least 20 hours per week.

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, KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN – KENERGY PLAN is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY on or as of the day and year first below written.

By Kirk Ellis
KENERGY

Date April 9, 2020

Witness _____

Date _____

AMENDMENT #4 TO THE KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS FOURTH AMENDMENT TO THE KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (the "Amendment"), is made and shall take effect as of March 1, 2020. This Amendment is made and entered into by Kentucky Rural Electric Cooperative – Kenergy Employers Benefit Plan, (the "Plan Sponsor"), with its principal place of business located at 6402 Old Henderson-Corydon Road, Henderson, KY 42419.

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 March 1, 2020;

NOW, THEREFORE, the Plan Document and Summary Plan Description for Kentucky Rural Electric Cooperative - Kenergy Employers Benefit Plan is hereby amended as follows:

1. Amendments to existing Plan Document and Summary Plan Description.

   (a) SCHEDULE OF BENEFITS, MEDICAL BENEFITS SCHEDULE. The Medical Benefits Schedule for the PPO Plan are hereby amended. The Live Health Online/Telehealth Consultation benefit located on page 1-4 is hereby deleted and replaced with the following.

MEDICAL BENEFITS SCHEDULE
PPO PLAN

	NETWORK	NON-NETWORK
COVERED BENEFITS		
PHYSICIAN SERVICES	YOUR COST SHARE RESPONSIBILITY	
Live Health Online	$30 Copayment per visit	Not Covered

   (b) SCHEDULE OF BENEFITS, BENEFITS SCHEDULE NOTES. The Benefit Schedule Notes for the PPO Plan is hereby amended. The Benefit Schedule Notes located on page 1-11 is hereby deleted and replaced with the following.

Benefit Schedule Notes for PPO:

Any services available at an in-person setting that can be received remotely will be covered and the same member cost shares will apply.

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

Cost Containment Penalties are excluded from the Out-Of-Pocket Limits.

Network and Non-Network Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximums are separate and accumulate separately.

Dependent Coverage to end of the Calendar 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.

SPC 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 Calendar Year Basis beginning January 1st and ending December 31st.

[1] Charges in excess of the Maximum Allowed Amount do not contribute to the deductible. Deductible Amounts accumulate separately for In Network and Out of Network.

[2]Out of Pocket amounts accumulate separately for In Network and Out of Network Charges.

[3]Preventive Mammograms are covered at 100%.

[4] Breast Pumps are Covered at 100% by an In Network or Out of Network DME (Durable Medical Equipment) Provider as well as retail stores. Members are reimbursed for any breast pumps at purchase price, including sales tax.

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, KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN – KENERGY PLAN is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for KENTUCKY RURAL ELECTRIC COOPERATIVE EMPLOYERS BENEFIT PLAN - KENERGY on or as of the day and year first below written.

By Keith Ellis VP Administrative Services
KENERGY

Date 10-27-2020

Witness _____

Date _____