Medical Plan Document and
Summary Plan Description (SPD)
For COUNTY OF STODDARD MISSOURI

Stoddard County

Effective 01/01/2023

For the Schedule of Benefits, see page 4

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For assistance in a non-English language, please call 844-671-4963.
Para obtener asistencia en Español, por favor llame al número arriba.

Introduction

Welcome to the COUNTY OF STODDARD MISSOURI Medical Plan.

This Plan Document and Summary Plan Description (“SPD”) explains the operation of your health plan. Please call 844-671-4963 if you have any questions.

Introduction
The Plan Sponsor has established the Plan, for the benefit of its Employees, to help offset the financial impact of an Injury or Sickness.

The Plan Document describes the terms for payment of covered medical and prescription charges.

Applicable Law
This Plan is a governmental plan as defined in (and exempt from) the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The Plan shall be governed by Missouri state law.

Type of Administration
The Plan is a self-funded group health plan. HealthEZ serves as a third-party claims administrator for the Plan.

Discretionary Authority
The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD. The Plan Administrator also has full discretionary authority to interpret the Plan and to determine all questions relating to the Plan as they relate to eligibility to participate in the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals, committees, or third-parties.

Fiduciary
The Plan Administrator is the named fiduciary of the Plan.

Legal Entity; Service of Process
The Plan is a legal entity. Legal process may be served on the Plan Administrator. You must exhaust your appeal rights (other than external review) before bringing legal action.

Plan Contributions & Funding
The Plan is self-funded by the general assets of the Plan Sponsor. The Plan Sponsor determines the level of Employee contributions.

Schedule of Benefits

Call 844-671-4963 to verify eligibility for benefits before the charge is incurred.

Reimbursement from the Plan may be reduced or denied due to the provisions in the Plan, such as coordination of benefits, subrogation, or medical necessity.

DEDUCTIBLE

Before benefits can be paid in a Plan Year, a Plan Participant must pay the Deductible shown in the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

After the deductible is met, a Plan Participant will be required to continue to pay for a share of the Covered Expenses until the out-of-pocket maximum is met. Once the out-of-pocket maximum is reached, the Plan will pay for the entirety of the Covered Expenses for the remainder of the Plan Year.

COPAY AND COINSURANCE

Copay. A flat fee that is paid each time a service is provided.

Coinsurance. A portion of the cost of the service that the Plan Participant pays after the deductible is met.

Copayments and coinsurance accrue toward the out-of-pocket maximum, but not toward the deductible.

MAXIMUM ALLOWABLE CHARGE LIMITATION

The Plan has a fiduciary obligation to its participants to preserve Plan assets against charges that exceed the Maximum Allowable Charge. The Plan only pays benefits based on the Maximum Allowable Charge rather than billed charges. If a Provider charges more than the Maximum Allowable Charge (as determined by the Plan), the Plan Participant may be responsible for the amount in excess of the Maximum Allowable Charge, unless prohibited by applicable law. Any excess amount charged to the Plan Participant is not counted toward satisfaction of the Deductible, and it is not paid by the Plan even after satisfaction of the Deductible.

The Maximum Allowable Charge will not include charges for Unbundling, as defined by this Plan Document, which includes any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

ADVOCACY

It is the Plan's position that a Provider should not balance bill a Plan Participant for amounts in excess of the Maximum Allowable Charge. It is the Plan's position that these Excess Charges are clearly excessive and exorbitant.

PROVIDER NETWORK

Your Provider network name, phone number and website are displayed on your ID card.

This Plan has entered into an agreement with Provider networks. In-network Providers have agreed to charge reduced fees to Plan Participants.

The Plan may pay for out-of-network services at the in-network benefit level if:

- A Plan Participant has no in-network Providers in the necessary specialty within the PPO service area; or
- A Plan Participant unavoidably receives services from an out-of-network Provider at an in-network facility.

Also, pursuant to the No Surprises Act, effective January 1, 2022, the Plan shall provide for out-of-network services at the in-network benefit level if:

- A Plan Participant receives emergency services from an out-of-network Provider or emergency facility;
- A Plan Participant receives non-emergency services from an out-of-network Provider at an in-network facility, unless the Provider furnishes notice to the Plan Participant, beneficiary, or authorized representative and receives consent from the individual in compliance with the No Surprises Act; or
- A Plan Participant receives air ambulance services furnished by an out-of-network Provider.

The Plan may also pay for out-of-network services at the in-network benefit level if the claim falls under the Missouri Unanticipated Out-of-Network Care Law (as described in the "Important Notices" section below).

Additional information about this option, as well as a list of in-network Providers, will be made available to a Plan Participant upon request and without charge.

You have a free choice of any Provider (i.e. in-network or out-of-network) and you, together with your Provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Effective January 1, 2022, if a Provider is removed from the Plan's network, the Plan will notify Plan Participants who are receiving care from the Provider under a continuing care relationship that the Provider is no longer in the Plan's network and that the Participant has the right to elect to continue receiving transitional care from the Provider under the same terms and conditions that would have applied had the Provider remained in-network for up to a 90-day period from when the notice was furnished to the Participant.

SUPPLEMENTAL INFORMATION AND RECORDS REQUESTS

The Plan Administrator or its delegate may require additional information to make a benefit determination. The Plan Participant or Provider must send this information in the timeframe requested. Failure to send such requested information may result in denial of payment.

CLAIMS REVIEW

The Plan Administrator or its delegate may use its discretionary authority to utilize an independent bill review and/or claim audit program.

The Plan Administrator or its delegate has the discretionary authority to reduce any charge to a Usual and Customary or Reasonable amount. The Medicare reimbursement methodology is used in determining a Usual and Customary or Reasonable amount by the Plan.

Schedule of Benefits
Copay Plan 1

Embedded Deductible Embedded Out-of-Pocket Maximum	In Network	Out of Network
DEDUCTIBLE		
Individual Coverage	$1,500	$3,000
Family Coverage	$3,000	$6,000
OUT-OF-POCKET MAXIMUM		
Individual Coverage	$2,850	$4,500
Family Coverage	$5,700	$7,500

PLAN OPERATIONS

- All deductible and out-of-pocket payments cross accumulate toward the in network and out of network deductible and out of pocket limits, as well as the individual and family limits.
- Both Medical and Pharmacy copayments, along with the services counted towards the deductible, will accrue toward the out-of-pocket maximum

For those who have elected family coverage:

- This health plan has an embedded Deductible. This means that each individual will only have to meet the individual Deductible before the Plan begins paying benefits for such individual that are subject to a Deductible.
- This health plan(s) has an embedded out-of-pocket maximum. This means that each individual will only have to meet the individual out-of-pocket maximum before the Plan begins paying in full for such individual.

Deductible Year	Grandfathered status	Coinsurance/Copay
Calendar	Not grandfathered	Indicates Plan Participant responsibility.

PREVENTIVE CARE SERVICES		
Well Child Care (up to age 18)	No Charge	50% Coinsurance after Deductible
Adult Preventive Care	No Charge	50% Coinsurance after Deductible
Routine Prenatal Care	No Charge	50% Coinsurance after Deductible
Breast Feeding Equipment Limit to one pump per pregnancy with a $350 limit for reimbursement unless otherwise precluded by applicable law.	No Charge	
Routine Eye Exam One per 12 months	No Charge	50% Coinsurance after Deductible

Any other preventive care services required by the Affordable Care Act.	No Charge	
TELEMEDICINE SERVICES PROVIDED THROUGH TELADOC		
General Consultations	No Charge	
Dermatology	Not Covered	
Mental Health – Therapist	Not Covered	
Mental Health – Psychiatrist, initial evaluation	Not Covered	
Mental Health – Psychiatrist, ongoing session	Not Covered	
CLINIC AND INDEPENDENT LAB SERVICES		
Primary Care Office Visit	$30 Copay	50% Coinsurance after Deductible
Specialist Office Visit	$60 Copay	50% Coinsurance after Deductible
Urgent Care Clinic	$75 Copay	50% Coinsurance after Deductible
In Office Procedures	Primary: $30 Copay Specialist: $60 Copay	50% Coinsurance after Deductible
Labs, Pathology, Ultrasound and X-Ray	No Charge	50% Coinsurance after Deductible
Allergy Shots, Testing, and Serum	Primary: $30 Copay Specialist: $60 Copay	50% Coinsurance after Deductible
Immunizations-Foreign Travel	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Temporomandibular Joint Disorder (TMJ) No hardware coverage.	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Infertility Care, services, supplies for the diagnosis and charges for surgical correction of physical abnormalities. No coverage for assisted reproduction.	20% Coinsurance after Deductible	50% Coinsurance after Deductible
INJECTIONS AND INTRAVENOUS THERAPY		
Infusions and Injections	20% Coinsurance after Deductible	50% Coinsurance after Deductible
ADVANCED IMAGING		
Complex Imaging: MRI/CT/PET Scans	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Nuclear Medicine, DEXA Scans, Diagnostic Mammogram	20% Coinsurance after Deductible	50% Coinsurance after Deductible

HOSPITAL AND SURGICAL SERVICES		
Inpatient Hospital Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Procedures – Facility and Physician Charges	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Hospital Labs, Pathology, Ultrasound and X-Ray	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Organ Transplants Must be performed at a designated center of excellence for transplants.	20% Coinsurance after Deductible	Not Covered
EMERGENCY SERVICES		
Emergency Room Care Covered at in-network benefit level if determined medically necessary.	$300 Copay, then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
Ground Ambulance Covered at in-network benefit level if determined medically necessary.	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Air Ambulance	20% Coinsurance after Deductible	
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES		
Inpatient, Residential, Partial Hospitalization, or Intensive Outpatient	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Office Visit	$60 Copay	50% Coinsurance after Deductible
REHABILITATIVE/ HABILITATIVE OUTPATIENT THERAPY		
Occupational Therapy 30 visit limit per year.	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Speech Therapy 30 visit limit per year.	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical Therapy 30 visit limit per year.	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Chiropractic Services 24 visit limit per year.	20% Coinsurance after Deductible	50% Coinsurance after Deductible
ANCILLARY SERVICES		
Skilled Nursing Facility	Not Covered	50% Coinsurance after Deductible
Hospice	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Private Duty Nursing Care Inpatient, only when ICU is not available.	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Home Health Care	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Nutritionists and dietitians	20% Coinsurance after Deductible	50% Coinsurance after Deductible
MEDICAL EQUIPMENT		
Medical Equipment	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Prosthetics	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Medically Necessary Wigs $1,000 Lifetime Maximum unless otherwise precluded by applicable law.	No Charge	
PRESCRIPTION DRUG SERVICES		
	Retail (per 30-day supply)	**Mail Order (per 90-day Supply)**
Generic	$15 Copay	$30 Copay
Preferred Brand	$45 Copay	$90 Copay
Brand Non-Formulary	$75 Copay	$150 Copay
	Retail and Mail Order (per 30-day Supply)	**Mail Order (per 90-day Supply)**
Specialty Drugs	$200 Copay	Not Available

Eligibility

Eligibility Requirements are determined by your Employer and set forth below. If you have any questions regarding eligibility, contact your Employer.

REQUIREMENTS	
Employee	30 hours per week or 130 hours per month
Waiting Period	Coverage Effective Date is the date of hire.
Eligible Dependent	1. An Employee's Spouse; 2. An Employee's Child who is less than 26 years of age, without regard to the child's student or marital status or whether the child is the Employee's financial dependent; 3. An Employee's Child, regardless of age, who became Disabled prior to reaching 26 years of age and who has been continuously covered by the Plan since becoming Disabled. For purposes of this section, a Child is considered "disabled" if he or she meets the criteria used by the Social Security Administration to determine disability for purposes of the Supplemental Security Income program. The Plan reserves the right to require documentation to establish a Dependent relationship.
Coverage Termination	The day no longer eligible. For dependents turning 26, coverage will be terminated the last day of the month in which the dependent turns 26.
Rehired Employees	If an Employee is rehired within 13 weeks of their termination, they are eligible no later than first of the month following that rehire.

Enrollment

An Employee must enroll for coverage with the Plan Sponsor within 31 days after the Employee becomes eligible. This enrollment cannot be changed or dropped without a qualifying event. During Open Enrollment, Employees will be able to elect, change, or discontinue coverage. The Plan Sponsor must forward the completed enrollment to HealthEZ in a timely manner.

Special Enrollment Rights

Federal law allows a Special Enrollment right if you had a qualifying event. This request for enrollment must be made within 31 days of the qualifying event unless a longer time is provided in this Plan Document or required by law. Coverage will be effective on the date of the qualifying event. An Employee or Eligible Dependent who is already enrolled in the Plan at the time of the Qualifying Event may also make changes to their enrollment at this time.

Qualifying events include:

- Loss of eligibility for health coverage:
  - Losing eligibility for existing health coverage, including job-based, individual, and student plans.
  - Losing eligibility for Medicaid or CHIP or becoming eligible for a state premium assistance subsidy under Medicaid or CHIP.
    - If an Employee has declined enrollment in the Plan for themselves or Dependents because of coverage under Medicaid or CHIP and loses that coverage or becomes eligible for a state premium assistance subsidy under Medicaid or CHIP, there is a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the Medicaid or CHIP coverage ends or after becoming eligible for a state premium subsidy under Medicaid or CHIP.

- Changes in household:
  - Acquisition of a new spouse due to marriage
  - Acquisition of a new Dependent through marriage, birth, adoption, or placement for adoption

Note: If other health plan coverage was lost because of failure to pay coverage premiums or required contributions, that Employee does not have Special Enrollment Rights based on such loss of coverage.

Termination of Coverage

Coverage will terminate on the earliest of these dates:

- The date the Plan is terminated or amended such that an individual loses coverage; or
- The last date the Employee ceases to be eligible for participation in the Plan.

The Plan Sponsor also has the right to rescind any coverage for cause, including making a fraudulent claim or lying when obtaining coverage. In addition to being considered fraud on the Plan and an intentional misrepresentation, enrolling ineligible dependents or maintaining coverage for a person who no longer satisfies the dependent eligibility rules violates COUNTY OF STODDARD MISSOURI policy. If COUNTY OF STODDARD MISSOURI determines that an ineligible dependent has been enrolled, coverage may be canceled retroactively. COUNTY OF STODDARD MISSOURI reserves the right to recover any and all benefit payments made for services received by ineligible dependents and to terminate the Employee's employment.

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where the required Employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Coverage During Disability or Leave of Absence

A person may remain eligible for a limited time if disabled or during a leave of absence. Refer to your Employee handbook and/or policies for further information. If coverage continuance is granted, coverage will end when the Employer ends the continuance.

For continuation during FMLA leave, coverage ends at the end of the FMLA maximum coverage period. Refer to your Employee Handbook for further information. Continuation coverage under Missouri law may be available after FMLA coverage ends.

Employees on Military Leave

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), if an Employee is absent from work because of service in the uniformed services, the Employee can continue health coverage for the Employee and the Employee's Dependents. If the Employee or the Employee's covered Dependents choose coverage under USERRA, then the Employee or the Dependents must pay monthly premiums for coverage.

During a military leave that is expected to be 30 days or less, the Employee's current employee coverage will continue without interruption, assuming the Employee pays the normal share of premiums for the coverage.

While on paid military service leave (for up to one year), the Employee may maintain the health benefits for which the Employee was enrolled before military service leave by paying the Employee's normal share of premiums for coverage.

For Employees who continue coverage while in military service, coverage will terminate at the earliest of these dates:

- The 24-month period beginning on the date absence begins; or
- The date the Employee fails to return to work as required.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, unless on active duty for 30 days or less.

A Waiting Period may not be imposed upon reemployment if one would not have been imposed had coverage not been terminated because of military service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of active military service.

After your paid military service leave ends, the Employee may elect continuation coverage for up to 24 months under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under Missouri continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. Dependents do not have any independent right to elect USERRA health plan continuation.

Covered Expenses

Covered Expenses are subject to the Usual and Customary Charge as determined by HealthEZ.

1. **Ambulance.** Professional land or air service, if medically necessary, to the nearest Hospital or Skilled Nursing Facility.

2. **Breast Cancer Treatment.** Treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

3. **Cardiac Rehabilitation.** Following a myocardial infarction, coronary occlusion, or coronary bypass surgery.

4. **Chemotherapy and Radiation Therapy.**

5. **Chiropractic services.** When performed by a licensed M.D., D.O. or D.C.

6. **Clinical Trials.** Routine patient costs for participation in an Approved Clinical Trial**.** Charges relating to the prevention, detection, or treatment of a life-threatening disease or condition, as defined under the PPACA, provided the clinical trial is approved by:

    - The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
    - The National Institute of Health;
    - The U.S. Food and Drug Administration;
    - The U.S. Department of Defense; or
    - The U.S. Department of Veterans Affairs.

7. **Contact Lenses.** The initial contact lenses required following cataract surgery.

8. **Contraceptives.** The charges for all FDA approved contraceptive methods are covered in accordance with Health Resources and Services Administration (HRSA) guidelines.

9. **Diabetic Supplies, Equipment and Devices.**

10. **Home Health Care Services and Supplies.** When a Hospital or Skilled Nursing Facility would otherwise be required. The care must be prescribed by the attending Physician and be contained in a Home Health Care Plan. A Home Health Care Service visit is defined as a periodic visit by a nurse or therapist, or four hours of home health aide services.

    In the case of a mother and newborn child if the inpatient hospital stay for the birth of the newborn was less than 48 hours following a vaginal delivery or less than 96 hours following a caesarean section, Home Health Care Services shall include a minimum of two post-discharge care visits, at least one of which will be in the home by a registered nurse with experience in maternal and child health nursing or a Physician. The location of the post-discharge visits shall be determined by the attending Physician. The post-discharge services shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory.

11. **Hospice Care Services and Supplies.** When the patient is not expected to live more than six months, as certified by a Physician, and is placed under a Hospice Care Plan.

12. **Hospital Care.** After 23 observation hours, charges will be considered under inpatient confinement.

13. **Human Leukocyte Antigen Testing.** Coverage for the cost for human leukocyte antigen testing (also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. Each participant is limited to one test per lifetime to be reimbursed at a cost no greater than $75.

14. **Implantable Device.** An invoice must be included and represent the actual cost (net amount, exclusive of rebates and discounts) for the implantable device. The maximum allowable under the Plan is 135% of the documented invoice amount.

    In the event the implant invoice is not obtained by the Plan, the plan will have the discretionary authority to apply for a Reasonable payment, the PPO discount and/or audit negotiation in place of the calculation based on the actual billing.

15. **Infertility**. Diagnosis and surgical correction of physical abnormalities.

16. **Lead Poisoning.** Testing for lead poisoning for pregnant women or for certain children, as provided in Mo. Rev. Stat. §§ 701.340, 701.342, 701.344.

17. **Mental Disorders and Substance Abuse.** Treatment when billed by a Physician (M.D.), licensed consulting psychologists (Ph.D.), or licensed consulting Master of Social Work (M.S.W.). Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

18. **Medical/Surgical Equipment Purchase or Rentals.** Rental costs cannot exceed the fair market value of the equipment.

19. **Newborn Hearing Screenings.** Newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.

20. **Nutritionists and dietitians.**

21. **Occupational / Physical Therapy.** Rendered by a licensed therapist. Therapy must be rehabilitative and result from an Injury or Sickness other than a learning or Mental Disorder.

22. **Oral Procedures:**

    - Facility and Anesthesia charges are covered, when recommended by a physician, and when incurred during a dental procedure by: (i) a child under age 5; (ii) an individual who is severely disabled; or (iii) an individual who has a medical condition.
    - Oral surgery for partially or completely unerupted impacted teeth, such as impacted wisdom tooth removal; or tooth without the extraction of the entire tooth (this does not include root canal therapy); or the gums and tissues of the mouth, when not performed in connection with the extraction or repair of teeth.
    - Excision of tumors and cysts;
    - Surgery needed to correct injuries;
    - Excision of benign bony growths;
    - External incision and drainage of cellulitis;
    - Incision of sensory sinuses, salivary glands or ducts; or
    - Temporomandibular joint syndrome (TMJ).

23. **Organ transplant**. When performed at a **designated center of excellence for transplants**. Contact your network Provider for a list of designated centers of excellence for transplants.

24. **Obtaining donor organs or tissues.** When the donor has medical coverage, his or her plan will pay first. Donor charges include those for:

    - Evaluating the organ or tissue;
    - Removing the organ or tissue from the donor; and
    - Transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

25. **Orthotic Appliances.** The initial purchase, fitting, and repair of non-foot orthotics when required for support of an injured or deformed body part.

26. **Phenylketonuria and Low Protein Modified Food Products.** Expenses for formula and low protein modified food products recommended by a physician for the treatment of phenylketonuria or any inherited disease of amino or organic acids, as long as the individual is under the age of 6 years.

27. **Pregnancy.** Routine Prenatal is covered as Preventive Care.

28. **Preventive and Wellness Care for Adults and Children**. In accordance with Federal Law, benefits are available for evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

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

    A list of Preventive and Wellness Services can be found at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations

29. **Private Duty Nursing Care.** Rendered by a licensed nurse (R.N., L.P.N. or L.V.N.) when care is not Custodial in nature, or when the hospital has no Intensive Care Unit or is filled.

30. **Prosthetic Devices.** The original and replacement purchase, fitting, and repair of devices which replace body parts.

31. **Reconstructive Surgery.** Non-cosmetic procedures, including mammoplasties.

32. **Skilled Nursing Facility.** Covered when:

    - The patient is confined as an inpatient in the facility;
    - The attending Physician certifies that confinement is needed; and
    - The attending Physician completes a treatment plan.

33. **Smoking Cessation.** To the extent required by law and when under the treatment of a Physician.

34. **Speech therapy**. Rendered by a licensed speech therapist and ordered by a Physician. Must follow a surgery, Injury, or Sickness, other than a learning or Mental Disorder.

35. **Surgeons Fees.**

- If bilateral or multiple surgical procedures are performed, 50% of the Usual and Customary Charge will be allowed for each additional procedure performed through the same incision. Any

unrelated procedure will be considered "incidental" and no benefits will be provided for such procedures. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits will not exceed the Usual and Customary Charge percentage allowed for that procedure; and

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary Charge allowance.

36. **Sterilization.** To the extent required by the Patient Protection and Affordable Care Act (PPACA).

37. **Wigs.** Non-cosmetic, for medically certified conditions.

Plan Exclusions

The following are excluded from Covered Expenses.

Note: Please see Prescription Drug Coverage for exclusions related to Prescriptions Drugs.

1. **Abortions.** Except to save the life of the mother, when caused by rape or incest, or the fetus has been diagnosed with a lethal abnormality.

2. **Alcohol.** Ordered evaluation or treatment which occurred as a result of the Plan Participant's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. This exclusion does not apply to the extent not permitted by Applicable Law or if the injury resulted from the victim of an act of domestic violence, or as a direct result of the Participant's mental or physical medical condition.

3. **Alternative Medicine/Therapies**. This includes acupuncture, acupressure, aromatherapy, biofeedback, kinetic therapy, hypnotherapy, homeopathic medicine; massage therapy, and neurofeedback, among others.

4. **Amniocentesis.** Services performed solely for the purpose of determining the gender or paternity of a fetus.

5. **Behavior Therapy Treatment.** Programs for the treatment of autism spectrum disorders unless explicitly required by Applicable Law.

6. **Blood Products.** Collection and/or storage of blood products to include stem cells or non-covered medical procedures. Salvage and storage of umbilical cord.

7. **Breast Implants.** Including replacement and removal of breast implants, except when required to be covered by the Women's Health and Cancer Rights Act.

8. **Communications and Accessibility Services.** Provider charges for interpretation, translation, accessibility or other special accommodations. Devices and computers to assist in communication and speech, including professional sign language or foreign language interpreter services.

9. **Complications of Non-Covered treatments.** Treatment required as a result of a complication from a non-covered service under the Plan.

10. **Cosmetic Surgery/Services.** Medical, surgical, and mental health services for or related to cosmetic surgery or procedures.

11. **Court or Police Ordered Services.** Examinations, reports, or appearances in connections with legal proceedings, including child custody, competency issues, parole and/or probation, and other court-ordered related issues.

12. **Custodial Care.** Non-medical assistance for activities of daily life, or maintenance.

13. **Oral Procedures**. The medical portion of the Plan covers only those oral procedures specifically stated in the section titled "Covered Medical Expenses."

14. **Educational evaluations or vocational testing.** Exams or other services for employment, insurance, licensure, judicial or administrative proceedings or research.

15. **Exercise.** Equipment, programs, clothing, or devices for treatment of any condition.

16. **Experimental or Investigational Treatment.**

17. **Eye care.** Eye Exercises, Orthoptic and Vision Therapy, Radial keratotomy, Lasik or other eye surgery to correct refractive disorders.

18. **Facility Charges.** Treatment provided at group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes.

19. **Foot care.** Unless related to diabetic care, treatment of weak, strained, flat, unstable or unbalanced feet, and treatment of corns, calluses or toenails. Shoes; shoe lifts; corrective shoes; foot orthotics; shoe inserts and arch supports.

20. **Foreign services.** Non-emergency related treatment outside of the U.S.

21. **Gender Reassignment.** Non-congenital transsexualism, gender dysphoria or sexual reassignment or change. Including medications, implants, hormone therapy, surgery, medical, or psychiatric treatment

22. * **Gender Reassignment – Cosmetic Procedures.** The following procedures that may be performed as a component of gender reassignment are considered cosmetic:

    - Rhinoplasty
    - Face lift
    - Lip enhancement
    - Facial bone reduction
    - Blepharoplasty
    - Liposuction
    - Reduction thyroid chondroplasty
    - Hair removal
    - Hair plugs or implants
    - Laryngoplasty
    - Skin resurfacing
    - Chin implant
    - Nose implant
    - Lip reduction
    - Any other procedure to enhance masculinization or feminization, beyond those considered Medically Necessary to achieve and support gender reassignment.

23. **Genetic Testing.** For a patient that is asymptomatic, unless otherwise precluded by applicable law

24. **Hair loss (cosmetic).** Treatment including wigs (non-medically necessary), hair transplants or any drug for hair growth.

25. **Hazardous Pursuit, Hobby or Activity.** Treatment that results from engaging in a hazardous pursuit of extreme sports or activity.

26. **Hearing Aids, Cochlear Implants, and Exams.** Services in connection with hearing aids, cochlear implants, or exams for their fitting or for hearing loss if not due to Illness or Injury.

27. **Home Maternity Services.** Deliveries at home including Doula and birth coach expenses.

28. **Hospital-based Infusion Therapy.** Intravenous-administered services provided in a Hospital-based setting. This Exclusion may be waived in cases of emergency, if it is medically necessary for the

member to receive infusion therapy in a hospital-based setting or if treatment provided in a hospital-based setting is obtained at a lower cost to the Plan.

29. **Illegal acts.** Resulting from a Serious Illegal Act, active participation in a riot or public disturbance. Including:

    - The use of illegal drugs, or
    - Use of medications not administered on the advice of a Physician.

    Notwithstanding the foregoing, this exclusion shall not apply if the injury in question occurred as the result of being the victim of an act of domestic violence, or if it occurred as the direct result of the Participant's mental or physical medical condition.

    For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence of a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed or result in a conviction.

30. **Impotence/Sexual Dysfunction.** Behavioral Treatment or medication regardless of the cause of the dysfunction.

31. **Infertility Treatment.** Infertility treatment which is not expressly included in the Schedule of Benefits.

32. **Maintenance Therapy.** Treatment after an individual has reached the maximum level of improvement.

33. **Malpractice**. Services required to treat injuries or illnesses including infections and complications that are contracted while under the care of a Provider that are not reasonably expected to occur. This includes but is not limited to: surgery on the wrong body part, foreign object left in the patient after surgery, electric shock, burn, or fall while confined in a facility.

34. **Medical Equipment.** Examples include, but are not limited to, the following:

    - Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
    - Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds, and oxygen tents;
    - More than one device designed to provide essentially the same function;
    - Deluxe, electric, model upgrades, specialized, customized or other non-standard equipment;
    - Scooters and other power operated vehicles;
    - Warning devices, stethoscopes, blood pressure cuffs;
    - Repair, replacement or routine maintenance of equipment or parts due to misuse or abuse;
    - Over-the-counter braces and other devices, prophylactic braces; braces used primarily for sports activities;
    - Replacement of braces of the leg, arm, back, neck, or artificial arms or legs;
    - Communication devices (speech generating devices) and/or training to use such devices;
    - Bionic and hydraulic devices;
    - Oxygen when services are outside of the Service Area and non-emergent or urgent, or when used for convenience;
    - Personal comfort items such as compression stockings and Transcutaneous Electrical Nerve Stimulation (TENS) units.

35. **Non-Compliance.** Additional or noneffective treatment that is the result of noncompliance or against medical advice from a Hospital, Mental Health or Substance Abuse Facility, to the extent permitted by Applicable Law.

36. **Non-Emergency Ambulance Services/ Hospital Admissions.** Non-emergency ambulance services and/or non-emergency hospital admissions unless pre-certified and/or expressly covered under the Schedule of Benefits.

37. **Nutrition.** Infant formulas or other internal supplementation.

38. **Obesity.** Treatment for weight loss, dietary control, or Morbid Obesity except to the extent required by Applicable Law. Bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.

39. **Occupational Services.** Charges that arise from work for wage or profit, including self-employment.

40. **Over-the-Counter Medical Supplies and Medications.** Over-the-counter medical supplies and medications except to the extent required by Applicable Law.

41. **Physical and Psychiatric Exams.** Testing and/or other services in connection with obtaining or maintaining employment, school or camp attendance or insurance qualification, or any type of license or medical research.

42. **Private Duty Nursing.** Charges for outpatient private duty nursing care, treatment or services.

43. **Rehabilitation/Habilitative Services.** Maintenance and/or non-Acute therapies; or therapies where a significant and measurable improvement of a condition cannot be expected in a Reasonable and predictable period of time.

44. **Self-Inflicted Deliberate Injury.** Unless resulting from being the victim of an act of domestic violence or a medical condition (including both physical and mental health conditions).

45. **Surrogate Mother Pregnancies.** Surrogate mother pregnancies are excluded unless the surrogate mother is a Plan Participant, then the Plan will cover preventative care services only, as required by Applicable Law.

46. **Temporomandibular Joint Disorder**

    - Dental splints, dental prosthesis or any treatment on or to the teeth, gums, or jaws;
    - Treatment of pain or infection due to a dental cause, surgical correction of malocclusion, maxilla facial orthognathic and prognathic surgery, orthodontia treatment.

47. **Transportation, Travel or Accommodations.**

48. **War and Riots.** Expenses caused by or arising out of riots, insurrection, rebellion, armed invasion, or aggression.

Defined Terms

These terms have significant meaning and when used in this Plan Document will be capitalized.

1. **Adverse Benefit Determination.** A failure to provide or make payment (in whole or in part) for a benefit. This includes, but is not limited to: denials, reduction, termination, or rescission.

2. **Allowable Expenses.** The dollar amount considered payment in full by an insurance plan. The allowable charge is a discounted rate rather than the actual charge.

3. **Approved Clinical Trial**. means 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 Participant 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.

4. **Center of Excellence.** Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the best outcomes in performing transplant procedures and the best survival rates. The Plan Administrator or its delegate shall determine what network Centers of Excellence are to be used.

5. **Child.** Employee's own blood descendant of the first degree, a stepchild, lawfully adopted Child, or a Child placed with a covered Employee in anticipation of legal adoption, and/or a covered Employee's Child who is an alternate recipient under a "Qualified Medical Child Support Order" required by law.

6. **Chiropractic Services.** Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

7. **Claim**. A detailed invoice that you or your healthcare Provider sends to your health plan. This invoice shows the services you received**.**

8. **COBRA.** The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

9. **Covered Expense.** A service or treatment which is eligible for coverage in this Plan.

10. **Custodial Care.** Services that are rendered for assistance in daily living that can be provided safely and reasonably by individuals who are neither skilled nor licensed medical personnel.

11. **Dependent.** A non-Employee who is eligible for coverage under the Eligibility section of the Plan.

12. **Emergency.** A serious, unexpected, or dangerous situation requiring immediate medical attention.

13. **Employee.** A person who is employed by the Plan Sponsor and eligible for coverage.

14. **Effective Date**. The first day of coverage.

15. **ERISA**. The Employee Retirement Income Security Act of 1974, as amended.

16. **Errors.** Charges based on billing mistakes, improprieties, or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible, or improper based on any applicable law, regulation, rule, or professional standard. It is in the Plan Administrator's sole discretion to determine what constitutes an error under the terms of this Plan.

17. **Experimental and/or Investigational.** Services or treatments that are not United States Food and Drug Administration (FDA) approved. Services or treatments which are not widely used or accepted by most practitioners or lack credible evidence, and that are not the subject of, or related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment.

18. **Family.** The covered Employee and the Dependents who are covered under the Plan.

19. **FMLA.** Family and Medical Leave Act of 1993, as amended.

20. **FMLA Leave** is a leave of absence, which the Employer is required to extend to an Employee under FMLA.

21. **Formulary.** A list of covered prescription medications compiled by the Pharmacy Benefit Manager.

22. **Generic Drug**. A Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration.

23. **GINA**. The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of Genetic Information.

24. **HIPAA**. The Health Insurance Portability and Accountability Act of 1996, as amended.

25. **Home Health Care Agency.** An organization whose main function is to provide Home Health Care Services and Supplies; The agency must be federally certified and licensed by the state in which it is operating.

26. **Home Health Care Plan**. A formal written plan made by the patient's attending Physician; which states the diagnosis and specifies the type and extent of Home Health Care required.

27. **Home Health Care Services and Supplies.** Part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

28. **Hospice Care Plan**. A plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

29. **Hospice Care Services and Supplies.** Those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, and home care. See the Schedule of Benefits to determine whether this includes family counseling during the bereavement period.

30. **Hospital.** An institution which is engaged primarily in providing medical care is accredited as a Hospital by The Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program or is approved by Medicare as a Hospital. The definition of "Hospital" shall be expanded to include the following: A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

31. **Illness.** A bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

32. **Incurred**. A Covered Expense is "Incurred" on the date the service is rendered, or the supply is obtained.

33. **Infertility.** Incapable of producing offspring.

34. **Injury.** A physical Injury to the body caused by unexpected or external means.

35. **Intensive Care Unit.** A department of a hospital of which patients who are dangerously ill are kept under constant observation.

36. **Legal Guardian.** A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual.

37. **Maximum Allowable Charge.** The benefit payable for a Covered Expense item in the Plan.

    Note: The Plan Administrator has the discretionary authority to decide if a charge is Reasonable, Usual and Customary and Medically Necessary. The Plan will reimburse out-of-network charges at the billed rate if it is less than the Reasonable amount. The Maximum Allowable Charge will not include any billing mistakes including, up-coding, duplicate charges and services not performed.

    If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

    When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

    With respect to non-contracted emergency services, the Maximum Allowable Charge will be an amount equal to the greatest of the following three amounts, as applicable:

- The median of the amount negotiated with contracted Providers for emergency services without regard to copayments and coinsurance (if no per-service amount is negotiated, this amount is disregarded);
- The amount the plan generally pays for out-of-network services, such as usual, customary and reasonable (UCR) amount, but without regard to in-network copayments or coinsurance and without reduction for the plan's usual cost-sharing generally applicable to out-of-network services; or
- The amount that would be paid under Medicare Parts A and B, without regard to copayments and coinsurance.

38. **Medical Care Necessity**, **Medically Necessary**, **Medical Necessity.** Health care services ordered by a licensed Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition. To be considered Medically Necessary, the services:

    (1) Must not be maintenance therapy or maintenance treatment;
    (2) Purpose must be to restore health;
    (3) Must not be primarily custodial in nature; and
    (4) Must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).

    The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

    For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Plan Participant is receiving or the severity of the Plan Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

    To be Medically Necessary, all these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the FDA and other medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

39. **Medical Equipment.** Equipment and supplies ordered by a healthcare Provider for everyday or extended use.

40. **Medicare**. The Health Insurance for the Aged and Disabled under Title XVIII of the Social Security Act, as amended.

41. **Mental Disorder.** A disease or condition is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human

Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

42. **Morbid Obesity.** A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the Plan Participant.

43. **No-Fault Coverage.** The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

44. **Open Enrollment**. The yearly period when employees can enroll in benefits.

45. **Outpatient Services.** Medical procedures or tests that can be done in a medical center without an overnight stay.

46. **Partial Hospitalization.** A structured program of outpatient psychiatric or substance abuse services. This treatment is provided during the day and does not require an overnight stay.

47. **Pharmacy.** An establishment where covered Prescription Drugs are filled and dispensed by a licensed pharmacist.

48. **Physician**. A Doctor of Medicine (M.D.), Osteopathy (D.O.), Podiatric Medicine (D.P.M.), Chiropractic (D.C.), Dental Surgery (D.D.S), or Optometry (O.D). Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Licensed Professional Occupational Therapist, Psychiatrist, Psychologist (Ph.D.), or Licensed Professional Speech Language Pathologist. All physicians must be practicing within the scope of their license.

49. **Plan.** COUNTY OF STODDARD MISSOURI Medical Plan, which is a group health plan for eligible Employees.

50. **Plan Participant.** An Employee or Dependent who is covered under this Plan.

51. **Plan Sponsor.** COUNTY OF STODDARD MISSOURI

52. **Provider**. A health professional who provides health care services.

53. **Prenatal.** Existing or occurring before birth.

54. **Prescription Drug.** A pharmaceutical drug that legally requires a medical prescription to be dispensed.

55. **Preventive Care**. Routine healthcare that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

56. **Reasonable** and/or **Reasonableness.** In the Plan 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 or its delegate.

    This determination will consider the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) the U.S. 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 it or its delegate. 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 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.

57. **Rehabilitative.** The process of helping a person who has suffered an Illness or Injury, restore lost skills and regain maximum self-sufficiency.

58. **Sickness.** A person's Illness, disease or Pregnancy (including complications).

59. **Skilled Nursing Facility.** A facility that fully meets all of these tests: (i) services are provided for compensation and under the full-time supervision of a Physician; (ii) provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse; (iii) maintains a complete medical record on each patient; (iv) has an effective utilization review plan; (v) has ability to store and dispense Prescription Drugs; and, (vi) is approved and licensed by Medicare. This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

60. **Special Enrollment Period**. A time outside the yearly Open Enrollment Period when you can enroll in benefits. You qualify for a Special Enrollment Period if you’ve had certain life qualifying events.

61. **Special Enrollment Rights.** A right granted by federal law to enroll in the Plan during a Special Enrollment Period.

62. **Spouse.** An individual who is lawfully married to an Employee under the law of the state where the Employee resides.

63. **Substance Abuse.** Any use of alcohol, any drug (whether obtained legally or illegally), 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 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 12-month period:

    - Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home
    - Recurrent substance use in situations in which it is physically hazardous
    - Craving or a strong desire or urge to use a substance;
    - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

64. **Substance Abuse Treatment Center.** A facility operating primarily for the treatment of Substance Abuse if it meets these tests: (i) maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; (ii) has a Physician in regular attendance; (iii) continuously provides 24-hour a day nursing service by a registered nurse (R.N.); (iv) has a full-time psychiatrist or psychologist on the staff; and (v) is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse. This Institution must be:

affiliated with a Hospital under a contractual agreement with an established system for patient referral; accredited as such a facility by The Joint Commission on Accreditation of Hospitals; or licensed, certified, or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

65. **Temporomandibular Joint (TMJ) Syndrome**. Jaw joint disorders, including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular joint.

66. **Unbundling.** Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

67. **Usual and Customary (U&C).** Covered Expenses which are identified by the Plan Administrator or its delegate, taking into consideration the fee(s) which the Provider most frequently charges 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 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 is 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 a person of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

    The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator or its delegate will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and 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, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Care Management Services

Care Management Services Phone Number: 844-671-4963

The Plan Participant or a family member must call to receive certification of certain Care Management Services.

UTILIZATION REVIEW

Utilization review is designed to help ensure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses. Utilization review criteria will be based on many sources, including medical policy and clinical guidelines. The Plan Administrator reserves the right to review and update these clinical coverage guidelines from time to time. Plan participants are entitled to ask for and receive, free of charge, reasonable access to any records concerning the Participant's request. If you have any questions about the utilization review process, the Plan, or clinical guidelines, you may call the phone number on the back of your membership card.

The program consists of:

- Precertification of Medical Necessity for certain non-Emergency services before services are provided;
- Continued stay/concurrent review of the listed services requested by the attending Physician during an ongoing stay in a facility or course of treatment; and
- Post-service review of the service, treatment or admission for a benefit coverage that is conducted after the service has been provided.

If a course of treatment or medical service is not certified, it means that the Plan may not pay in full for the charges. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Precertification

The utilization review program is set in motion by a telephone call from the Plan Participant or Provider. Initiate the review at **least 48 hours before** services are scheduled by calling the precertification phone number on the ID card with the following information:

- The name of the patient and relationship to the Employee, Subscriber number, and address.
- The name and telephone number of the Physician.
- The name of the Medical Facility, proposed admission date, and proposed length of stay.
- The diagnosis and/or type of surgery or treatment.

Find a list of services that commonly require Precertification at www.StoddardBenefits.com. For a list of services specific to the Plan that require Precertification, please call 844-671-4963.

Generally, utilization review for benefits will be conducted based on the timeframes listed below:

Type of Review	Timeframe Requirement for Decision	Timeframe Requirement for Notification
Emergency Service requiring immediate post evaluation or post-stabilization	Authorization decision will be provided within 60 minutes of received the request or such serves shall be deemed approved	The Plan will notify the Provider by telephone within 24 hours of the decision and notify the Participant or Participant representative and Provider by

Urgent Prior Authorization Review (non-Emergency service)	36 hours from the receipt of request, including 1 business day	written or electronic means within 2 business days of the approval decision or within 1 business day of the adverse determination.
Non-Urgent Prior Authorization Review	36 hours from the receipt of the request, including 1 business day	
Urgent Continued Stay/Concurrent Review	1 business day from the receipt of the request	For approval determination, the Plan will notify the Provider by telephone within 1 business day of the decision and notify the Participant or Participant's representative and Provider by written or electronic means within 1 business day of the telephonic notification. For adverse determination, the Plan will notify the provider by telephone within 24 hours of the decision and notify the Participant or the Participant's representative and the Provider by written or electronic means within 1 business day of the telephonic notification. The service will continue without Participant liability until the Participant has been notified of the determination.
Non-Urgent Continued Stay/Concurrent Review for Ongoing Outpatient Treatment	1 business day from the receipt of the request	
Post-Service Review	10 business days from the receipt of the request	The Plan will notify the Participant by written means of the determination within 10 business days of the determination.

If there is an **Emergency** admission to the Facility, the utilization review administrator must be contacted **within 48 hours** of the first business day after the admission.

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

Failure to pre-certify required service may result in denial of or reduction in payment for services.

Boost Your Baby- Maternity Management

If included in your Plan, Moms-to-be are identified, assisted, and followed by a Mommy Mentor to support a healthy Pregnancy. Those determined to be high risk are placed with a nurse in Care Management. All moms in Boost Your Baby are followed monthly and through six months post-delivery.

Alternative Care Plans

When a medical service at a specific place of service is not deemed medically necessary, the Plan reserves the right to limit coverage for the service to the amount that would apply from the more cost-effective location.

A care manager consults with the patient, the family, and the Physician to develop a plan of care. Once a plan has been implemented, the Plan will reimburse for expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Prescription Drug Coverage

Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. Contact your Pharmacy Benefit Manager ("PBM") for more information.

If a drug is purchased from a non-participating pharmacy or when the Plan Participant's ID card is not used, the total amount eligible for benefits will be the ingredient cost and the dispensing fee.

Prior Authorization

Certain prescription drugs require a Prior Authorization. This means a review of a medication prescribed will be done before the Plan will cover it. A prior authorization may be required for drugs listed or not listed on the PBM's formulary.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

1. **Appetite suppressants.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for Prenatal vitamins requiring a prescription, or prescription vitamin supplements containing fluoride.

2. **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.

3. **Experimental, Investigational, or non-FDA Approved.**

4. **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance. Human Growth Hormone except for children or adolescents who have one of the following conditions:
    - Documented growth hormone deficiency causing slow growth;
    - Documented growth hormone deficiency causing infantile hypoglycemia;
    - SHOX
    - Short stature and growth due to Turner syndrome, Prader-Willi syndrome, chronic renal insufficiency prior to transplantation, central nervous system tumor treated with radiation;
    - Documented growth hormone deficiency due to a hypothalamic or pituitary condition.

5. **Impotence.** A charge for impotence medication.

6. **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

7. **Inpatient medication.** A drug or medicine that is to be taken while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises. Instead, inpatient medication may be covered by the Plan's medical coverage.

8. **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

9. **Copay Assistance.** A charge for Prescription Drugs which may be properly received without charge under local, state, or federal programs.

10. **Off-Label drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

11. **No prescription.** A drug or medicine that can legally be bought without a written prescription.

12. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

How to Submit a Claim

In-network Providers will submit Claims to the Plan. When a Plan Participant has an out of network claim to submit for consideration, they must submit:

- Subscriber number
- Employee's name
- Patient's Name
- Name, address, tax ID, NPI, and telephone number of the Provider of care
- Type of services rendered, with diagnosis and procedure codes
- Date of service(s)
- Any receipt

Send information to HealthEZ:

Mail – PO Box 211186, Eagan, MN 55121
Email – claimsubmission@healthez.com

WHEN CLAIMS SHOULD BE FILED

Claims must be filed within 180 days of the date of service or they will be denied as untimely, unless tolled under the COVID-19 tolling rules. Benefits are applied based on the date of service.

If the Plan Participant is accessing the Cigna PPO network, the timely filing limit is 365 days of the date of service.

HealthEZ reserves the right to request more information from the Plan Participant or Provider.

TIMEFRAMES

The following timetable applies to post-service claims:	
Notification to Plan Participant of an adverse benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by the Plan Participant following notice of insufficient information	45 days
Review of Adverse Benefit Determination	60 days after benefit appeal
The following timetable applies to non-urgent pre-service claims:	
Notification to Plan Participant of a benefit determination	15 days
Notification to Plan Participant of failure to follow procedures	5 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by the Plan Participant following notice of insufficient information	45 days
Review of Adverse Benefit Determination	30 days after benefit appeal
The following timetable applies to urgent care claims:	

Notification to Plan Participant of a benefit determination	72 hours from receipt of a complete claim. If initial claim was incomplete, 48 hours after the earlier of: (1) date claimant provides requested information, or (2) end of the 48-hour period for claimant to provide the information.
Notification to Plan Participant of failure to follow procedures	24 hours from receipt of a claim
Notice of incomplete claim	24 hours
Time for claimant to provide requested information	48 hours
Review of Adverse Benefit Determination	72 hours
Deadline to notify claimant of determination on request to extend treatment involving urgent care (concurrent care)	24 hours after receipt of claim if claim made at least 24 hours prior to expiration of treatment
The following timetable applies to concurrent care claims:	
Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of recission	30 days
Notification of determination on Appeal of Claims involving urgent care	24 hours (provided claimant files appeal more than 24 hours prior to scheduled termination of course of treatment
Notification of Adverse Benefit Determination on Appeal for non-urgent claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for recission claims	30 days
Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal

EXPEDITED CLAIM REVIEW

If a Plan Participant's claim concerns a decision or action by the Plan that could significantly increase the risk to the Participant's life, health, or ability to regain maximum function, the claim may be made by phone or e-mail, rather than going through the mail, by calling 844-671-4963. Under an expedited claim, HealthEZ will notify the claimant orally within 72 hours after receipt of the expedited review request and will send written confirmation to the claimant within 3 working days.

APPEAL AND GRIEVANCE REVIEW PROCEDURES

A participant may file an appeal or grievance with HealthEZ. An "appeal" is a written complaint that involves any nonpayment of benefits (an Adverse Benefit Determination). A "grievance" is a written complaint about any of the following: the availability, delivery or quality of health care services (including a complaint regarding an adverse determination made pursuant to utilization review); claims payment, handling or reimbursement for health care services; or matters pertaining to the contractual relationship between the Participant and the Plan. A Participant will not be charged for filing an appeal or grievance and filing a grievance will not affect the Participant's benefits.

FIRST LEVEL APPEAL OR GRIEVANCE REVIEW

When a Plan Participant receives an Adverse Benefit Determination, the Plan Participant has 180 days following receipt of the notification in which to appeal the decision, unless a shorter timeline is prescribed by applicable law.

A standard appeal or grievance should be submitted to HealthEZ in writing and sent to:

HealthEZ
Attn: Appeals
7201 West 78th Street, Suite 100
Bloomington, MN 55439

The appeal or grievance should include any records or other information the claimant believes supports the appeal or grievance. HealthEZ will acknowledge receipt in writing of the appeal or grievance within 10 working days, unless it is resolved within that period of time.

HealthEZ will conduct a complete investigation of the appeal or grievance within 20 working days after receipt of it, unless the investigation cannot be completed within this time, in which case the claimant will be notified on or before the 20th working day of the specific reasons why additional time is needed and the investigation will be completed within 30 additional days.

The appeal or grievance will be reviewed by a person or committee who was not involved in the initial decision and does not report to, or is not subordinate to, the person involved in the initial decision. If the decision subject to review was based on medical judgment, then the review will include consultation with a health care professional who has training and experience in the appropriate medical field and who was not involved in the initial decision.

Within 5 working days after the investigation is completed, the person or committee tasked with reviewing the appeal or grievance will decide on the appropriate resolution and notify the claimant in writing of the decision and the right to file the appeal or grievance for second review. The notice will explain the resolution of the appeal or grievance in terms that are clear and specific. The person who submitted the appeal or grievance will be notified of the resolution within 15 working days after the investigation is completed.

SECOND LEVEL APPEAL OR GRIEVANCE

The claimant may submit any additional information, including written comments, records, or documents that the claimant wants HealthEZ to consider along with the initial letter of appeal or grievance to itemized.records@HealthEZ.com.

A second level appeal or grievance will be reviewed by the Plan Administrator within 20 working days after receipt, unless the investigation cannot be completed within this time, in which case the claimant will be notified on or before the 20th working day of the specific reasons why additional time is needed and the investigation will be completed within 30 additional days. A panel of other Participants and HealthEZ representatives who were not involved in either the initial decision or the first appeal will review the second level appeal.

If the decision subject to review is based on a medical judgement, and the panel makes a preliminary decision that the determination should be upheld, HealthEZ will submit the grievance for review to two independent clinical peers in the same or similar specialty who were not involved in either the initial decision or the first grievance. In the event that both independent reviews agree with the panel's preliminary decision, the panel's decision will stand. If both independent reviews disagree with the panel's preliminary decision, then the initial adverse determination will be overturned. If one of the two

independent reviewers disagrees with the panel's preliminary decision, the panel will reconvene and make a final decision.

Within 5 working days after the investigation is completed, the panel will decide upon the appropriate resolution of the appeal or grievance and will notify the claimant in writing, in terms that are clear and specific, of the panel's decision. If the appeal involved an adverse determination, HealthEZ will notify the claimant of the right to file a grievance with the director of the Missouri Department of Commerce and Insurance, including the toll-free telephone number and address of the director. The claimant will be notified of the resolution of the appeal or grievance within 15 working days after the investigation is completed.

At any time, a claimant may request free copies of all records and other information relevant to the written complaint, including the name of any health care professional consulted.

External Review Process

At any time, a claimant may request help from, or file an appeal with, the Missouri Department of Commerce and Insurance ("DCI"). The telephone number is 1-800-726-7390. The address is:

> Missouri Department of Commerce and Insurance
> Consumer Complaints
> P.O. Box 690
> Jefferson City, MO 65102

If a claimant files an appeal or grievance with the DCI and the appeal or grievance is not resolved after the DCI completes its consumer complaint process, then the DCI will refer the appeal or grievance to an independent review organization ("IRO"). Within 20 calendar days after receiving the appeal or grievance, the IRO will complete an external review and submit its opinion to the DCI. Within 25 calendar days of receiving the IRO's opinion, the DCI will notify the claimant of its decision, and it will be binding on the claimant and the Plan.

The claimant may request an expedited external review if the appeal or grievance involves emergency care (and the claimant has not yet been discharged from the hospital) or if a delay would jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function. If the claimant requests an expedited review, the IRO will submit its opinion to the DCI as expeditiously as possible; and the DCI will notify the claimant of its decision as expeditiously as possible, but not more than 72 hours after the IRO receives the request for an expedited review.

Deadline to Sue

A Plan Participant must commence any lawsuit under the Plan within 2 years after you knew or reasonably should have known of the facts behind your claim or, if earlier, within 6 months after the claims procedure is completed.

Venue

All litigation in any way related to the Plan (including but not limited to any and all claims brought under ERISA, such as claims for benefits and claims for breach of fiduciary duty) must be filed in the United States federal court siting in or otherwise having jurisdiction over where the Plan Sponsor maintains its principal place of business.

Recovery of Payments

Occasionally, benefits are paid in error. HealthEZ has the right to recover any erroneous payment directly from the entity or person who received it and/or from other payers and/or the Plan Participant on whose behalf the payment was made.

The Plan Administrator will have the sole discretion to choose who will repay an erroneous payment and whether such payment will be reimbursed in a lump sum. When an entity or person does not comply, the HealthEZ will have the authority to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable by the amount due.

Any payments made in accordance with the above provisions will be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against an entity to enforce the provisions of this Plan, then that entity or person will pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Payments to Providers and Assignment of Benefits

A Plan Participant's right to receive payment hereunder is personal to that Plan Participant and may not be assigned, alienated, sold, encumbered, or transferred, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or otherwise be liable for the debts or obligations of a Plan Participant, without the express written consent of the Plan. Unless otherwise prohibited by Applicable Law, the Plan will not accept an assignment of benefits to a Provider or facility for any reason, including, but not limited to, an assignment of:

- The benefits due under the Plan.
- The right to receive payments due under the Plan.
- Any claim you make for damages resulting from an alleged violation of the terms of the Plan, including, but not limited to, any alleged breach of fiduciary duties under ERISA.

For this section, "assignment of benefits" is defined as an arrangement whereby a Plan Participant attempts to assign its right to seek and receive payment of eligible Plan benefits, less deductible, co-payments and coinsurance amount, to a Provider.

Any direct payments made by the Plan to a Provider do not confer upon the Provider status as a beneficiary or grant the Provider any rights under the Plan or Applicable Law, including ERISA, and shall not be construed to be an assignment of benefits to the Provider. Any attempt to create such rights will not be recognized by the Plan, except as required by Applicable Law.

Coordination of Benefits

Coordination of benefits sets out rules for the order of payment when two or more plans are paying.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision will pay first.

2. Plans with a coordination provision will pay their benefits up to the Allowable Charge in this order:

    a. The benefits of the plan which covers the person directly ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

    b. The benefits of a plan which covers a person as an Active Employee are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

    c. The plan which covers a person as an Active Employee or a Dependent of an Employee is determined before those of a plan which covers the person as a beneficiary under Missouri continuation coverage laws.

    d. When a child's parents are married, these rules will apply:
        i. The plan of the parent whose birthday falls earlier in the calendar year is determined first.
        ii. If both parents have the same birthday, the plan which has covered the patient for the longer period is determined first.

    e. When a child's parents are divorced or legally separated, these rules will apply:
        i. When the parent with custody has not remarried, their plan will be considered first.
        ii. When the parent with custody has remarried, their plan will be considered first. The plan of the stepparent will be considered next. The plan of the parent without custody will be considered last.
        iii. A court decree state may overrule the above and state which parent is financially responsible for medical and dental benefits of the child.
        iv. For parents who were never married, the rules apply as set out above as long as paternity has been established.

    f. If there is still a conflict after these rules have been applied, the plan which has covered the patient for the longer time will be considered first. When there is a conflict in the coordination of benefit rules, this Plan will never pay more than 50% of allowable charges when paying secondary.

3. When the Plan Participant is covered by Medicare and Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B in compliance with the Medicare coordination of benefits rules.

4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first.

End-Stage Renal Disease. When an individual is covered under this Plan, this Plan will reimburse treatment for End-Stage Renal Disease (ESRD) as required by Applicable Law. For Plan Participant's

enrolled in Medicare, the coverage for ESRD or any other dialysis will continue for the initial 30 months at a rate not to exceed 135% of the Medicare allowable rate.

Subrogation

Payment Condition

1. The Plan may elect to conditionally advance payment of benefits in situations where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to No-Fault Coverage, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. The Plan Participant, their attorney, and/or the legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits. The Plan will have an equitable lien on any funds received by the Plan Participant and/or their attorney from any source and said funds shall be held in trust until the obligations under this provision are fully satisfied. The Plan Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant settles, recovers, or is reimbursed by any Coverage, they agree to reimburse the Plan for all benefits paid conditionally. If the Plan Participant fails to reimburse the Plan, they will be responsible for any expenses associated with the Plan's attempt to recover the money.

4. If there is more than one party that is responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties, of which the Plan Participant is only one, are considered as an "identifiable" fund from which the Plan may seek reimbursement.

Plan Participants assign the right to subrogate and pursue claims that may arise against any individual, entity, or coverage to the Plan Administrator or its delegate. If a Plan Participant receives benefits or becomes entitled to receive benefits, from any party causing their Sickness or Injury, an automatic equitable lien attaches in favor of the Plan to any claim the Plan Participant might have. The Plan may, at its discretion, in its own name or in the name of the Plan Participant, pursue such claims.

Assignment: If the Plan Participant fails to file a claim or pursue damages against a third party, they authorize the Plan to pursue such claims and will fully cooperate with the Plan to pursue a claim and the recovery of all expenses.

Right of Reimbursement

1. The Plan will be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan will have an equitable lien which supersedes all common law or statutory laws of any State prohibiting assignment of rights which interferes with the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs or litigation expenses, including expert's fees, may be deducted from the Plan's recovery. In addition, the Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant, whether under any doctrine in law.

3. These rights of subrogation and reimbursement do not require a separate written acknowledgment from Plan Participant and will not limit any other remedies of the Plan provided by law.

Separation of Funds

Benefits paid, funds recovered, and funds over which the Plan has an equitable lien exist separately from the estate of the Plan Participant. The Death of or filing of bankruptcy by the Plan Participant will not affect the Plan's lien or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event a wrongful death or survivor claim is asserted against a third party, the Plan's subrogation and reimbursement rights still apply.

Obligations

It is the Plan Participant's obligation:

- To fully cooperate with the Plan;
- To provide the Plan with pertinent information;
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- To promptly reimburse the Plan when a recovery or other payment is received; and
- To not settle or release any claim without the prior consent of the Plan.

Minor Status

In the event the Plan Participant is a minor, the minor's parents or guardian will cooperate in all actions by the Plan to seek and obtain requisite court approval to bind the minor and their estate insofar as these subrogation and reimbursement provisions are concerned. If the minor's parents or guardian fail to take such action, the Plan will have no obligation to advance payment of medical benefits on behalf of the minor and any court costs or legal fees associated with obtaining such approval will be paid by the minor's parents or guardian.

Offset

If Plan Participant or their attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant in an amount equivalent to what the Plan is owed.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and the Plan Document/SPD.

Responsibilities of Plan Administrator

PLAN ADMINISTRATOR. COUNTY OF STODDARD MISSOURI is the Plan Administrator. The Plan Administrator has legal discretionary authority to interpret the Plan and to decide disputes which may arise. The decisions of the Plan Administrator or its delegate will be final and binding on all interested parties.

The Plan pays for all expenses for plan administration. Legal proceedings may be initiated against the Plan once the appeals process has been exhausted.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

Funding is derived from the funds of the Plan Sponsor and contributions made by the covered Employees. HealthEZ facilitates benefit payments on behalf of the Plan.

CLERICAL ERROR. Any clerical error in making any changes in eligibility will not invalidate coverage or continue coverage validly terminated. In the case of clerical error, the Plan requires reimbursement for the overpayment.

AMENDING AND TERMINATING THE PLAN. If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination. The Plan Sponsor reserves the right, at any time and for any reason, to amend, suspend, or terminate the Plan.

SUMMARY OF MATERIAL MODIFICATION (SMM). A Summary of Material Modification reports changes in the Summary Plan Description.

The Plan Sponsor will notify all Plan Participants of any plan amendment considered a Summary of Material Modifications, no later than 210 days after the close of the Plan Year in which the changes became effective.

The Plan Sponsor will notify all Plan Participants of any plan amendment considered a material reduction, no later than 60 days after adoption.

If a Plan's Material Modifications are not reflected in the most recent Summary of Benefits and Coverage (SBC) then the Plan will provide written notice to Plan Participants at least 60 days before the effective date of the modification.

Important Notices

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

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

(i) All stages of reconstruction of the breast on which the mastectomy was performed;
(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
(iii) Prostheses; and
(iv) Treatment of physical complications of mastectomy, including lymphedemas.

These benefits are subject to the same deductibles and coinsurance as other procedures covered by the Plan.

GINA NOTICE

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), prohibits discrimination on the basis of Genetic Information. GINA expands on HIPAA in several ways:

- Group health plans and health insurers cannot base premiums on Genetic Information;
- Plans and insurers are prohibited from requesting or requiring an individual to undergo a genetic test; and
- Plans and insurers are prohibited from collecting Genetic Information (including family history) prior to or in connection with enrollment, or for underwriting purposes.

NOTICE OF RIGHTS UNDER THE MOTHERS & NEWBORNS HEALTH PROTECTION ACT

Under Federal law, group health plans offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan may pay for a shorter stay if the attending Provider (*e.g.,* your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan may not, under Federal law, require that a physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

MENTAL HEALTH PARITY

The Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), enforce parity between covered health care benefits and covered mental health and substance disorder benefits.

COMPLIANCE WITH HIPAA PRIVACY REQUIREMENTS

This Plan provides each Plan Participant with a separate Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. 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 the Plan's Notice of Privacy Practices are available by contacting the HIPAA Compliance Officer(s).

HIPAA Compliance Officer(s): Cecil Weeks, 573-568-3339

MICHELLE'S LAW NOTICE

Under a Federal law known as "Michelle's Law," the Plan cannot terminate coverage for a dependent child whose enrollment in a plan requires student status at a postsecondary educational institution, if the student status is lost because of a medically necessary leave of absence. In this situation, the Plan will continue the dependent's coverage until the earlier of: (a) the date that is one year after the first day of the medically necessary leave of absence or (b) the date on which the dependent's coverage would otherwise end under the Plan's terms. The dependent must provide written certification from the dependent's treating physician to the Plan.

NOTICE REGARDING COVERAGE FOR OBSTETRIC OR GYNECOLOGICAL CARE

You do not need prior authorization from the Plan or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

NOTICE REGARDING DESIGNATION OF PRIMARY CARE PROVIDERS

The Plan generally allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in your network and who is available to accept you and your family members.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

Please contact 844-671-4963 to request of a copy of the written procedures used by HealthEZ to determine QMCSOs.

MEDICARE PART D PRESCRIPTION DRUG CREDITABLE COVERAGE

If you or a covered dependent are eligible for prescription drug coverage under the Plan and are also eligible for Medicare, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the employer to provide you with an annual notice addressing whether the Plan's prescription drug coverage is creditable or non-creditable. You should receive the notice each year by October 15.

Creditable means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard prescription drug benefit under Medicare Part D will pay. You do not need to enroll in coverage under Medicare Part D if your coverage under the Plan is creditable.

If your coverage under the Plan is non-creditable, you may pay higher Medicare Part D premiums if you have a break in creditable coverage of 63 days or more and then enroll in Medicare Part D prescription drug coverage.

Additional information about your prescription drug coverage under the Plan is available in the notice that you receive. The notice is intended to help you decide between Medicare Part D prescription drug coverage and employer-provided coverage, if available. You can request a copy of the notice by contacting the Plan Administrator.

NO SURPRISES ACT

The No Surprises Act of the 2021 Consolidated Appropriations Act prohibits “surprise billing” or “balance billing” for: (1) emergency care at an out-of-network Hospital; (2) post-stabilization services provided in a Hospital following an emergency visit at an out-of-network Hospital: (3) care received from an out-of-network Provider while at an in-network Hospital or certain other facilities; or (4) air ambulance services from an out-of-network Provider. The Plan must cover emergency services without requiring prior authorization and must cover emergency services even if the services are provided by Providers who are outside of the Plan’s network. Any required cost sharing (co-pays, coinsurance, or deductibles) for emergency care received from an out-of-network Provider or facility must be the same as the cost sharing for emergency care received from a Provider or facility in the group health plan’s network.

MISSOURI UNANTICIPATED OUT-OF-NETWORK CARE LAW NOTICE

If a Participant receives emergency care from an out-of-network professional Provider at an in-network facility, the Participant’s out-of-pocket costs will be limited to the in-network cost-sharing amounts for services received from the time of the emergency admission until discharge from the in-network facility. Out-of-network professional Providers may not bill Participants for any difference between the Maximum Allowable Charge and the out-of-network Providers’ billed charges for the time the Participant was an inpatient at the in-network facility.

COVID-19 BENEFITS

Effective March 18, 2020, through the end of the national public health emergency, the Plan will cover 100% of the cost of:

- diagnostic testing for the detection of SARS-CoV-2 or the virus that causes COVID-19 (as long as such test is FDA-approved or otherwise required to be covered at no cost-sharing under Federal law), and the related Provider visit;
- health care items and services necessary for such testing (including the Provider visit) where such testing is ordered or administered; and
- items, services and the Provider visit where the participant is being evaluated for the need for such diagnostic testing and where such testing is ordered or administered or where the visit results in a COVID-19 diagnosis code.

Effective as of the date required by Federal law and through the date required by Federal law, the Plan will cover 100% of the cost for an item, service or immunization that (i) has an “A” or “B” rating from the United States Preventive Services Task Force and is intended to prevent or mitigate COVID-19, and (ii) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Effective January 15, 2022, coverage also is provided for over-the-counter COVID-19 diagnostic tests authorized, cleared, or approved by the FDA. The Plan will cover up to eight over-the-counter COVID-19 tests per covered individual per month.

COVID-19 TOLLING RULES

In response to the proclamation declaring that COVID-19 constitutes a public health emergency, federal agencies issued rules extending various deadlines. Under the guidance, the Outbreak Period is

disregarded when calculating (i) the Plan Administrator's deadline to notify you of the right to elect COBRA after a COBRA qualifying event; and (ii) an individual's deadline associated with the following:

- Requesting HIPAA special enrollment under the Plan
- Electing COBRA
- Making COBRA premium payments
- Notifying the Plan Administrator of a COBRA qualifying event
- Notifying the Plan Administrator of the Social Security Administration's determination of disability of you or another COBRA qualified beneficiary
- Filing a claim for benefits under the Plan
- Filing an appeal of an Adverse Benefit Determination under the Plan
- Filing a request for external review under the Plan
- Perfecting a request for external review upon a finding that the request was not complete

The Outbreak Period begins the date the individual or the Plan is first eligible for relief, but no earlier than March 1, 2020, and ends the earlier of: (a) one year from the date the individual or the Plan was eligible for relief or (b) 60 days after the announced end of the COVID-19 public health emergency. The Outbreak Period may not exceed one year.

For example, if a COBRA qualified beneficiary would have been required to make a COBRA election by March 1, 2021, then the deadline for making the election is delayed until the earlier of March 1, 2022, or 60 days after the end of the public health emergency.

General Plan Information & Establishment of the Plan

Name of Plan:	COUNTY OF STODDARD MISSOURI Medical Plan
Plan Sponsor:	COUNTY OF STODDARD MISSOURI PO Box 110, 401 S. Prairie St. Bloomfield, MO 63825
Plan Administrator (Named Fiduciary):	COUNTY OF STODDARD MISSOURI PO Box 110, 401 S. Prairie St. Bloomfield, MO 63825
Plan Sponsor EIN:	43-6003627
Source of Funding:	Self-Funded
Applicable Law:	Missouri
Plan Year:	01/01 – 12/31
Plan Number:	501
Plan Status:	Non-Grandfathered
Plan Type:	Group health plan providing medical and prescription drug benefits
Third-Party Claims Administrator:	America's TPA, LLC d/b/a HealthEZ P.O. Box 211186 Eagan, Minnesota 55121
Type of Administrator:	Contract administration
Agent for Service of Process:	COUNTY OF STODDARD MISSOURI PO Box 110, 401 S. Prairie St. Bloomfield, MO 63825

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this non-grandfathered Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

COUNTY OF STODDARD MISSOURI

By: [signature]

Name: Cecil Weeks

Title: County Clerk

Date: 12/22/2022